A REVIEW OF THE USE AND FUTURE OF

NGA KAIAKATANGA HAUORA MO AOTEAROA

HEALTH PROMOTION COMPETENCIES For AOTEAROA-NEW ZEALAND

A report to the Ministry of Health
from the
Health Promotion Forum
PO Box 99064
Newmarket

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Runanga whakapiki ake i te hauora o Aotearoa
Health Promotion Forum of New Zealand

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Summary

Review of the current health promotion competencies

1. The Health Promotion Forum was asked as part of its MOH contract to review the use and future of *Nga Kaiakatanga Hauora Mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand,* also referred to in this report as the health promotion competencies. The review also included assessing requirements for developing the health promotion competencies into national standards and possible pathways for that to occur if consultation confirmed such a need.

2. In gathering information for this review the Forum monitored developments in the health and tertiary education sector affecting health workforce development, health promotion practice and training. Feedback was obtained from the workforce through workshops, meetings, focus groups, a questionnaire and key informant interviews. Specific note was taken of the views of Maori and Pacific practitioners.

Use and perceptions of the competencies

3. *Nga Kaiakatanga Hauora Mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand* were developed through a two year consultative process with the workforce and were published and disseminated in May 2000. They contain seven knowledge clusters and nine skill clusters and a values and ethics statement.

4. Workforce feedback indicates the health promotion competencies are being used in several ways. These include in the areas of S*taff Development:* eg assistance with developing orientation programmes, appraisal tools; workforce development plans; job descriptions; staff training needs; informing development of issue specific competencies; S*trategic development*: eg supporting advocacy for health promotion; guiding organisational strategic development re human resources; helping understanding of health promotion and social change; framing of constitutional objectives; informing programme and project planning and development; S*taff recruitment and retention:* eg used for identifying skills and knowledge for positions; informing interview questions and referee checks; and used by recruitment agencies; *Training:* eg developing activities and guiding assignment plans for training programmes for Maori health promoters; informing curriculum/programme development, background reading and training needs assessment; *Quality Assurance*: eg framework for quality assurance programmes, developing research ethical guidelines and guiding evaluation processes and *Programme Development*: eg as a guide for programme planning and focus; identifying programme barriers and as a framework for programme review, debrief and reflective peer evaluation.

5. The health promotion competencies are used in varying degrees by public health units, public health related non-government organizations (NGOs), education/training

providers, Ministry of Health staff and self employed consultants. Feedback indicated staff in some organizations were not aware their organization used them, and more effort may be needed to encourage greater visibility and use. Approximately 2500 copies are in circulation and the relevant Health Promotion Forum web page has over 100 hits each month.

6. Generally, feedback suggests the health promotion competencies are seen to provide concrete evidence of the substance and breadth of health promotion, are a useful and informative tool and rate highly as a good benchmark of the knowledge and skills required in health promotion.

7. Concerns about them relate to lack of use and support for health promotion, especially by management and secondly around assessment and appraisal procedures.

8. The values and ethics section is considered to provide underpinning principles for health promotion practice and has been used for drawing up job descriptions, developing service codes of ethics, resource allocation and discussion on service plans. Suggestions for future development include giving greater consideration to identifying cultural values and ethics for Maori and other groups and more discussion and reflection by health promoters on their personal ethics, values and roles played in their work.

9. Suggestions for revision of the health promotion competencies document include some additions to knowledge and skill clusters, clarification of others and some more user-friendly formats. More development and discussion is necessary in the values and ethics section.

Perspectives of Maori health promoters

10. Consultation and other feedback indicates many Maori health promoters do not think *Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa/New Zealand* are relevant to the reality of Maori practice, particularly community-based workers in Maori specific work settings. The document is considered to strongly reflect Pakeha perspectives and does not adequately identify Maori values, ethics, skills and knowledge, approaches and models required to work for and with tangata whenua.

11. Suggestions were made that these should be identified by Maori through a culturally safe and sanctioned process and included as a separate section in the document.

12. It was considered important for Maori health promoters to have knowledge of the generic competencies and utilise them in terms of workforce development and skill building.

13. Only culturally acceptable assessment processes and adequately trained Maori should assess kaimahi Maori and Maori organisations working in health promotion.

14. While there was general support for the development of standards, it was thought this should be assessed through appropriate organisational accreditation and auditing processes. There was very little support for individual practitioner standards. There were strong concerns about the possible exclusion of kaimahi Maori if practitioner standards of practice are introduced.

15. Maori needed more access to training opportunities. A range of pathways and processes was required to support work aspirations. This should include recognition of existing knowledge, skills and experience for kaimahi who did not have formal qualifications.

Pacific workforce perspectives

16. Discussions amongst Pacific health promoters at the *Fono Malie Walking the Talk* held in February 2003 and other fono identified the need for: cultural competency to work with Pacific ethnic specific approaches; knowledge and skills in issues or topics (eg nutrition) thereby encouraging a multi-skilled approach; knowledge and skills in Pacific health promotion models and ensuring relevance to diverse socio-economic and cultural realities and experiences of Pacific peoples and their communities; and knowledge and skills in general health promotion.

17. A small critical mass in the workforce, increasing workloads as the Pacific population grows and danger of burn out for practitioners are some of the concerns raised by the Pacific workforce. Funding opportunities for the workforce to get together to share knowledge and skills, training for Pacific practitioners drawing on Pacific models, skills and knowledge as well as general health promotion and training of Pacific health promotion tutors are important.

Assessment of factors relating to developing standards in health promotion.

18. Work related standards are established to provide a benchmark of accepted skill, knowledge and practice expected of a person preforming a task. They apply to a person practicing in a profession eg a social worker, teacher, electrician, lab technician, or general practitioner. They are set to identify a commonly agreed level of performance, safety, knowledge or skill. The present health promotion competencies document is descriptive and could be developed into standards by the addition of measures.

19. In identifying ways forward to strengthen health promotion knowledge, skills, practice and outcomes, many interrelated contextual factors need to be taken into account. These include

- the status of and trends within the health promotion field and workforce
- trends and developments in health policy and infrastructure,
- organisational and management support for and competence in health promotion,
- opportunities and investment in health promotion training and qualifications,
- quality assurance trends and procedures.

20. Some of the trends influencing the development of the workforce include

- a steady increase in the number of Maori and Pacific organisations and practitioners in the field;
- more students and practitioners from related disciplines and sectors using health promotion concepts and components in their work and qualifications
- and more school leavers gaining health promotion and related degrees then looking for jobs.

21. Some of the broad health system trends that will impact on the capacity, delivery and standard of health promotion include

- more government emphasis on reducing inequalities in health,
- more emphasis on intersectoral cooperation to address the determinants of health,
- the development of Primary Health Organisations (PHOs) who are required to undertake some health promotion,
- the emergence of guidelines and other quality assurance measures.

22. Any move towards developing standards should be considered in the context of general trends and governmental policy and plans in health promotion practice, public health workforce development and health quality management. Standard development should not and in fact could not progress in the absence of attention being paid to these and other factors.

23. The aspirations of tangata whenua, the specific factors noted previously affecting the development of health promotion for Maori by Maori, as well as the contextual factors identified above must be considered in strategic development in this area.

Views of the workforce regarding health promotion standards

24. Consultation indicates many in the health promotion workforce believe it is important to have some standardisation of health promotion practice. Reasons include that it would help define health promotion practice, provide greater consistency, quality improvement and benchmarking in the field, give more recognition and understanding to health promotion as an important area of work and help career development, recruitment and retention. It was thought important that any development of standards be driven through the workforce rather than imposed or defined externally.

25. Concerns about developing standards included that there were not the numbers, structure, resources, capacity or vocational identification as a health promotion workforce to develop and monitor standards. There was also concern that having standards might mean some of the social justice, community driven, social change values and elements would not be incorporated and any trend towards professionalising health promotion risked workers without qualifications not being recognised and valued. These concerns need to be carefully considered.

26. Issues that were raised for consideration in developing standards included what is the definition of a health promoter; who would be required to meet the standards; what structure(s) and processes would be needed to develop, implement and monitor them; what would be the cost and timeframe; and what would be required to meet the needs of a workforce that is diverse in its qualifications, experience, and background and works with general population, Maori, and Pacific communities.

27. The consultation identified that health promotion needs to be more valued through financial and other investment from MoH, employing organisations, managers and practitioners into training and workforce development on the ground level. The development of standards needs to be accompanied by more opportunities for participation in formal training, supervision, mentoring, peer support and professional development through conferences, sabbaticals, internships, scholarships and placements.

28. This commitment needs to be expressed through;
- increased funding for both provision and uptake of opportunities
- organisational and operational support eg time to participate
- recognised career pathways and wage structures
- extra support and commitment is needed for culturally specific opportunities and culturally appropriate assessment procedures.

29. The development of standards would be an effective way to improve health promotion effectiveness and consistency. The best approach will be a mix of strategies to improve both individual practitioner standards and quality service delivery at an organisational level.

Which process and pathway to establish standards?

30. Theoretically there are several processes, which could be used to develop health promotion standards in Aotearoa-New Zealand. We believe the best approach will be a mix of strategies to improve both individual practitioner standards and quality service delivery at an organisational level. Standards should not be developed in isolation from training, assessment and monitoring opportunities and procedures. Developments within the broader public health sector regarding workforce requirements, training, competence and standards need to be considered as part of any efforts and discussions in strengthening health promotion.

31. People already working in health promotion would need mechanisms to ensure their skills and experience are recognised. Care must be taken to include grassroots community workers who may not have formal qualifications and to value their expertise. They need to be provided with culturally appropriate and safe opportunities to develop their skills and knowledge and have them recognised formally if they so choose. Grandparenting, mentoring and other mechanisms with culturally appropriate procedures would need to be explored.

32. One of the major issues to be grappled with is who constitutes a health promoter and whom would need to reach health promotion standards? Increasing attention on reducing inequalities in health, primary prevention and so on is contributing to an increased focus on health promotion. Many health promotion skills and knowledge are generic to other community development, social justice and social service areas of human endeavour. Health promotion related work is also conducted outside of the health sector, through local government for example or other agencies. Training and quality of delivery needs to be available for those who are employed as health promoters and those whose job includes some health promotion skills and knowledge.

33. There is also concern about possible implications for practitioners with combined clinical and health promotion roles. They may have other degree qualifications and belong to specific clinical based professional organisations. Presently there is no clarity about how these people might fit into any formal process that requires assessment of health promotion practice standards.

Pathways for individual practitioner standards

34. One option for the health promotion field is requiring a recognised entry level qualification. This is currently not required of people wanting to work as a health promoter; but required of people wishing to be a nurse, teacher and so on. However there has been no official educational or workforce driven desire or demand to establish this requirement, nor are there the training choices available to fulfil it.

35. Another option to develop standards in skills and knowledge is through the New Zealand Qualifications Framework, (NZQF) which provides nationally recognised, consistent unit standards and qualifications and recognition and credit for all learning of knowledge and skills. National standards are registered, which are then used by accredited training organisations and an industry based moderation system ensures national consistency.

36. This pathway might provide workforce qualifications through two mechanisms

- training for a national certificate, degree or diploma through a training establishment,
- and further down the track it is possible to develop a mechanism to assess health promoters in the workplace, undertaken by trained assessors experienced in health promotion. Workplace assessment is a method of validating the learning and experience of people who have not undergone formal training or qualifications. It provides a way into the qualification structure.

37. Any move to develop unit standards under the NZQA system needs to be preceded or accompanied by several things being in place;

- the establishment of an expert group in health promotion (mandated by the sector) to develop standards in conjunction with an Industry Training Organisation (ITO). Research shows that the most suitable ITO for health promotion is likely to be Te Kaiawhina Ahumahi which sets national standards of competence for the social services. It has a Tiriti and social change/social justice focus.

- financial investment to engage with the ITO, write the standards and establish assessment processes.

38. None of the present training courses are part of the NZQA system and all tertiary education providers have their own accreditation systems. There is no apparent benefit for them being involved in the NZQA system.

39.One way to support competent practice and standards is through an occupation developing a professional association. The establishment of a health promotion association with a range of roles could set minimum requirements and standards for workforce membership and write and develop standards in association with other agencies.

40. There are a range of possible ways an association might then promote standards eg
- criteria for membership might be linked to recognised qualifications and or training,
- future developments might include voluntary registration,
- endorsement and promotion of particular training courses both at entry level and for ongoing professional development,
- development of codes of practice and or ethics with supporting compliance and discipline procedures.

41. Most professional bodies are developed through considerable effort and voluntary commitment from the workforce. Health promotion is a relatively young field of work. It has not developed a vocational pathway that occupations in the medical and personal care arena have, such as nursing, physiotherapy or occupational therapy. The workforce has not clearly identified it wants to develop a professional association and begin the process of working for an occupation called health promotion. If the health promotion workforce followed that path, it may identify steps towards a clear occupational pathway. During consultations and exploration of this option there was no indication from the workforce that the commitment or capacity is available. There was some support for the Health Promotion Forum being funded and supported to take this role but this may not be appropriate.

42. Other options such as voluntary compliance with standards, or the Government requiring a profession of health promotion to become registered by statute are not practical long term or are very unlikely.

Pathways for organisational standards

43. Several accreditation mechanisms exist for organizations to reach standards of quality.
- For public health units, standards are included in the Public Health Service Standards, as part of the District Health Board accreditation system.

- For non-governmental organizations, Te Wana Quality Programme accreditation system, developed by Health Care Aotearoa (HCA) might be a suitable option. The

underpinnings of this programme are Te Tiriti o Waitangi, community governance and participation, collaborative teamwork, continuous quality improvement, health promotion and social justice. Initially for the primary care sector this programme is now extending into other health and social welfare fields.

44. Several Public Health providers already enrolled in the Te Wana Quality Programme are also members of the Health Promotion Forum.

45. Present organisation accreditation processes apply to service delivery standards and not to individual practitioner competence.

46. Generally accreditation requires the organisation to employ staff with the range of competencies required to fulfil its work appropriately. The employer is required to provide/access training opportunities, encourage staff to develop their skills and provide management support and understanding to enable staff to continually improve practice standards.

47. Auditing and implementation of health promotion competencies are harmful when carried out or assessed isolated from cultural process. Cultural auditing must be included alongside service development.

48. The Ministry of Health and other funders requiring organizations to demonstrate they have adequately trained and competent staff and meet quality control measures is a possible process to explore further in improving the quality of health promotion service delivery. Suggestions were made that the Ministry should require proof of organisations meeting health promotion standards as a prerequisite for contract funding.

49. One suggestion that has been made is that an advisory party be resourced to identify, and support further development of good health promotion practice. This advisory group could guide the development of a comprehensive strategic and action plan to strengthen the development of health promotion knowledge, skills and practice and progress the development of standards.

Recommendations

Preamble

The future development of competencies and associated initiatives will require funding for consultation and development work. It should be considered in conjunction with other workforce development needs. Some components should be started as soon as possible, others could be considered more medium or long term in development.

1. That a comprehensive strategic and action plan to strengthen the development of health promotion knowledge, skills and practice be developed in conjunction with other workforce development initiatives in public health.

2. The plan should consider
   - changing health promotion workforce trends such as PHO development needs, qualification and training opportunities
   - entry level training and qualification needs and opportunities for ongoing education and training
   - promotion of competencies, writing and implementing standards
   - long term professional development structures and resourcing of such.

3. The plan should be guided by an advisory group, developed through consultation and participation of representatives from Maori, mainstream, and Pacific health promoters, management, practitioners and training providers.

4. A working party/caucus of Maori health promotion practitioners be established to undertake a consultation with tangata whenua on the possible development of culturally appropriate and sanctioned competencies to reflect kaupapa Maori values, models, skills and knowledge requirements in health promotion and to also consult on any related matters identified by the working party. The working party must be properly resourced by the Ministry of Health to set their terms of reference and fulfil their work programme appropriately.

5. The development and dissemination of any workforce development related resources identified by the consultation and working party as necessary to support Maori health promotion be funded by the Ministry of Health.

6. Depending on the findings and recommendations of the above consultation, the document *Nga Kaiakatanga Hauora mo Aotearoa/ Health Promotion Competencies for Aotearoa-New Zealand* be revised as appropriate. This is likely to include a section relevant for Maori health promotion kaimahi/workers.

Nga Kaiakatanga Hauora mo Aotearoa/ Health Promotion Competencies for Aotearoa-New Zealand be revised, published and disseminated widely to health promotion practitioners, Public Health providers and primary health organisations.

7. That a collaborative and coordinated approach to support Pacific health promotion development be taken between MOH, DHBs, other providers and relevant educational organisations to ensure alignment on planning and implementation of initiatives and to avoid duplication of effort and use of resources.

8. That recommendations from the report of the 2003 'Fono Malie Walking the Talk,' including establishment of a national Pacific public health and health promotion network be supported through appropriate funding and other resources.

9. That Pacific health promoters be resourced to discuss their requirements re training, competencies and other needs regarding skill and knowledge development.

10. That initiatives currently being developed such as the national Pacific cultural competencies framework and health promotion approaches for supporting Pacific screening programmes are allocated resources to ensure effective training in and implementation of these.

11. Other formats to support easier access and use of the competencies be explored and developed. These may include web based files and discussion groups; examples or templates of job descriptions, appraisal procedures and so on. To increase the uptake, different versions of the document may be necessary for management and workforce.

12. A comprehensive survey be undertaken to identify and define the health promotion workforce including educational qualifications, relevant experience, career plans and structures, pay scales. Such a survey could provide a framework to start identifying the workforce.

13. That a working party be established to consult on and develop health promotion standards to support the development of minimum nationally consistent benchmarks for health promotion practice. Use of the standards will be initially voluntary.

14. That the health promotion sector in association with other appropriate parties begin the process of developing standards from the revised health promotion competencies, to include establishing the appropriate pathway writing of standards and development of appropriate training, assessment and monitoring procedures and promotion of standards.

15. That the heath promotion sector investigates the feasibility of setting up a health promotion association to support and strengthen the development of health promotion knowledge, skills and practice.

16. That organisational competence in health promotion delivery be encouraged through the use of accreditation processes such as Te Wana Quality Programme, DHB public health standards and other avenues.

17. That more emphasis be given to encouraging management level understanding and support for health promotion and development of skills and knowledge through workshops, seminars and other mechanisms.

Introduction

As part of its contract with the Ministry of Health on National Workforce Development and training, the Health Promotion Forum was asked to

- monitor the uptake and review the document *Nga Kaiakatanga Hauora mo Aotearoa: Health Promotion Competencies for Aotearoa-New Zealand*
- reassess the requirements for developing competency-based performance criteria into national standards and develop a process, structure and timeframes, including stakeholder involvement, for their implementation and monitoring.
- re-assess the need for the establishment of a standard setting body (SSB) for health promotion.

In undertaking this work, consultation with practitioners, employers, training providers, key stakeholders and decision makers in both education and health sectors was to take place, with particular note taken of the views of the Maori and Pacific workforces. Changes and developments in both the health and education sectors were to be monitored.

This report examines these three areas and discusses possible future directions in relation to health promotion competencies and standards.

These directions are interlinked to other workforce related developments that are already or will affect the health promotion sector and these factors are discussed as part of this report.

The report is divided into several sections.

Section One describes the methodology used to collect the data that has informed this report.

Section Two looks at the ways in which *Nga Kaiakatanga Hauora mo Aotearoa: Health Promotion Competencies for Aotearoa-New Zealand* is being used, and summarises suggestions for revision.

Section Three reports on the views of Maori and Pacific members of the workforce on the above and related topics around the future of the competencies, standards and related issues. Where relevant, information from this section is also included in other sections of the report.

Section Four examines some of the trends and factors that are or will affect health promotion and which should be taken into account in discussions about strengthening health promotion knowledge, skills and practice, including discussions around standards.

Section Five examines the views of members of the workforce around the future and the question of standard development.

Section Six looks at requirements for the workforce to develop skills and knowledge and possible mechanisms or pathways for writing and for developing standards.

Section Seven what the workforce would need to be able to meet the standards – possible training, qualification and assessment processes.

Section Eight looks at what health promotion standards might look like.

Section Nine summarises the key issues and recommendations for further action.

SECTION ONE

Methodology

Information for this report has been gathered from;

- monitoring and analysis of national and international official documents and other literature related to public health workforce training and developments,
- monitoring and analysis of developments concerning standards, quality mechanisms and professionalising of other health disciplines and public health providers,
- involvement in health promotion workforce related meetings, hui, fono and forums,
- interviews and discussions with key stakeholders, including; training providers, Te Wana Quality Programme, Public Health Leaders Group, Crown Public Health, Mid Central Region Workforce Development Group, several people in the Ministry of Health Public Health Directorate, and other health professional groups,
- focus groups conducted with Te Waipounamu Health Promotion Coalition, Auckland based health promotion practitioners, and senior Maori practitioners,
- feedback on a questionnaire on the use of the health promotion competencies,
- feedback from training workshops and conference sessions,
- compilation of anecdotal comments and other information received from the health promotion workforce since the release of the document in May 2000.

Detailed lists can be found in Appendix 3

A briefing paper called *The Future of Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aoteraroa-New Zealand* was written earlier in 2003 and feedback was sought from the workforce on it. This paper was circulated to all people involved with interviews and focus groups and was widely advertised as being available on the Health Promotion Forum web site. It provided background for all the consultations and informs sections of this report. This paper can be found on the Health Promotion Forum web site www.hpforum.org.nz

SECTION TWO

2 Workforce Use of Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa/New Zealand

This section examines the ways in which the health promotion workforce is using the health promotion competencies, feedback on how they are perceived, any concerns emerging about their use and suggestions for revision.

The goal of the document *Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand* is to support a competent and well-trained health promotion workforce throughout Aotearoa – New Zealand.

The aims of *Nga Kaiakatanga Hauora mo Aotearoa: Health Promotion Competencies for Aotearoa-New Zealand* are;

- to strengthen health promotion practice and training
- to provide a framework and description of the knowledge and skills needed for best practice
- to make the ethical basis of health promotion practice visible.

The health promotion competencies were sent out in their current form to the health promotion workforce in a bulk mailout of approximately 1800 in May 2000. Since then further copies have also been distributed to people on request, at conferences and workshops. A copy has been on the Forum's website. Approximately 2500 copies are now in circulation and the specific page on the web site has over 100 hits per month.

Feedback for this section of the report is compiled from feedback at workshops and discussions with providers, and the questionnaire on the use of the competencies sent out in December 2002 to the Forum's database. Although unfortunately the response rate was very low (only 37 returned), comments have been included to provide an indication of feedback. Most responses were from managers, co-ordinators or team leaders and health promotion advisers based in public health units or non-government organisations. A few responses were from lecturers or research analysts working in health promotion.
Most people responded to the questionnaire as an individual rather than on behalf of the organization.

Feedback from other sources is collected in archive files and is too detailed to be elaborated in this report. Most of it has been reported to the Ministry of Health through contract reports over the last four years. Broad themes of the earlier feedback are reflected in the responses from the questionnaires.

2.1 Uses

When the document was published in 2000 several anticipated uses were outlined. These included:

Quality improvement programmes - use in quality improvement programmes by bench-marking good practice.

Training courses - inform the development of training and qualifications.

Strategic development - to develop strategic human resource plans for teams, to map the team's competencies, to identify gaps and develop strategies to fill them.

Staff development - to illustrate what is expected of practitioners and to help identify training needs, and enabling workers to critically reflect on their practice.

Staff recruitment and selection – as a framework for developing job descriptions.

Feedback and information from the workforce through workshops, the review questionnaire, and other contact indicates the competency document has been used extensively in these and other ways.

Staff Development

- As reference material for professional development to reflect on and assess own work and as reference point for mentoring and supervision
- to benchmark professional progress
- to identify training needs of staff
- to develop training programmes/courses
- to promote discussion to ensure broad range of health promotion is discussed by staff
- to assist development of health promotion handbook for staff
- as core information to develop orientation programme, appraisal tool, workforce development plan, development of job descriptions
- to inform development of issue specific competencies, eg road safety coordinators
- to inform development of DHB public health unit competencies, eg Crown Public Health, Midlands, and Waikato.
- to identify current staff's skills and knowledge who may have non health promotion backgrounds

Strategic development

- to advocate for the role of health promotion and as a rationale for funding
- to guide organisational strategic development re skill, knowledge and staffing needs for human resource planning,
- to frame NGO constitutional objectives based on the values and ethics
- as a guide to support health promotion practice and ethics and to guide organisational strategic development and change and understanding of health promotion and social change

Quality Assurance

- as a framework for quality assurance programs
- to develop research ethical guidelines, and guide evaluation processes

- as a framework for organizational consistency
- to provide a bench mark of good practice

Staff recruitment and retention
- to guide staff recruitment, eg identify attributes, values and competencies in new staff, short-list criteria, interview questions, referee check questions, inform recruitment agencies
- to inform a background paper for collective wage bargaining, and progression criteria for salary scales
- to guide orientation programmes, identify start point for new workers and identify and match buddies
- to guide assessment for promotion

Training
- to develop activities and guide assignment plans for a Maori Health Promoter training programme
- as a guide and valuable check list to inform curriculum, programme and workshop development
- as a toolkit which describes health promotion
- as background reading for students
- as a tool to identify staff knowledge and skill gaps and training needs
- as a framework to learning steps

Programme development
- as an outline for programme planning and a guide for programme focus
- as a tool to identify programme barriers eg cultural and community
- as justification for media advocacy
- as a framework for programme review, and debrief and for reflective peer evaluation.
- to inform programme and project planning and development and to assess suitability of people and projects

International

The health promotion competencies have been used as a resource to inform the development of health promotion competencies in other countries. Communications and information were exchanged with people working on similar issues in USA, South Africa, Canada, and Australia.

During the development phase an article was published in the IUHPE journal March 2000. Several articles from Curtin University (Perth) have referred to the health promotion competencies and they have been mentioned in international list serves. The document has also been commended for the attempting to address health promotion and indigenous values which underpin practice in this country.

2.2 Uptake

Use of the competencies is voluntary. Feedback indicates it is being used in a range of public health organisations or by people working in public health such as public health units in District Health Boards (DHBs), non-government organizations (NGOs), Ministry of Health staff and self employed consultants. Staff at the Forum understand the document has been used extensively in the formation of workforce development plans and competencies for specific units, eg Community and Public Health in Christchurch, the Waikato public health unit and Midland's public health unit. Responses to a question in the questionnaire on 'did their organisation use the document?' indicated many respondents thought their organizations were not using the document, although in some cases Forum staff knew the particular organisation was using it. These responses indicate the competencies in such organizations are not a visible part of the organisation's system and that more effort needs to be made to encourage the document's use across all practitioner levels and in organisational planning and practice.

Reasons given for its non use by an organization included lack of management familiarity with the document, lack of understanding about and priority given to health promotion within the organization either at a higher level of decision making and management or within the specific unit. In addition, comments were made from people in supervisory or management positions who also had practitioner roles, that the daily practice demands of the job made it hard to find time for management processes around eg training needs that would draw on the competencies. One comment was that "delivery of programs takes up a lot of time and is the main focus. Competencies is an extra, but this does not mean it is not valued."

2.3 Usefulness of Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand

Questionnaire respondents rated the usefulness of the document on a scale of 1 (no use at all) to 10 (extremely useful). Four rated them a 10, five respondents rated the competencies a 9, ten rated them an 8 and four rated them as a 7. One respondent rated them a 4.

Comments on why respondents had given them a high score fell into three areas of appreciation.

Firstly they provided "concrete evidence of the substance of health promotion" and its breadth and conceptual basis. This was useful in clarifying what skills and knowledge were required in health promotion to non-health promoters, such as those whose training and skills were clinically or medically based.

The second area of appreciation concerned the document as a tool in its design, content and uses. Comments noted that it was informative, clear in language and format design, focused and well prepared. The knowledge and skill clusters were considered logical and easy to understand.

The format was easily adopted by organizations for their own staff use. Other points were made that it was very useful for critically reflecting on what competency criteria are needed to work in health promotion and for planning staffing and training needs.

The third area of appreciation was that the document helped to create a benchmark of health promotion knowledge and skills. Comments included: *"they help create a benchmark which will help us more effectively target areas of development and they give some indication of a national level of competence to measure yourself against." "They were a solid bench mark from which to start to plot professional progress." "They help lift the professional practice of health promotion." "They are very progressive and lead the way in public health."*

Some practitioners rated them highly or stated they were an excellent starting point but still thought further development is needed. Other comments referred to the difficulty of finding a common tool considering the diversity of practice throughout the country.

2.4 Concerns about their use

Questionnaire respondents were asked if they had any concerns about their use. Of those who responded to the question, most did not have any specific concerns. Of the remainder replies, there were two main areas of concern.

The first related to lack of use and valuing of the health promotion competencies. It was thought they needed more promotion, there should be more emphasis on health promotion training for staff and encouraging management to understand and value them.

The second area of concern was around appraisal and assessment procedures. Several respondents thought there needed to be more emphasis on identifying and training able assessors. One noted that in her experience of undertaking assessments, many good community health promoters undervalued their competencies. Some respondents thought the relationship between competencies, appraisals, and pay scales need to be considered more. There was comment that the competencies needed to be seen as a guide and adapted to individual or organizational experience and skills. Health promotion skills and the nature of it could change, so there is need for regular review. On the other hand, comments were also made that the competencies needed to be used in a standardised and consistent way to be of any real value.

In the 2000 training workshops on using the health promotion competencies, many concerns were raised that are still valid. These concerns were broadly grouped into management, assessment processes, cultural considerations and some general issues. The concerns are consistent with those raised in responses to the questionnaire. They are briefly listed in Appendix 2.

2.5 Values and Ethics

Comments from questionnaire respondents indicated the values and ethics statement in the document provided underpinning principles for health promotion practice. The statement had been used for drawing up job descriptions, for developing service codes of ethics, for presentations on health promotion, teaching health promotion ethics and for discussions with the Ministry of Health and other government agencies and policy makers on writing service plans around reducing inequities in health. One respondent noted they formed a checklist, both consciously and subconsciously, when decisions were made on resource allocation.

Comments were made about the relevance of the statement for Maori and other ethnic groups. A comment that summed this up was 'what would kaupapa Maori ones look like for Maori practitioners?' It was thought the current statement does not reflect te Tiriti o Waitangi or Maori values. It covered generic values and ethics but there were other things to consider in working with other ethnic groups.

Suggestions for further development included the need to give greater consideration to identifying cultural values and ethics for Maori and other groups. This section in the competencies needed further development.

Values and ethics were seen as a key component to health promotion. Respondents thought more discussion and reflection by health promoters was needed on their own personal ethics and values and the role they played in their work. One respondent noted that a "philosophical stance which recognises the positive health effects of 'being' in charge of one's life sits uneasily with a portioned and mechanistic detailed description of what someone promoting 'health' does. These concerns needed to be part of the debate. Opportunities to network and debate these issues and discuss the content of such documents as the competencies were appreciated.

Other suggestions for inclusion were:

- include respect for diversity of gender and sexual orientation
- importance of working in partnership with people and communities to address their needs
- recognition of inequality and a commitment to reducing disadvantage
- ensuring health promotion practice does not reinforce or perpetuate existing inequalities including power and gender inequalities.

Other information collected indicates this section of the competencies is possibly the least used.

2.6 Format

Most respondents liked the format finding it easy to read, simple and user friendly.
Suggestions for further development included a workbook for personal assessment and providing a computer format as well for easy use. The format that Mid-Central Public Health Unit use was mentioned as a practical and user friendly one. A section for assessors and managers on bringing the competencies into practice was also suggested.

Feedback from sources other than the questionnaire suggest that including graphics and colour might make the document more appropriate and acceptable for some of the people who are not using it at present. One focus group suggested that a range of formats might make it more relevant to and easier to access for different users. These may include web based files and discussion groups, examples or templates of job descriptions, appraisal procedures and so on.

2.7 Knowledge clusters

The seven knowledge clusters are:

One	Te Tiriti o Waitangi – *The Treaty of Waitangi*
Two	Nga Kanorau Tikanga i Aotearoa – *Cultural Diversity in Aotearoa-New Zealand*
Three	Nga Putaketanga me te Kunenga mai o te Whakapiki Hauora Puta noa i te Ao – *Origins and Evolution of Global Health Promotion*
Four	Te Aria o te Mahi Whakapiki Hauora – *Theory underpinning health promotion practice*
Five	Te Hauora o nga Tangata o Aotearoa – *The Health Status of New Zealanders*
Six	Nga Mohiotanga Totika – *Community and Political Awareness*
Seven	Te Rangahau, te Maheretanga me te Arotakenga – *Research, Planning and Evaluation*

The seven clusters of knowledge were generally considered to reflect what competent health promoters/organizations needed to know, according to most people who answered the questionnaire. There were suggestions for more emphasis on knowledge of cultural diversity including Pacific and Asian cultures, refugees and new migrants.

2.8 Skill Clusters

The nine skill clusters in the competencies are:

One	Te Mahi Tahi me Tiriti o Waitangi – *Working with te Tiriti o Waitangi*
Two	Te Maheretanga, te Whakatinanatanga me te Arotakenga – *Programme Planning, Implementation and Evaluation*

Three	Te Tautoko Awhina i te Akoako a etahi atu – *Contribute to the Learning of Others*
Four	Te Kanohi Tautoko ka Kitea – *Advocacy and Political Action*
Five	Te Whakawhitiwhiti Korero/Whakaaro – *Communication*
Six	Te Awhina Rapuara – *Facilitation*
Seven	Nga Mahi Rangahau – *Research*
Eight	Te Whakapakari Pukenga – *Professional Development*
Nine	Te Whakahaere Whakapiki Hauora – *Health Promotion Management*

These nine skill clusters were generally considered by most of the people who answered this question in the questionnaire, to reflect the skill areas needed in health promotion.

One respondent thought that areas such as 'facilitation', 'research', 'professional development', 'contribute to the learning of others' and 'programme planning' were areas that needed to have a cultural component. Working in these areas with ethnic communities would be "totally different to mainstream."

Other suggestions in knowledge and skill areas included ideas for new clusters and/or strengthening present clusters. When the competencies are revised, these suggestions need to be carefully considered alongside previous collated information and further consultation, eg the development of kaupapa Maori competencies is likely to influence the structure and placement of a number of these suggestions (see Section 3).

2.9 Levels

Performance criteria which identify elements for each of the knowledge and skill clusters, are divided into three performance levels in the document. These recognise learning gained through training and experience for someone of up to two years experience (Level One); two to five years experience (Level Two) and more than five years experience (Level Three). The document notes it is best to think of the levels as discrete and continuous and that most practitioners will overlap more than one level.

The three levels of performance criteria were considered by about half of the people who answered the questionnaire. Overall there seemed to be general acceptance that the levels provide a good base but comments ranged from "It's an excellent starting point" to "this whole emphasis repels me."

Several comments about the number of years that are suggested as a guide at each level indicate that the time frames are seen as too rigid eg *" I don't like the time span attached to levels. This denotes that everyone learns at the same rate and it is simply not the*

case." Reframing these guidelines to emphasise the flexibility that was intended will be needed when the competencies are revised.

Other comments provided detailed suggestions referring to specific clusters and levels within those clusters. Again this information will be valuable during the revision phase.

SECTION THREE

3.1 Summary of consultation with Maori health promotion practitioners.

Information on the views of Maori health promotion practitioners and other stakeholders on *Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand* and related matters has been gathered from consultations with training providers, Te Waipounamu Health Promotion Coalition Think Tank, Auckland Focus Group, Mid Central Workforce Development Group, and the Maori Focus Group. All participants were sent the Briefing Paper prior to the consultations. Feedback from various informal discussions throughout the history of the Competencies project has also been used including from the questionnaire.

Much of the recent feedback strengthens concerns raised in earlier reports to the MoH and reflects many of the issues arising from the 2001workshops. These centre around the fact that many Maori do not see the present competencies relevant to their mahi because the document strongly reflects Pakeha perspectives, not indigenous kaupapa and values.

There is also a perception that the processes revolving round competencies, standards and assessment procedures reflect Pakeha perspectives and ways of working, they do not reflect indigenous ways of working and values.

3.1.1 Common themes

- To be relevant for Maori, all processes and content development around competencies or standards must reflect indigenous values, skills, knowledge, models and ways of working that are appropriate to the reality of kaimahi Maori and their culture.

  Both content and processes must be sanctioned and guided by kaumatua and the Maori workforce.

- One theme centres around assessment processes for competencies or standards. Questions arise about the cultural appropriateness and level of understanding of assessors and or auditors.

  It is seen that only adequately trained Maori should assess kaimahi Maori and Maori organisations.

- There is some difficulty aligning individual practitioner assessment to the collective kaupapa that is integral to Maori practice. Support for organisational accreditation seems to be stronger than any preference for individual practitioner assessment.

- Many questions were raised about the lack of Maori values in mainstream management processes and how kaimahi Maori are required to fit into mainstream structures and management process, instead of managers and systems valuing what Maori means.

- The need for Maori specific health promotion training was often raised and there is an expectation that the MoH should resource appropriate training.

3.1.2 Perceptions of current health promotion competencies

There is recognition that it is important for Maori health promoters to have knowledge of the generic competencies and utilise them in terms of workforce development and skill building.

However there is a strong reflection that the current document and proposed process have little to do with the reality of Maori practice, particularly community-based workers in Maori specific work settings.

It was thought that the document *Nga Kaiakatanga Hauora Mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand* does not adequately identify Maori values, ethics, skills and knowledge, approaches and models required to work for and with tangata whenua.

Suggestions were made that these should be identified by Maori through a culturally safe and sanctioned process and included as a separate section in the document.

One proposal was to set up a properly resourced working group to carry this work forward. To make the new competencies relevant it will be essential to bring the Maori workforce on board. Kaumatua guidance, consultations lead by their own leaders for their own workforce, and a range of presentation styles were all identified as important factors.

Although a full consultation round is still required a lot of useful information was offered to make the current document more culturally appropriate and this is reported in Section Two.

3.1.3 Views on standards

Overall the need for health promotion standards is acknowledged and there is general support for the development of standards, but these should be assessed through organisational accreditation and auditing processes. There was very little support for individual practitioner standards.

There are strong concerns about the possible exclusion of kaimahi Maori if practitioner standards of practice are introduced. A professional body requiring certain membership criteria such as specific tertiary qualifications would exclude some people, especially those without qualifications and those who do not wish to pursue qualifications. Maori community workers must still be able to participate.

There are strong concerns about how cultural values will fit into any formalised process towards competency standards and assessment. Maori wish to see their own competencies and standards being used through culturally acceptable assessment processes. Both competencies and standards will need a stronger commitment to Maori issues and diversity.

Some suggestions for appropriate process include;

- the process needs to be flexible and might include a range of standards in both te reo Maori and English,
- the focus must be on the processes, at present it seems as if the focus is simply on meeting the criteria in the document *Nga Kaiakatanga Hauora Mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand*,
- values which encompass working collectively and accountability to whanau/hapu/iwi and community must be acknowledged and included in the process,
- peer review at conferences and hui where kaimahi Maori gather.

Appropriate practitioner competencies might become an integral part of organisational accreditation, ie as part of accreditation the organisation needs to provide necessary support for practitioners to be competent, in order for the organisation to have the knowledge and skills overall to do its work.

3.1.4 Organisational auditing and accreditation

Auditing and accreditation of organisations are seen as the most appropriate pathway to achieve competent health promotion practice. Accreditation recognises diversity in ways of working and values. It is part of ongoing quality improvement instead of a once off qualification for an organization.

The following concerns were raised about accreditation;

- Accreditation processes for organisations must include consultation with the practitioners on the ground in relation to appropriate and relevant criteria for accreditation.
- Auditing and implementation of health promotion competencies are harmful when carried out or assessed isolated from cultural process. Cultural auditing must be included alongside service development.
- There is a need for the Public Health Directorate in the Ministry of Health to develop a skilled Maori auditing workforce. Maori need to be measuring Maori by Maori standards.

- Maori practitioners feel their credibility and accountability is to their own communities not to Crown structures. But the present reality is that regulatory and contractual accountability is much stronger than Maori kaupapa and values.

3.1.5 Access to training and recognition of knowledge and experience

It was noted that many kaimahi do not have formal qualifications but have considerable knowledge, skill and experience. It was thought they should have the option of having this appropriately recognised and assessed to fulfil organisational and collective accountability and to support their own personal work related aspirations.

The need to support more access to training opportunities was raised. The cost of enrolling in a qualification was often expensive and it was difficult for many Maori to participate. This was both for young people wanting to get into a field of work or for people who had whanau to support.

Grand parenting was raised as one way of recognising prior experience and qualifications in meeting standards. Whatever path was followed to recognise this, criteria needed to be transparent, consistent and relevant for Maori. It was felt there needed to be a range of pathways and processes, re assessment and recognition of skills and knowledge, on the job training and formal qualification opportunities.

3.1.6 PHO sector and health promotion standards

A further concern that has been raised centres around perceived standards of health promotion that might be practiced by the newly developing PHO sector. The level of health promotion understanding and knowledge in this sector is unknown but believed to need greater depth.

Encouraging organisational accreditation was thought to be a constructive way of promoting improving practice in this sector.

Some suggested that meeting a set of Maori competencies or standards should be a requirement to be met by all DHBs and PHOs in order to obtain vote public health funds.

3.1.7 Vision for the Maori health promotion workforce

- The Maori health promotion workforce will be familiar with standards and competencies that reflect and value Maori approaches, skills, tools, models and values.
- Kaumatua will be involved and processes will be appropriately sanctioned.
- Auditing and assessment will be done by Maori auditors; using Maori standards, values and models to audit both Maori and mainstream organisations and will evaluate practitioners in their own ways of working.

- There will be opportunity to access appropriate training. Training will be supported (with putea and time,) available, appropriate and incremental. There will be a range of opportunities for qualifications but the need for qualification will be optional.
- There will be opportunities for Maori to be trained as trainers.
- Maori health promotion will be recognised as a specialist field with different ways of working and separate training.

3.2 Pacific workforce views on health promotion competencies

3.2.1 Views on workforce needs in relation to competency

Invitations to participate in the Auckland focus group on the review of the competencies unfortunately were not able to be taken up by invited Pacific practitioners and further consultation on the revision of the document will be required. One of the sources of information for views on Pacific health promotion workforce and health promotion competency issues was the Pacific health promotion fono ' Fono Malie Walking the Talk' held in Auckland in February 2003. The priority objective of the Fono was to Develop and Strengthen Pacific Public Health and Health Promotion. Outcomes sought from the Fono were agreement on:

- Establishment of a national Pacific public health and health promotion network
- What types of health promotion services are needed, how many, and where
- What workforce competencies are required and training available to support these
- Priorities for public health and health promotion research

HPF staff members attended part of the Fono as appropriate. One of the key areas of development the Fono discussed was defining Pacific health promotion, identifying components for cultural competencies and best practice, identifying workforce gaps, research priorities and approaches to national co-ordination.

Discussion at the Fono noted requirements for competency in working with Pacific communities included the need for

- Cultural competency to work with practitioners' own cultures (Pacific ethnic specific approach)
- Knowledge and skills in the issue or topic with which the practitioner worked, eg nutrition (encouraging a multi-skilled approach)
- Knowledge and skills in Pacific health promotion models and approaches (ensure relevance to diverse socio-economic and cultural realities and experiences of Pacific people and their communities)
- Knowledge and skills in general health promotion

The Pacific health promotion workforce also discussed the topic of cultural competencies and implications for practice at a Central Region Pacific Health Fono held by Capital and Coast District Health Board and Hutt Valley Health District Health Board in November 2002.

Issues identified in discussions included small critical mass in the workforce, increasing workloads as the Pacific population grows and danger of 'burn out' for practitioners.

- Funding of opportunities for the small Pacific workforce to get together and share skills and knowledge;
- Training for Pacific practitioners drawing on Pacific models, skills and knowledge as well as general health promotion.
- Training of Pacific health promotion tutors.
-

3.2.2 Developments regarding workforce competencies

Pacific cultural competencies have been developed for the areas of mental health and drug and alcohol treatment and may be resources for the development of health promotion related ones. The Ministry of Health is developing a national Pacific cultural competencies framework, currently in progress.

Goal 5 of the Pacific Health and Disability Action Plan (King, 2002) incudes objectives on developing a Pacific Workforce Plan, best practice guidelines for the Pacific health workforce and ensuring the mainstream workforce organizations support the development of the Pacific health workforce. Priority 4 in the Action Plan is on Pacific provider development and workforce development and also addresses this area. Priority 2 on Promoting Pacific healthy lifestyles and wellbeing also notes the need for a framework which includes appropriate competencies. The Health Workforce Advisory Committee noted the need for collaboration between the Ministries of Health and Education on Pacific workforce development (HWAC, 2003).

SECTION FOUR

4. Health system trends affecting health promotion

Decisions about what direction the field should take regarding standards need to take into account several trends that will have an impact on health promotion practice and the skills and knowledge required in the future.

These factors include the status of and trends in the health promotion field and workforce, government health policy, developments in public health workforce policy and programmes, and trends in risk management, quality assurance and assessment.

4.1 Status of and trends in health promotion and the workforce

Some of the trends influencing the development of the workforce include a steady increase in the number of Maori and Pacific organizations and practitioners in health system, the development of Primary Health Organisations leading to an increase in staff

needing health promotion skills and knowledge, more students and practitioners from related disciplines and sectors using health promotion concepts and components in their work and qualifications and more school leavers gaining health promotion and related degrees then looking for jobs. A benchmarking survey of health promotion and health protection officer work force in DHB public health services, conducted in May 2002 on behalf of the Public Health Leaders Group, noted difficulties in recruitment and retention of both health promotion and health protection staff (Pritchard and Simmons, 2002). The average turnover for health promoters in a two year period was 35%. Of resigning health promoters, over a third were reemployed by non-governmental organisations, particularly Maori development and provider organizations, so there is likely to be some redeployment within the sector. It recommended a closer investigation of the determinants of job satisfaction and retention for both groups.

The Public Health Directorate is conducting two public health sector stocktake surveys in 2004, firstly with managers of public health organisations contracting with the MOH and secondly with staff who work in the organizations. This should help provide more comprehensive information than has been available in the past about the status, trends and views of the workforce to help inform planning.

4.2 Government health policy directions

Government policy is putting greater emphasis in on reducing health costs and improving people's health and wellbeing through more resources into primary health care, health promotion and reducing inequalities in health. This puts more onus on the public health workforce to respond and deliver. Several strategic policy documents and ministerial directives released in the last three to four years seek a response from the health related workforce to addressing the determinants of health, intersectoral cooperation with local government and other agencies in developing, policy and environments supportive of health. These include; broad strategies such as the New Zealand Health Strategy, Primary Health Care Strategy, He Korowai Oranga, Whakataataka – Maori Health Action Plan; the Pacific Health and Disability Action Plan, Reducing Inequalities in Health; Achieving Health for All – A Framework for Public Health Action and specific issue or setting based strategies and action plans in the areas of mental health promotion, youth health, cancer control, education, primary health organizations, injury prevention, healthy eating, positive aging and others.

In Ottawa Charter terms this may be seen as "Reorientation of the Health Sector". These strategies identify the broad range of approaches incorporated in the Charter and acknowledge Maori models of health promotion such as Whare Tapa Wha and Te Pae Mahutonga. Te Tiriti o Waitangi has paramount relevance to health promotion in Aotearoa-New Zealand and putting it into operation is increasingly acknowledged in policy and through frameworks such as *TUHA-NZ: A Treaty Understanding of Hauora in Aotearoa-New Zealand* developed by the Health Promotion Forum in consultation with the sector in 2002. Health promoters of the future can expect to continue to need knowledge and skills relevant to and be practising in this broad strategic context.

4.3 Developments in Public Health Workforce Policy and Initiatives

In *The New Zealand Health Workforce - Stocktake of Issues and Capacity 2001*, the Health Workforce Advisory Committee (HWAC) noted the Government policy shift towards prevention and primary health raises questions about the competencies required to meet this new service direction and the selection and education of the future health workforce.

The *Stocktake* noted that:

'the public health workforce has suffered from a low profile over the last few years, yet a strong public health workforce is crucial to delivering the New Zealand Health Strategy. The development of Maori at all levels and across all workforce groups is essential to improving health outcomes for Maori and to meet Treaty of Waitangi obligations. The development of Pacific community health workers is seen as crucial to the development of an effective public health workforce." (2001, pp xvi).

New approaches to workforce planning in health are emerging. Some of these are more concerned with care delivery with a person-centred and patient-involved focus than a population approach, but they signal an emphasis on using interdisciplinary knowledge and skills. The models of care approach, as one example, no longer sees professions in isolation but gives consideration to all workforce groups. It is oriented towards competence and continuing skill and knowledge development and requires responsiveness on the part of the practitioner to the person needing health services.

The HWAC's report on future directions and recommendations to the Minister of Health suggests that *"the focus of the whole system must shift and become more firmly fixed on ….a person and community oriented approach…the population health approach, which considers the determinants of health, also placed demands on all health practitioners for the skills to deliver such an approach."(2003 pp 3)*

HWAC's recommendations to the Ministry fall into seven areas, including addressing health workforce implications of PHOs, to progress Maori health workforce development, to progress Pacific health workforce development and that DHBs actively promote the use of public health workers to deliver early intervention strategies and explicitly invest in components of workforce development (HWAC, 2003).

Currently the Public Health Directorate in the Ministry of Health is leading the development of a national plan for public health workforce development. The aim is to develop a planning framework that will guide the development of a strong and competent workforce able to meet the needs of the population. Preliminary investigations include a review of previous initiatives; a consultation about the needs of the Maori public health workforce, the needs of the Maori health protection workforce and the public health workforce needs of PHOs.

The greater emphasis on population health, primary health and health promotion will require more people working in those areas. A broad range of training and skills will be needed to do the work and meet social and health related outcomes. In the public health area, there is also growing specialisation i.e. people with particular career skills and training such as research, law, planning or environmental engineering to apply those skills to the public health field. Some will be core health promoters and others will need and use health promotion related skills and knowledge as part of their job.

These trends mean how workforce needs for skills and knowledge in health promotion are meet or are assessed may need different opportunities.

4.4 Trends in quality control, risk management and development of guidelines/standards of practice – implications for health promotion

World wide and nationally there is increasing attention being paid to risk management, quality control and associated assessment, monitoring, auditing and accreditation mechanisms. These trends are and will continue to impact on health promotion.

While many of the quality related initiatives currently focus on clinical practice they have started to move into primary and public health areas. Recently the Ministry of Health consulted on and published *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector*. It notes that poor quality consumes resources that could be used for more and/or better care at both an individual and a population level. Resources are consumed through waste, rework and avoidable escalation of issues at both the individual and population level. At the population level there is a cost in terms of forgone opportunities to reduce inequalities in health status between population groups. "In this sense, the inequalities in health status between Maori and Non-Maori are a quality issue."

The work of Quality Health New Zealand, the Guidelines Group and Te Wana Quality Programme, developed by HealthCare Aotearoa, are examples of quality related initiatives with relevance to health promotion.

Quality Health New Zealand

Quality New Zealand is New Zealand's national accreditation body for hospitals and other health and disability support services. It promotes, measures and recognises quality in the health sector through surveys and audits, recognises achievement through awarding accreditation status and other certificates of endorsement and achievement. A system of approved and trained peer surveyors work on organisational accreditation.

It has developed accreditation standards for Public Health Services which it says on its website at **www.qualityhealth.org.nz** are based on best international practice, legislative requirements and the government's priorities for health and its health strategies by incorporating

- A service continuum structure
- A focus on the integration or coordination and linkages of services

- A population health or wellness approach.

These standards are outcome focused, with mainly process based criteria. This is seen as the most effective way to develop and measure quality.

The Public Health Standards are part of the Acute Care Standards used by DHBs undertaking accreditation for health and disability services, and include promotion, prevention and protection services. They include standards on planning and population needs; access for the public; information; record keeping; service goals and linkages; quality control; human resource management which includes staff competence; policies and procedures; consultation with the community; needs assessment; management of the facilities and so on. They refer to Te Tiriti, Ottawa Charter and the Jakarta Declaration.

In the standards, professional staff are expected to demonstrate the maintenance of contemporary professional standards and practice. This might be through peer review, clinical supervision, participation in college programmes, graduate and post graduate study, membership of professional associations, attendance at seminars and conferences, research and literature reviews.

Another example of Quality Health's work, which may have a bearing on the health promotion field are the Primary Care standards. Maori health providers who are clients of Quality Health and who provide both health promotion and personal health services are directed to use these. Community health providers also use them. The Primary Care standards were due for revision in 2003 and will incorporate the recent policy directions in primary health. The development of PHOs and the requirement to include health promotion programmes in their work will have significant implications for health promotion training and practice.

Guidelines Group

The New Zealand Guidelines Group (www.nzgg.org.nz) was established by the National Health Committee in 1996 as an informal network of expertise and information on guideline development and implementation. Its primary purpose in establishing the NZGG was for training health and disability professionals and consumers in the development and implementation of evidence-based best practice guidelines. Some of its work in the prevention area includes the development of smoking cessation guidelines, which were put together by a multi-disciplinary team and advisory group. The advisory group included a number of people working in health promotion/public health. The guidelines have been endorsed by organisations including ASH, Smokefree Coalition, Apaarangi Tautoko Auahi Kore (ATAK) and the New Zealand Heart Foundation.

The work of these organizations has implications for health promotion, through the definition and development of accepted approaches, skills and tasks for health promotion. These should include determinants of health approach if inequalities and government

strategic policies and plans are to be met. This will impact on the knowledge and skills required by health promotion practitioners and health promotion organizations.

Te Wana Quality Programme

Te Wana Quality Programme (www.hca.org.nz) is an organisational standards model from Health Care Aotearoa, a national network of primary health care providers, who are not for profit, community-controlled, providing health care to low income, high need populations. However it is considered relevant to any community-based organization whose values align with it. Since late 2001 when it was launched more than 30 organisations have joined the programme, from marae and iwi services to national lobbying groups and local health centres.. The programme is a modular system that uses a review process so any participating group or agency can measure against a set of standards. The programme is based on an organisational learning model and focuses on self-review with the development of a Quality Plan for ongoing improvements. The underpinning values of Te Wana Quality Programme are:

- Te Tiriti o Waitangi,
- Community governance and participation,
- Collaborative team work,
- Continuous quality improvement,
- Health promotion,
- Social justice.

Te Tiriti o Waitangi standard is written in two perspectives – Maori and Tau Iwi. Services choose which of these perspectives they wish to use, they do not do both perspectives. The Te Wana Quality Programme is the Aotearoa part of the Australian Quality Improvement Council Programme. It emerged from the Community and Health Accreditation and Standards Programme known as CHASP.

These developments and trends in quality control mean more attention will be paid to the competence and quality of delivery of services in health promotion and in other sectors of the health system. Health promotion will not be able to opt out and nor is this desirable. However it is important that a robust discussion occurs to protect the values and approaches of health promotion in what is a health system dominated by a medical care based philosophy and training.

In the light of these external developments and trends, the health promotion sector needs to be engaged in these processes and opportunities, using such resources as *Nga Kaiakatanga mo Hauora o Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand*, TUHA-NZ and Te Pae Mähutonga to support good health promotion development, training and practice in whatever context. Engagement will lessen the possibility that health promotion will become predominantly shaped by individualistic behavioural change models.

SECTION FIVE

5. Development of *Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand* into standards: Workforce views

5.1 Introduction

This section examines the questions and views around what happens now to strengthen health promotion skills and knowledge. What are some of the requirements and possible future pathways for health promotion skill and knowledge development? The Ministry has asked for a reassessment on the question should the next step be to develop the revised *Nga Kaiakatanga Hauora mo Aotearoa: Health Promotion Competencies for Aotearoa-New Zealand* into standards?

- What does the workforce think?
- What might standards in health promotion look like?
- What might be processes and steps involved?
- What risks might there be?
- How might Maori health promoters be affected?

Views have been sought through focus groups, meetings, questionnaire and key informants on whether or not the development of standards in health promotion would be an appropriate strategy. Overall, there is support for developing standards, but several issues were identified which need to be considered.

5.2 Relationship between occupational/professional competencies and work standards

In *Nga Kaiakatanga Hauora mo Aotearoa/Health Promotion Competencies for Aotearoa-New Zealand*, competency is taken to mean "a combination of attributes that enable an individual to perform a set of tasks to an appropriate standard. These attributes have been interpreted as including not only knowledge and skills but also the values and beliefs, which shape health promotion practice."

Competence was defined in a 1996 UK government review of vocational qualifications as

> "The ability to apply knowledge, understanding and skills in performing to the standards required in employment. This includes solving problems and meeting changing demand." (cited on Skills for Health website www.skillsforhealth.org.uk at the following page: http://195.10.235.25/cms.php?page=standards_quals)

Work related standards are established to provide a benchmark of accepted skill, knowledge and practice expected of a person preforming a task. They apply to a person

practicing in a profession eg a social worker, teacher, electrician, lab technician, or general practitioner.

They are set to identify a commonly agreed level of performance, safety, knowledge or skill.

The relationship between competencies and standards is that competencies refer to the ability to apply knowledge, understanding, practical and thinking skills to preform effectively (maybe to an occupational standard), and an occupational standard describes good practice. It is a statement of what someone is expected to achieve at work. It is developed by representatives of the occupational area.

As an example, the United Kingdom's National Occupational Standards were developed to describe performance – what people are expected to do at work. They state from the perspective of employers, workers, regulatory bodies and government interests, the quality of service expected. These standards describe what needs to happen in a workplace – not what professional standard people perform to. They are a source of information to help people make informed decisions about:

- The demands of employment
- Good practice in employment
- The coverage and focus of services

The website of the Skills for Health organization in the UK www.skillsforhealth.org.uk states:

> "National occupational standards can help establish the link between the aims and objectives of an organization and what individuals need to be able to achieve. Consequently, national occupational standards are of use in the design of education and training and in the design of qualifications. National occupational standards can also be used in the management and development of organizations and individuals, for job design, recruitment, individual and team development, career planning and appraisal."
>
> National occupational standards can be used by:
>
> - individuals to help them develop their own knowledge and skills and improve their own performance and to gain credit for their achievements
>
> - people who offer education and training through identifying individuals' learning needs, defining the learning outcomes which individuals need to achieve and acting as the basis of qualifications
>
> - workers and agencies to improve the quality of the services they offer."

Standards are developed for several reasons. These include but are not limited to;

- protecting people and communities from bad practice
- defining boundaries around who may be eligible to work with or practice a particular occupation
- measuring consistency of practice
- providing a baseline for career pathways
- setting minimum standards for training quality
- providing a reference point for funders.

The current health promotion competencies are descriptive and could be developed in standards by the addition of measures. Any move towards developing standards in health promotion in Aotearoa-New Zealand must be considered in the context of general trends in health promotion practice, in workforce development issues and in health quality management. Standard development should not and in fact could not progress in the absence of attention being paid to these and other factors.

5.3 Views from the health promotion workforce about standards

Views about the future of the health promotion competencies and whether or not they should be developed into standards have been expressed in a range of meetings, workshops hui and focus groups over the past eighteen months. Information also comes from responses to the review questionnaire and other documents. The sources include:

- Workshop at Health Promotion Forum Conference April, 2002, Christchurch
- A Perspectives on Health Promotion Northern Meeting 'Health Promotion Centre Stage – coming ready or not"
- Te Waipounamu Health Promotion Coalition regional hui in Dunedin and Nelson October and November 2002
- Mid Central workforce development hui December 2002
- Competencies review questionnaires on the use of the health promotion competencies (Dec 2002)
- Workforce Development Proposal Public Health Leaders Group, Feb 2003
- Focus groups with health promoters in Auckland and with Te Waipounamu Health Promotion Coalition
- Focus group with Maori health promoters June 2003
- Interviews with key informants including training providers.

Consultation indicates many in the health promotion workforce believe it is important to have some standardisation of health promotion practice. Reasons include providing consistency and benchmarking and giving more recognition to health promotion as an important area of work. It was thought important that any development of standards be driven through the workforce rather than imposed or defined externally.

Several issues have been raised by members of the health promotion workforce in discussing the future of the competencies and the question of standards. These include a number of challenges facing the workforce identified by Faye Ryan in a presentation at the HPF conference in 2002 (Ryan 2002):

- proliferation of new practitioner organisations doing health promotion with little or no knowledge of theory and practice
- high expectation of health promotion to deliver results
- high expectation of the health promotion workforce to be able to do the work
- current health promotion sector is fluid, disorganised and with no shared sector standards of practice that are visible and easily accessible
- no identity or organised ability to protect definitions of health promotion best practice and standards
- new era could see large new practitioner organisations redefine health promotion practice to meet own needs.

This latter point is relevant to concerns about the level of understanding about health promotion and standard of health promotion practice in PHOs. Risk management mechanisms Ryan identified include:

- strong shared decision-making agreement between MOH and DHBs for public health
- well thought out and resourced strategic and action plan for public health
- adoption of nationally applied and audited standards of health promotion practice that will inform and drive, not only existing health promotion activity but also PHO activity.

Ryan suggests the way to manage these risks is through the development of a national association of health promotion. The full text of her presentation is in Appendix 1.

A remit from the workshop at which Faye Ryan gave her paper put forward the following statement:

1. Action Statement from Competencies Workshop

The Health Workforce development competencies workshop strongly recommends that the Health Promotion Forum urgently;

a) progresses the health promotion competencies to nationally adopted health promotion practice standards.

b) be resourced to develop mechanisms to establish, implement and monitor health promotion standards of practice through the health sector.

Eg:

- professional body/association. Advocacy to Ministry of Health re contracting from a standards position

- HPF take a public stance in support of nationally applied accountable health promotion standards of practice.

Presented by Faye Ryan. Passed with the concern noted by the conference that these processes and mechanisms should support the ability of Maori to determine standards for their workforce and not impose control.

5.4 Views of some training providers about the development of standards

Views were sought from a range of training providers. They all supported the development of standards relating to practice, but indicated they would not be interested in being part of a national standards system. At present training providers participate in accreditation processes as required by their employing institution and there was little or no perceived benefit in being involved in another accreditation.

However the development of standards may help guide workforce training and education needs and it may be necessary for training providers to engage in the process in some way.

Trainers indicate no mechanism exists for peer review or networking between providers, therefore there is no measure of consistency or quality of health promotion training.

The following issues were raised by training providers for consideration;

- Just developing standards will not be enough on its own, a range of strategies are needed to improve health promotion practice.
- How will standards improve health and what will they do to tackle inequalities?
- Standards must be consistent and apply to mentoring, coaching, the tertiary education sector and PHOs.
- The Health Promotion Forum could be a 'logical' organisation to develop standards because of its close alignment with the competency structure.
- Several training providers supported the idea of a co-ordinator to identify; available training (including overseas,) training needs, advocate for more resources into training and encourage training uptake by advertising and promotion.
- The need for entry level qualification for health promotion in all settings
- Competencies and standards are a very western concept, how will the concept be shared with Maori?
- Standards development processes should model community development processes and need to be very visible.

5.5 Reasons suggested for the development of standards in relation to individuals

Several reasons were suggested within the sector for developing the competencies into standards in relation to individual practitioners.

Leadership and Service Definition

- It would help provide leadership in health promotion by defining what health promotion and practice in this country is. Given the ongoing trend towards standards and quality control, if the health promotion workforce does not act, other parts of the health sector may start defining what health promotion practice is.
- Moving the competencies from a voluntary system to a more integrated system with workforce training and career development will provide national consistency in health promotion practice, including organisational progress in this area.
- It would provide some common platform and understanding from which to work.

- It would give greater recognition to health promotion and increase its impact and worth.
- It could lead to a more powerful and organised workforce.

Workforce Development
- Standards provide a formally recognised and nationally approved system for 'measuring' or 'describing' health promotion competence.
- Without standards many workers are trained on the job to different criteria or levels of performance. This is not safe for either the practitioner or the communities they work with.
- Standards provide an agreed standard or benchmark of skill, knowledge and behaviour expected of a health promotion practitioner.

Career Development
- Standards will define and protect the occupation and develop its professionalism.
- Standards could support career development, as part of a recognised career structure.
- A recognised career structure should help standardise recruitment and retention.
- Standards provide a means of valuing health promotion workers.

Quality Assurance
- It is possible the Ministry of Health may require standards to be developed at some stage. It would be preferable for the sector to have a primary and significant role in the process and the content rather than having these imposed.
- Standards would help protect the community from poor or harmful health promotion practice. A motivation for standards in other fields had been as a preventative measure to reduce the likelihood of physical or psychological harm being done to an individual. In health promotion, harm might not be so direct but health promoters could give bad advice or act inappropriately. It was felt health promoters needed to be on top of knowledge and skill developments.
- It would help ensure people for whom a service is intended that they were receiving quality service through standardised assessment and monitoring.
- Development of guidelines in several health areas had included or were including health promotion for example, breast and cervical screening; cardiovascular disease prevention and smoking cessation. Would the focus be on behaviour and lifestyle change or also include determinants of health approaches as well? Some standardisation of skills and knowledge was considered important.
- Standards would provide a measure for nationally consistent service and practice.

5.6 Reasons suggested for not developing standards

Several reasons were put forward as to why it may not be an appropriate step to develop individual practitioner standards.

Capacity

There may not be the numbers, resources, capacity or identification as a health promotion workforce to develop standards and to monitor implementation of them.

Kaupapa

Standards might define, too narrowly, some health promotion strategies such as media work and political advocacy. This could constraint health promotion and its community driven political, social justice and social change elements.

Exclusion

Professionalising health promotion risks a lack of recognition and appreciation of workers without qualifications. This includes many community practitioners who have knowledge and credibility. These workers often bring huge experience to their jobs but may not want to or have the opportunity to gain formal qualifications.

Division

There is a risk of excluding those practitioners who do not join the system, and this could lead to a "them and us" division in the workforce.

5.7 What might happen if standards are not developed?

If the workforce chooses not to support the development of health promotion standards and an implementation pathway, then progress may rely on voluntary implementation of the health promotion competencies. Without standards or a process to implement them any progress will be very slow, and some people believe health promotion risks being absorbed and redefined by other parts of the health sector.

The following list is adapted from Ryan 2002 and outlines some implications of not developing standards.

Career development - without standards there will be no;

- recognised career development or pathways
- standardised or recognised wages structures
- entry level qualification into the job, anyone can call themselves a "health promoter"
- nationally standardised health promotion education
- process for identifying and rewarding individual excellence, in particular how do we recognise expert practitioners?

Consistent practice - without standards there will be no;

- bench mark for new health promotion providers with little or no knowledge of theory and practice.
- standardised approach to recognition of best practice and ethical action in the health promotion sector
- identity or organised ability to protect definitions of health promotion best practice and standards.

Accountability - without standards there will be no;

- safety mechanisms to protect communities from poor practice.
- Responsibility to the peer/sector for practice

- bench mark for employer organisations that are not Health Promotion specific
- bench mark for funders to judge the quality of service they are purchasing.

Without standards there is a risk that health promotion activity will be defined by contracts, with mobile parameters. Contracts might be defined by money rather than evidence or need.

As a consequence of poorly understood theory and poor practice there is a risk that Health Promotion could become a tool of maintaining status quo, or used to oppress and victimise.

5.8 Issues that need to be considered

Many comments were made about issues that need to be considered in any moves towards standards, including that more discussion and consultation is needed. Specific issues which have been raised for further consideration include:

- How will a health promoter be defined and who would be subject to standards?
- How will other workers undertaking health promotion as an incidental part of their job be affected?
- Who will take responsibility for implementing and monitoring standards?
- Should there be two streams – Maori/Non Maori?
- What are possible pathways for supporting people to meet standards
- What will happen or be the process of not meeting them?
- What kind of mandate is needed and by whom?
- What role does management have in supporting any such developments?
- What time frame would be needed?
- What would be the relationship between tertiary institution qualifications and standards?
- Who would recognise the standards? Would the Ministry of Health?
- Will they be adhered to?
- Stepping stones would be needed to ensure the existing workforce could at least meet the first level of performance criteria.
- Sustainable workforce development is necessary to meet the demands. For staff to reach levels, accessible and affordable courses needed to be offered. The infrastructure needs to be in place for it to happen.
- Monitoring and compliance would need to be done by independent bodies.
- What form should such a body take? One respondent thought that the health promotion workforce was unwilling to form a registration body like the Nurses Council that could prohibit non-registered people practising as health promoters. Another option was a Master Builders Association type of association that could verify the level of training and experience. Some thought the most important thing that there is an organization with profile (perhaps the Health Promotion Forum) that could give authoritative statements on training and skills in health promotion and be prepared to say what does not count as health promotion. This was seen as particularly valuable with the development of PHOs.

- How to 'sell' the need for workers and workplaces to support the need for standards.
- How could the workforce ensure the standards recognise and value the diversity of health promotion and the cultural diversity of workers?
- Can other workers (health sector workers, youth workers, teachers) be part of the health promotion standards?
- "Standards should not inhibit the ability of health promoters to utilise their passion and creativity to the max! They should not be so academic as to disadvantage those wonderful community practitioners who have so much knowledge and proven credibility."
- What would be the costs and logistics of setting standards up. Where should they be housed – within a health promotion professional body? There may be political and conflict of interest issues.
- What would be the cost of setting them up as enforceable standards – would it be worth it?
- Would health promotion, people and communities lose out by the practice of health promotion becoming more professionalised?

If health promotion is to progress on any pathway towards professionalisation or recognition of standards, a number of other issues arise. The workforce has raised many of these while others have come from our research. These concerns apply to all options and pathways and will need careful consideration before any action is taken.

Cultural

- How do Maori and Pacific practitioners see they fit with these pathways?
- Consultation needs to determine if they want to be part of any developments, if they wish to continue as part of an integrated process, or if they wish to develop their own parallel processes.
- How can we best honour Te Tiriti during these developments?
- What other issues arise for people working within their own cultures?

Diversity of background and experience

Health promotion practitioners come from diverse backgrounds with a wide range of qualifications. These range from degrees and postgraduate qualifications to undergraduate certificates in a variety of fields. An unknown proportion of practitioners have no relevant qualifications. They contribute to the richness of the health promotion workforce with great knowledge and experience learnt in other fields, on the job and in their communities.

Whatever pathway is adopted must be inclusive and honour the knowledge and expertise of those people without formal qualifications.

Models from other professional groups indicate possible problems from variable commitment and fragmentation in the workforce. People working in the field may not self identify as a health promotion practitioner, instead they tend to identify from their base training or current position eg; as a researcher, policy analyst, injury prevention advisor, community medicine specialist, or a public health nurse etc.

Any move to develop standards needs to be preceded or accompanied by several things being in place. These include;

- more opportunities for obtaining qualifications, increasing knowledge and skills in health promotion through tertiary education, in service training, short courses, accredited workshops and so on.
- greater financial investment in training by the Ministry of Health.
- greater support from management and the MoH of health promotion, training and career development opportunities.
- Culturally appropriate assessment procedures to be developed.
- A system of training in assessment of health promotion to be developed depending on what pathway is chosen.

SECTION SIX

6. Development and Implementation of standards

This section looks at how standards could be written and what the workforce would need to be able to meet the standards – possible training, qualification and assessment processes

6.1 Writing of standards

In the first instance this could be done through a working party/advisory group of senior health promotion practitioners, resourced with project workers and with access to expertise in standards writing and other quality programmes. While initially health promotion standards may be voluntary, they should be established in such a way that they could be adopted to other mechanisms, rather than be developed in isolation.

Standards should not be developed in isolation from training, assessment and monitoring procedures.

6.2. Requirements and Possible Mechanisms to meet standards

Meeting standards requires acquisition of knowledge and skill and structures to recognise, assess and monitor standards.

Options for ensuring health promotion workers are able to meet health promotion standards are noted below. They are not mutually exclusive and will be needed in combination.

6.2.1. A recognised entry level qualification or access to qualifications and other training

This would meant that if a person wishes to be employed as a health promoter they need to do a recognised health promotion or related qualification, same as if they wanted to be a physiotherapist or nurse they would need to complete a recognised qualification. Currently in New Zealand there is no requirement for health promoters to have an entry level qualification before they can be employed as health promoters or can call themselves health promoters. There has been no official or workforce driven move to date to set up such a requirement.

There are very few qualifications in NZ focusing on health promotion. If an entry level requirement was considered a good idea, there would need to be more resources into and development of tertiary education qualifications to support this and identification of what other qualifications and training might be considered as relevant.

A requirement to have an entry level qualification might exclude many current health promoters who do not have relevant qualifications, but do have relevant experience, skills and knowledge which should be recognised.

Mechanisms for recognising and valuing the experience will need to be part of the mix.

If an entry level qualification is not considered necessary, to be skilled, knowledgeable and competent, a workforce still requires access to relevant educational qualifications and other training opportunities to develop its capabilities.

Formal qualifications available specifically in health promotion in Aotearoa-New Zealand include:

- **Certificate in Health Promotion** run through Otago University's Department of Public Health at the Wellington School of Medicine. It is a two year, four paper, part time, distance taught qualification.

- **Bachelor of Health Science in Health Promotion**, a three year full time degree run through the Auckland University of Technology's School of Community Health and Sports Studies.

- **Certificate of Achievement in Introducing Health Promotion** run through the Health Promotion Forum and the Manukau Institute of Technology. It is a module based course run in two 4 day blocks in various locations throughout New Zealand.

Papers in health promotion are taught as part of public health graduate or postgraduate degrees, diplomas and certificates through the University of Auckland, University of Otago, Auckland University of Technology.

Short courses and workshop training are also available in several competency related subjects such as media skills and facilitation and group work through the Health Promotion Forum and other agencies. With the increase in health promotion related work through PHOs and implementing government policy, such opportunities need expansion and development.

Compared to the considerable training resources available to the clinical and personal health care sector, the public health sector is poorly funded in training and needs more sustainable financial investment in this area.

6.2.2 NZ Qualifications Authority Framework

The Authority was established in 1991 to co-ordinate national qualifications, taking over the functions of several agencies that had run school, trades and vocational examinations. It also has responsibility to develop a National Qualifications Framework and to approve non-university degrees.

The National Qualifications Framework is designed to provide:
- nationally recognised, consistent standards and qualifications
- recognition and credit for all learning of knowledge and skills.

Only qualifications registered in the Framework can include "National" or "New Zealand" in their title, eg a National Diploma of Health Promotion.

The New Zealand Qualifications Authority system provides a possible long term pathway for workplace assessment to happen. People's existing skills, knowledge and competence in relation to standards may be assessed 'on the job' through properly recognised and established assessment processes. This might lead to acquiring a qualification on the job.

Once Unit Standards are written and registered they can be used by NZQA or NZPPC, accredited training organizations. Each unit standard registered on the Framework describes what a learner needs to know or what they must be able to achieve at a predetermined level.

Qualifications consist of a specified collection of unit standards, which can be collated from other appropriate levels throughout the Framework. For example a health promotion qualification might use already registered unit standards in fields of practice such as te reo Maori, Whakairo, Raranga and Tikanga. Some social/community worker unit standards might also be appropriate.
A moderation system ensures national consistency.

Standard setters

Unit standards are drafted by a group of industry experts and stakeholders usually referred to as a Standard Setting Body. Writing standards must be done in conjunction with an Industry Training Organisation (ITO.) Unit standards are valid only for specified time span then they have to be reviewed and re-registered.

The most relevant ITO for health promotion is Te Kaiawhina Ahumahi It sets the national standards of competence for the social services. It has a Tiriti and social change/social justice focus.

For health promotion to develop unit standards and qualifications in this way, it would need to have a recognised body that is formally mandated by and represents the workforce to work with Te Kaiawhina Ahumahi.

Workers can be assessed for their existing skills and competence against some unit standards. They can earn credits for achieving unit standards, which might then lead onto or contribute towards a qualifications.

6.2.3. Belonging to a professional association

One way to support competent practice in any field is through an occupation developing a professional association, much as has happened in nursing, social work, teaching and other occupational groups. A workforce can be recognised as having competent practitioners partially through the efforts of a professional association that sets the minimum requirements and standards for membership of a particular profession. These may include a recognised tertiary qualification and may require people to be registered to demonstrate they are competent to practice in the particular field, as part of protecting the standards of the profession.

A professional association set up for this purpose would require the development of entry level criteria or other processes to recognise qualifications, on the job skills, knowledge and competence.

Reflecting wider trends and strategic directions, other groups of health workers are organising themselves through professional associations to ensure standards are met in their field. Some groups do this through Codes of Ethics eg Aotearoa Youth Workers Collective, some are using competencies management eg Alcohol and Drug Workers and some are joining the NZ Registration Board eg Social Workers.

Different associations (eg Social Workers) have a range of processes for joining or renewing membership including; peer recommendation, compliance with disciplinary codes ie lack of complaints, attaining and/or maintaining specified qualifications or training, review of competence, formal registration and combinations of these processes.

Most associations require members, at some time, to re establish their competence/registration for ongoing membership.

The description of this option does not assume any particular structure. Most professional associations have a range of functions and this paper considers only the role that an association might have in developing, implementing and monitoring standards.

A professional body might encourage practitioner and training excellence through a variety of means eg;

- Require certain qualifications as a prerequisite for membership
- Endorse qualifications and training that achieve standards
- Develop nationally agreed standards of practice
- Assess and monitor member practitioner competencies
- Offer a certificate or use of a title as recognition of excellence for accredited individual or organisational members
- Set and implement ethical practice processes
- Benchmark Health Promotion activities and structures for new practitioner organisations.

Most professional bodies been developed through massive efforts and voluntary commitment from the industry workforce. During consultations and exploration of this option there was no indication from the workforce that the commitment or capacity is available. There was some support for the Health Promotion Forum being funded to fulfil this role.

6.2.4. Decision by government that a health promotion occupation be created

In some situations professional regulation is statutory and statutory professional regulation presumes some sort of profession exists. Five features were identified for a profession to be recognised as such by the United Kingdom company JM Consulting (cited by Royal Institute of Public Health, www.riphh.org.uk/volreg.html):

- the occupational group should cover a discrete area of activity, displaying some homogeneity
- the group must apply a defined body of knowledge and practice based on evidence of efficiency
- there should be an established professional group that accounts for a significant proportion of the occupational group
- the group should already operate a voluntary register with defined routes of entry and entry qualifications which are independently assessed
- the group should operate within a defined code of practice, with ethical standards and disciplinary procedures in operation.

At present health promotion in Aotearoa-New Zealand do not meet all of these criteria to identify as a profession either for statutory regulatory purposes, even if that were considered appropriate for health promotion, or to establish its own internal good practice regulatory processes to support good practice.

In the UK work is underway to establish a voluntary register for multidisciplinary public health practitioners or Specialists in Public Health, who do not meet the above criteria as a profession either. The government has decided a new professional group of Specialists in Public Health will be developed. Making this policy a reality is complex. The necessary work falls into three specific areas:

- The establishment of standards, based on core competencies for specialist public health practice
- Identification of the specific roles of Specialist in Public Health within the wider public health workforce
- Establishment of a ‘professional’ structure for such Specialists in Public Health to ensure that standards are maintained and the public protected.

In New Zealand this pathway involves an Act of Parliament leading to registration with the Registration Boards Secretariat. Government is not encouraging or resourcing any more professional registrations through this channel. Social Workers experience

indicates a need to convince MPs of a significant safety risk for clients if practitioners are not registered and it requires a profession to provide monitoring and other ongoing processes. The passing of the Health Practitioners Competence Bill in 2003 includes several already regulated occupational groups with personal health care roles and it is extremely unlikely that health promotion could make a case to be included under this Act.

6.2.5. Voluntary compliance

A fifth way is for people to voluntarily comply with standards of practice. This pathway may be administered by a body with structure and assessment processes or may be left to individual practitioners and employers to put their own processes in place.

A voluntary registration scheme is one way to provide some safeguards to the public. In the UK it is seen as a system for quality assurance for comparable standards of practice across the whole of public health specialist practice.

A second approach is the health promotion workforce establishing its own professional body and setting up a voluntary registration scheme. Voluntary compliance might work as an interim measure but it is unlikely to be a successful strategy long term as there is no real incentive beyond an ethical sense of obligation to comply.

6.2.6. Quality assurance and contracting mechanisms

Requirements imposed by funders is another possible option to influence standards, eg organisations might be required to prove they have adequately trained and competent staff to carry out the work before contracts are granted. The Public Health Standards embedded in the Acute Care Standards for DHBs include requirements under this. As far as we know, NGOs are not included in this regime. The Ministry of Health and DHBs would need to engage in this development.

This way forward is likely to become part of the mix because it is part of international and national trends relating to risk management, quality control and contractual obligations and effectiveness. The health promotion sector needs to be engaged in helping shape these requirements rather than having them determined externally.

6.2.7. Organisational Capacity Building

One way of building the workforce and its ability to undertake health promotion is by focussing on organisational competence and capacity building. This option has advantages through strengthening organisations and their health promotion competence as a key part of service or programme delivery.

Organisational and individual practitioner competencies need to be considered in tandem. These approaches are complementary and inclusive of each other. A competent

organisation will nurture the development and competence of its workforce because they are the capacity within the organisation to deliver health promotion.

Te Wana Quality Programme offers a model of this approach. It was developed by Health Care Aotearoa, a national network of primary health care providers who are not-for-profit, community-controlled, providing health care to low income/high need populations. However the programme is relevant to any community-based organisation whose values align with it.

Its underpinning values are Te Tiriti o Waitangi, community governance and participation, collaborative team-work, continuous quality improvement, health promotion and social justice. Organisations choose either a Maori or Tau iwi versions of the Te Tiriti standard. The section includes standards and indictors that assess the performance of a group or agency in terms of Te Tiriti principles of participation, tino rangatiratanga, active protection and partnership. The core module also covers management and leadership, consumer and community participation, consumer rights, planning, quality improvement and evaluation, training and development and the work environment.

The programme cycle takes a minimum of three years and includes a self-assessment phase, involving people from all levels of the service group or agency. Self assessment is followed by an onsite review by a review team, an independently audited report and the development and implementation of a quality plan for ongoing improvements based on the review's recommendations. An accreditation review can take place after the first cycle implementing and assessing improvements based on the quality plan.

6.3 Funding of developments

Funding requirements are difficult to quantify until a definite way forward is identified, but all formal pathways are expensive and research indicates costs are always higher than expected.

- Funding will have to be sourced for standards development.
- Financial sustainability of assessment, accreditation, and monitoring processes is a major issue.
- Contribution from the workforce can be expected for some of the cost e.g. user pays fees for processes such as assessment, or professional association fees.
- The financial role of employers and other stakeholders will depend on what pathway is chosen.
- Research has not uncovered any ready source of funding. Political trends are putting more responsibility for funding onto occupational groups.

Indications gleaned from other professional groups suggest initial costs to develop standards and establish a pathway will be at least $250,000. Further funding will be needed for sustainability.

SECTION SEVEN

7. Possible assessment procedures for health promotion competence.

7.1 New Zealand Qualifications Authority

7.1 1 Workplace Assessment

One of the concerns raised during the consultation on standards was, what would assessment processes be for identifying whether someone was meeting the required standards? It was thought any pathway adopted must include processes for recognition of prior learning. Prior learning includes acknowledgement gained from other related qualifications and learning gained from experience in the field.

The New Zealand Qualifications Authority system provides a possible pathway for workplace assessment. People's existing skills, knowledge and competence in relation to standards may be assessed 'on the job' through properly recognised and established assessment processes. Workplace assessment provides for assessment against Unit Standards from the National Qualifications Framework and can earn credits towards some accredited qualifications. The process and support structures operate through the ITO.

The Te Kaiwhina Auhumahi ITO has a process of workplace assessment, which could be a useful model for health promotion. Some other ITOs which focus on medical model qualifications also have established models that should be part of the information mix if health promotion chooses the NZQA pathway.

7.1.2 Recognition of Current Competence

Many skills, knowledge and understanding used in everyday work are not currently recognised. Recognition of Current Competence (formerly known as Recognition of Prior Learning (RPL) is a form of assessment which gives this formal recognition.

In the NZQA structure all forms of assessment, ie qualification and workplace, have developed RPL practices. RPL provides for assessment against Unit Standards from the National Qualifications Framework and can earn credits towards qualifications. Accredited organisations organise the actual assessment to suit their own circumstances and their learners.

7.1.3 Who carries out assessment?

The NZQA pathway might provide workforce development and compliance with standards through two mechanisms:

- workers undertaking training for a qualification through an accredited training establishment. (Note that people can also gain qualifications through the tertiary education system outside of the NZQA.)

- workers being assessed on their current competence in the workplace. They can be assessed against unit standards and gain credits towards a qualification.

If the workforce decided to proceed with developing standards, to follow this training/education standards pathway in developing the competencies into standards and implementing them, the health promotion sector might need to:

- Work with an ITO such as Te Kaiawhina Ahumahi (TKA), through the process of using the short course/diploma and competencies to register unit standards on the NZQA.

- In conjunction with TKA, develop a system of workplace assessors administered through TKA, who would be senior health promoters trained in workplace assessment who could assess individual practitioners on the health promotion standards.

- This would need to include the training of assessors and development of assessment processes that would be appropriate and relevant for health promotion by Maori for Maori.

7.2 Other options

If health promotion chooses not to follow the NZQA pathway the sector would have the flexibility to develop and implement whatever assessment processes it chooses. The main disadvantage would be lack of monitoring procedures and no transferability of any credits or standards achieved.

SECTION EIGHT

8. What health promotion standards might look like

Many examples of standards are available, but none are directly transferable to health promotion in Aotearoa-New Zealand. This document presumes any health promotion standards in this country will be based on the health promotion competencies. Looking at some of the different systems might help to inform a model for practice and training this country.

Appendix 4 includes three samples of different standards presently in use:

UK National Standards for Specialist Practice in Public Health

National Standards for Specialist Practice in Public Health (National Standards for Specialist Practice in Public Health: An Overview) Approved version Nov 2001.

The development of Public Health Specialist Standards in the UK includes health promotion related competencies that would be part of the work here at senior level. These standards apply to clinicians who are already qualified in their own profession, eg a doctor wanting to practice as a Public Health Specialist is expected to adhere to these standards. Similar approaches are being taken in Australia and in the US.

NZQA Unit Standard

The education standards developed under the NZ Qualifications Authority system are called Unit Standards. Combinations of these standards are used to make up qualifications. The sample shows Level 6 standards for Sexual and Reproductive Health.

Te Wana Quality Programme

Te Wana Quality Programme was developed by Health Care Aotearoa, a national network of primary health care providers, who are not-for-profit, community-controlled, providing health care to low income/high need populations. However the programme is relevant to any community-based organisation whose values align with it.

The sample shows the Maori and Tau iwi versions of the Te Tiriti standard.

SECTION NINE

9. Summary of key issues

If health promotion is to progress on any pathway towards professionalisation or recognition of standards a number of issues arise. The workforce has raised many issues

while others have come from our research. These concerns apply to all options and pathways and will need careful consideration before any action is taken.

9.1 Cultural

How do Maori and Pacific practitioners see they fit with these pathways?

- Consultation needs to determine if they want to be part of any developments, if they wish to continue as part of an integrated process, or if they wish to develop their own parallel processes.
- How can we best honour Te Tiriti during these developments?
- What other issues arise for people working within their own cultures?

9.2 Funding

Funding requirements are difficult to identify until there is clearer picture of which path the workforce want and are prepared to support.

- All formal pathways are expensive and research of other occupational groups and professions, indicates costs are always higher than expected.
- Funding will have to be sourced for standards development.
- Financial sustainability of assessment, accreditation, and monitoring processes is a major issue.
- Contribution from the workforce can be expected for at least part of the cost e.g. user pays fees for processes such as assessment, or professional association fees.
- The financial role of employers and other stakeholders will depend on what pathway is chosen.
- Research has not uncovered any ready source of funding. Political trends are putting more responsibility for funding onto occupational groups.
- Indications gleaned from other professional groups suggest initial costs to develop standards and establish an option will be at least $250,000. Further funding will be needed for sustainability.

9.3 Diversity of background and experience

Health promotion practitioners come from diverse backgrounds with a wide range of qualifications. Whatever pathway is adopted must be inclusive and honour the knowledge and expertise of those people without formal qualifications.

- How could the workforce ensure the standards recognise and value the diversity of health promotion and the cultural diversity of workers?

9.4 Identification of health promoters

People working in the field may not self identify as a health promotion practitioners.

- What kind of mandate is needed and by whom? Who would be affected by development of standards or pathways?
- Would health promotion, people and communities lose out by the practice of health promotion becoming more professionalised?

- How will other workers undertaking health promotion as an incidental part of their job be affected? Eg health sector workers, youth workers, teachers.
- How to 'sell' the need for workers and workplaces to support the trend towards standards?

9.5 Compliance

- What role does management have in supporting any such developments?
- Who would recognise the standards and how will they be adhered to?
- Monitoring and compliance would need to be done by an independent body.
- What form should such a body take?

9.6 Workforce Development and training

Sustainable workforce development is necessary to meet the demands. For staff to reach higher levels, accessible and affordable courses need to be offered. The infrastructure needs to be in place for it to happen.

- What would be the relationship between tertiary institution qualifications and standards?
- What are possible pathways for supporting people to meet standards?

"Standards should not inhibit the ability of health promoters to utilise their passion and creativity to the max! They should not be so academic as to disadvantage those wonderful community practitioners who have so much knowledge and proven credibility."

Further discussion about these issues within the workforce and with external stakeholders will be vital if standards are to be developed.

· REFERENCES

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Pritchard, K and Simmons, G (2002) Benchmarking the Health Promotion and Protection Workforce of New Zealand, Public Health Leaders Group, Auckland.

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APPENDICIES

Appendix 1

Health Promotion, Centre Stage, Coming Ready or Not

Presentation: Health Promotion Forum's 6th Conference,
"Making the Connections**"**

(This paper was originally presented at the Health Promotion Forum Biennial Conference in Christchurch in April 2002, as part of the Health Promotion Workforce Development stream.)

Introduction:
This paper articulates a personal opinion about the current challenges for health promotion, identifies future risks and opportunities given proposed new primary care delivery structures and asks some key questions about the role and readiness of the Health Promotion sector to be truly effective in achieving sustainable health gain. While the issues raised in this paper are fundamentally important to Health Promoters, they are also whole of sector issues that Health Planners and Funders both nationally and locally need to consider.

The opinions and assessments discussed in this paper are the result of working extensively with in the Public Health and Health Promotion fields, and I believe, also reflect serious sector wide concerns about Health Promotion as both a theoretical discipline and as a service delivery model.

Health Promotion, is the art and science of enabling individuals, communities and whole populations to have control over their own health. It is a discipline that draws its foundations principles from a number of diverse theories,

- Health
- Education
- Social justice/civil rights
- Philosophy
- Psychology

Health Promotion internationally has emerged as a theoretical model and service delivery structure in the last 25 yearrs and is the natural progression from the first and second waves of Public Health (sanitation movement and health education)

The introduction of Health Promotion into this country can be traced to the international developments of the Alma Ata Declaration and the Ottawa Charter.

Health Promotion in New Zealand:

- Alma Ata Declaration

- Ottawa Charter, adoption as theoretical guideline for practice
- Development of Health Promotion theory and practice in New Zealand, (eg NGO's such as the Cancer Society and Dept of Health, Health Development Units)
- Establishment of sector interest groups – Public Health Association, Health Promotion Forum
- Development and expansion of Health promotion workforce, nationally
- Establishment of training opportunities including certification
- Development of Health Promotion competencies (Voluntary adoption and application))
- Reorientation of the Health Sector
    1. Health Promotion theory and practice in Education policy (Health Curriculum)
    2. Strategic and Action Plan for Public Health
    3. Public Health and Disability Act 2000
    4. New Zealand Health Strategy
    5. Primary Health Care Strategy (New Health Service Delivery structures - PHO's)

The development of both the New Zealand Public Health and Disability Act 2000, and the New Zealand Health Strategy, with their attendant new service planning, purchasing and service delivery models are the direct result, I believe of effective Public Health and Health Promotion advocacy to redirect health services for a clinical treatment focus to a preventive enabling focus designed to help people achieve health.
These new directions for the health sector in New Zealand provide significant challenges for Health Promotion, in particular,

- Increased emphasis on Public Health and Health Promotion across the whole Health Sector
- Increase in new organisations doing Health Promotion, through new Primary Care organisations
- Expansion of the Health Promotion workforce.
- Increased demands on existing workforce to support, train and rescue new practitioners.
- Potential for new players to redefine Health Promotion from own comfort zone.
- Increased energy to ensure new practitioner organisations are "safe" rather than Health Promoters being able to get on with the work of Health Promotion
- Increased emphasis on Maori Health across all sectors, new practitioner organisations most likely to use Health Promotion strategies to address Maori Health Issues, with the associated risk of redefinition of Maori Health Promotion practice.
- Challenge for Health Promotion to have the same level of credibility and power in new health delivery structures, as biomedical clinicians, in order to ensure safe and effective health promotion practice.

If these are the new challenges for Health Promotion, how will we deal with them on top of the current challenges that face Health Promotion, such as,

- No entry level qualification necessary, you get a job and call yourself “Health Promoter”
- No nationally standardised Health Promotion education
- No recognised career development.
- No universally held Health Promotion practice competencies.
- Not safety mechanisms in place to protect communities from poor practice.
- Voluntary usage of theoretical best practice.
- No peer/sector accountability for practice
- Accountability to employer organisations which are usually not Generic providers not Health Promotion specific
- No standardised approach to recognition of best practice and ethical action in the Health Promotion sector.
- No process for identifying and rewarding individual excellence, in particular how do we know who are the expert practitioners.
- Health promotion activity defined by activity contract, with mobile parameters to suit workforce issues, and money

If we combine the current and future challenges for Health Promotion we might summarise then as:

- Proliferation of new Practitioner organisations doing Health Promotion with little or no knowledge of theory and practice.
- High expectation of Health Promotion to deliver results,
- High expectation of the Health Promotion workforce, to be able to do the work.
- Current Health promotion sector is fluid, disorganised, and with no shared sector standards of practice that are visible and easily accessible.
- No identity or organised ability to protect definitions of Health Promotion best practice and standards.
- New era could see large new practitioner organisations redefine Health Promotion practice to meet own needs.
- As a consequence of poorly understood theory and poor delivery Health Promotion becomes a tool of maintaining status quo, or used to oppress and victimise.

Having advocated strongly that Health Promotion has the potential to significantly contribute to improving Health status and reducing health disparities, we are in significant danger of not being able to deliver effective models of practice to fulfil this stated premise. Health Promotion poorly done is ineffective, and so becomes discredited as a strategy. Because we have failed to deliver we could see ”the baby thrown out with the bath water”

Are there solutions to this suggested scenario? Yes, there are potential risk management mechanisms, such as

- Strong Shared Decision Making agreement between the Ministry of Health and DHB's for Public Health.
- Well thought out and resourced Strategic and Action Plan for Public Health, especially around workforce development.
- Adoption of nationally applied and audited standards of Health Promotion practice, that will inform and drive, not only existing Health Promotion activity but also PHO activity
- Well organised professional Health Promotion Sector, including the development of

    1. National Association of Health Promotion, that might
        - Set nationally agreed standards of practice for member practitioners
        - Monitor member practitioner competencies,
        - Set ethical practice processes for member practitioners
        - Negotiate and monitor educational standards in Health Promotion as a requirement of membership of the Association
        - Offer recognition of individual excellence for member practitioners
        - Set scene for formalised peer review
        - Benchmarks Health Promotion activities and structures for new practitioner organisations

    Association membership and accreditation for both individual and practitioner organisations to become both the minimum and gold standards for Health Promotion in New Zealand

Conclusion

Health Promotion is about to take centre stage in Health service delivery. This centre stage position is the culmination of years of sound Health Promotion and Public Health activity. There are huge opportunities and risks for Health Promotion over the next 5 yrs, but if Health Promotion is not organised or credible enough to maximise this opportunity, and if we as practitioners are not professional, accountable and future proofed we will see Health Promotion fail as an effective tool, and we deserve to be discredited.

Appendix 2

Issues Arising from the Competencies Workshops 2001

Management
Of all the issues bought up by the workforce at the workshops, by far the biggest single section relates to management. Many issues about assessment refer to management's role in the process.

Participants felt that for them to be able to implement the competencies their management needs to:
- be onboard and understand,
- be educated about health promotion and the competencies,
- have the same definition and understanding of health promotion as their staff,
- understand the implications both positive and negative for their staff,
- support implementation from top down, while the workforce is implementing from bottom up,
- be involved from a strategic viewpoint as they usually drive the process in an organisation,
- become part of the process.

When describing management, participants referred to a range of layers and management structures that apply to different settings.
The following managers were mentioned;
- service providers including,
- immediate management, eg health promotion co-ordinators
- public health managers and the PHLG
- other managers eg human resources (who appoint health promoters)
- funders and contract managers
- DHBs and the various public health advisory committees.

Concerns were expressed about possible consequences of using the competencies as a base for appraisals/assessments/measurements. Further comments and concerns are listed in the assessment section.
Assessment may be threatening as management frequently have different understanding of health promotion to those being assessed
Management can misuse appraisal systems
It's a "double edged sword" ie while could be used to help increase wages could also be used negatively to block career development.
There is a safety issue - who tells the management? A suggestion was made that it could be done through the contract process so management knows what is expected in health promotion.

Participants spontaneously offered a range of ideas how they could engage their managers including;

- invite managers to workshop feedback sessions, build competencies into planning, lead the managers, input into the Public Health Action Plan, use the CPH document as a model, PSA is possibility for career issues, work on the organisational infrastructure, educate the managers and build relationships.

Specific comments were made in relation to education including;
- PHLG - need competency development. It was suggested that as the competencies development has been funded by the MoH, managers can't say no to training.
- DHBs - health promotion competencies need to be included in their handbooks
- DHBs and public health advisory groups/committees need training in community processes
- Its not enough just to work with the managers, the education also needs to be done at funding/contractor level.

Cultural
The relationship of the Ottawa Charter and te Tiriti o Waitangi was queried?
Is it a Maori or Pakeha understanding of te Tiriti underpinning of health promotion practice, reflected in the competencies document?

The actual recognition of tangata whenua was questioned and issues around this included;
- Who determines what is ethical?
- Who determines / defines confidentiality, Pakeha or other cultures?
- Is the cultural basis real or imposed externally?

Do we have a clear understanding of the whys and relevance of cultural differences? What does health promotion mean to Maori and how do Maori models of health fit with the competencies?

In several workshops these above issues were raised as concerns around assessment processes as well as other uses of the competencies.

There is an issue for Maori providers with combined contracts. Frequently members of multiple disciplinary teams have differing understanding of what health promotion is.
Maori providers are often not resourced adequately to be able to implement the competencies.

Assessment
Many concerns were expressed about a range of issues pertaining to appraisal and assessment. Clearly the processes and possible consequences are a major concern for the workforce.

These concerns can be broadly grouped into 3
- Who will be assessors?
- How will competencies be measured?
- Where to from here ie the consequences of assessment or measurement?

Cultural issues were reflected in each of these groups and are outlined in cultural concerns.

Who will be assessors?
- Who is going to drive the implementation within the work place?
- Who is going to do the appraisals?
- What are the appraisal mechanisms and process?
- Do the assessors understand the difference between professional and peer appraisal?
- How are the assessors going to be qualified?

How will competency be measured?
Measurements
- Who interprets the competencies?
- How are they assessed?
- How do you measure the competencies?
- Measurement can be subjective.

Measurement of competencies – do they meet needs of communities?
- An appraisal system that reflects health promotion needs to include community impact.
- Assessment criteria are not available at this stage so competencies have limited uses.
- Some felt that the competencies don't go far enough ie "not set" in any process or structure.
- Assessment is an issue of perception (there are differing individual perceptions about what assessment means.)
- Assessment tools need to measure skills not just qualifications (qualifications don't necessarily equate to competent skills)
- What about the people with part health promotion roles – where do they fit?
- What are the implications for those who have different managers for different parts of their job?

Once a practitioners the strengths and weakness are identified
- then what do you do?
- how do you support and strengthen, how do you give support to improve?

Several comments expressed concerns about using the competencies to identify training needs
- may be used to identify training needs but then there's no financial resource to access training
- there's not a lot of training available and there are issues around geographic accessibility to training
- these limitations (ie lack of resources and training) and the need to meet competencies add to the stress of an already stressful job
- time for training is an issue
- training content
  How do we ensure or know the quality of training providers?

How are the training providers qualified?

Other comments referred to wages

- Assessment can be a two edged sword, ie while could be used to help increase wages could also be used negatively to block development.
- We need better wages, ie remuneration that values competency

General Concerns

There was considerable concern about the lack of health promotion identity and lack of understanding what health promoters are trying to implement.

- Health promotion is still fighting against nursing / medical model for status, recognition and funding.
- Need to get rid of the predominant "tic box" mentality and allow room for health promotion process
- Tension between community and the realities of practice. Some asked that the competencies and workshops include an examination of what communities are
- There is a need for increased knowledge of health promotion throughout organizations
- Need to look at big picture planning, (within orgs)
- Peer support groups could help implementation
- Requests for resources to make competencies more accessible included more workshops and kits

Appendix 3

Methodology

Summary of research and consultation February – July 2003

Range of research

Information gathering at the Forum over the last two years has included research, collation of informal comments and feedback from the workforce, consultation with key stakeholders and focus groups, as well as the collated answers to the Competencies Review questionnaire last December.
This information has been put together in the Briefing Paper, The Future of Nga Kaiakatanga Hauroa mo Aotearoa – Health Promotion Competencies for Aotearoa-New Zealand and was posted on Health Promotion Forum's website in July in the Workforce Development section of the Website: www.hpforum.org.nz

Research and consultations occurring prior to February 2003 have been recorded in previous reports to the MoH. Some of these considered important to the present report are listed below.

Standards and related issues

Web sites regularly searched for relevant material

Standards New Zealand

Ministry of Education
Tertiary Education Commission
Steve Maharey Newsletters

NZQA
No new relevant standards found
Quality Assurance of providers

Health Workforce Advisory Committee

Ministry of Health - Primary Health and PHO pages

Universities of Otago, Massey and Auckland
Public Health / Health Promotion training and research information
Nursing 301 (Auckland) Primary Health Care / Health Promotion Strategy

Quality Health NZ – Accreditation Programme

PHSEDUC list serve Canadian Consortium for Health Promotion Research

Other web sites searched

Public Health Physicians NZ – Training Programme Core Skills and Competencies
Health Practitioners Competence Assurance Bill
NZ Association of Counsellors – Code of Ethics & membership
Nga Ngaru Hauora O Aotearoa – Maori nurses association
NZ Organisation for Quality – health standards
Pegasus Preventive Care Handbook NZ Guidelines – no longer in use
NZ Environmental and Occupational Health Research Centre

USA

Standards of Practice for Health Promotion in Higher Education – a self-assessment resource Jim Grizzell
City of Berkley – Manager of Health Promotion Job description
Maricopa Community College District Nursing Programme – clinical competencies – Clinical Evaluation Tool
Competencies Update Advisory Committee Virginia – re entry level health education competencies
National Commission for Health Education Credentialing – Website for Certified Health Education Specialists – Competencies Update Project
Best Practices in Health Promotion - Nova Scotia
Council on Linkages – related info and Core Competencies for Public Health Professionals

Sweden

Core Competencies Bergen University Master of Philosophy – health promotion

UK

Health Promotion European Learning Network – Models of Health promotion – still not available
Royal Institute of Public Health National Standards for Specialist practice in Public Health
Royal College of Speech and Language Therapists - Professional Accreditation Scheme

Australia

Australian Health Promotion Association
ACT Health Promotion - standards
NPHP Planning and Practice Improvement tools and Guides
Health Promotion Workforce Development Group
Update on Work in Progress
Performance Indicator Framework for Population Health
Public Health Associations
The Structure of Core Competency Standards for Aboriginal and Torres Strait Islander
HIV/Sexual Health Workers in NSW - NSW Health

Other Documents

Australia

June Redman and Lily O'Hara – **Perception of Credentialing for Health Promotion practitioners in Australia** Health Promotion Journal of Australia 2003-08-07

Trevor Shilton, et al **Health Promotion Development and Health Promotion Workforce** Competency in Australia Health Promotion Journal of Australia 2001 Vol 12 No 2

Trevor Shilton et al for Western Australian Centre for Health Promotion Research Curtin University and National Heart Foundation of Australia (WA Division) 2002
Review of Competencies for Australian Health Promotion - This document quotes the NZ competencies.

UK

Viv Speller et al **Developing Quality Assurance Standards for Health Promotion Practice in the UK** – Health Promotion International – vol 12 No 3

NZ

Nurse Practitioners – media releases

Primary Health Care and Community Nursing Workforce Survey 2001
Published by MoH May 2003

Public Health Workforce Proposal Feb 2003 Public Health Leaders Group

Health Promotion Forum Council - Organisational Review 1998

A Competency Framework for the Mental Health Workforce – A report of the National Mental Health Workforce Development Co-ordinating Committee MHC 1999

Workforce Development Competencies Community and Public Health (formally Crown Public Health)

Health Workforce Advisory Committee
Annual Report 2001

Health Workforce Summit March 2003
Building the Future Health Workforce - A paper prepared by District Health Boards NZ
NZ Council of trade Unions – Unions Role in Health Workforce Development
The Health/Education Interface- Marilyn Goddard MoH
Paradigm Shifts, making connections and managing change: A personal perspective – George Salmond

Quality Health NZ
Accreditation Programme and sample standards
Correspondence with Judy Wood.

Drug and Alcohol Practitioners' Association
Strengthening Community Action on Alcohol – Chapter: Professional development – for Alcohol health promotion workers in NZ ALAC
Correspondence with Ian McEwan – Association Constitution acquired – Code of Ethics under development
Ashley Conning – member of establishment working party – key informant

Te Wana Quality Programme
General programme information
Especially
Health Care Aotearoa Primary Health Care Services Module – Service Development Work Book
Primary Health Care Section – Guide to the standards and indicators
Primary Health Care Section – Health Promotion Standards.

Key informants

Training Providers

Susan Gower
Lecturer / researcher Dept Public Health and General Practice, Christchurch School of Medicine
Part lecture health promotion paper in DPH and associated with intern project at CPH

Dr Louise Signal
Senior Lecturer (Health Promotion) Dept Of Public Health Wellington School of Medicine and health Sciences, University of Otago
Certificate in Health Promotion (Distance Learning Programme)

Linda Marsh
Co-tutor Certificate of Achievement in Health Promotion HPF/MIT

Cherry Morgan
Previous trainer Health Promotion Forum

Others

Drug and Alcohol Workers Association
Ashley Conning - member of establishment steering group

Te Wana Quality Programme
Jac Lynch – Co Director
Pat Webster – reviewer and mentor

Public Health Leaders Group
Gerrie Vander Zanden – Workforce Development Committee

Workforce Development Project CPH
Closely aligned to PHLG workforce development
Dawn Gourdie - Workforce Development Project CPH

Mid Central Region Workforce Development Group
Report from June Meeting discussion and report from Fran Manahi

MoH PHO Workforce Development
Marion Poore

MoH Public Health Workforce Development
Waiting for reports on public health workforce development work done for the MoH from SHORE

Public Health Workforce - Plan of Action
Maggie McGregor - Ministry of Health

Victoria Smith – literature review

Pacific health – Public Health Directorate, MOH
Carmel Peteru – Project Manager

Workforce

Briefing Paper
The Future of Nga Kaiakatanga Hauora mo Aotearoa - Health Promotion Competencies for Aotearoa-New Zealand, - published on the Forum website June 2003 and used as background to many consultations.

Recent Health Promotion Forum newsletter articles
Review of health promotion competencies, April 2003
The competencies - Is it time to raise the standards? June 2003

Questionnaire
Questionnaire on Using Nga Kaiakatanga Hauora mo Aotearoa / Health Promotion Competencies for Aotearoa Dec 2002 – Feb 2003

Conference Workshop April 2002
Feedback from the Workforce Development Workshop expressed strong support for the development of practice standards, but this was challenged by Maori speakers later in the conference.

Competencies Workshops 2001
Collated issues arising

Informal Feedback
At times informal feedback from members of the workforce was captured.

Focus Groups

Te Waipounamu Health Promotion Coalition
Think Tank

Auckland
Comprised people who had indicated they wanted to be further involved from the Questionnaire

Maori
Comprised Maori members of the original Competencies think tank, and people recommended by those who couldn't come.

Review of Nga Kaiakatanga Hauora mo Aotearoa, Health Promotion Competencies for Aotearoa

Research that will be used to inform changes in the Competencies Document includes;

Workforce Questionnaire
Questionnaire on Using Nga Kaiakatanga Hauora mo Aotearoa / Health Promotion Competencies for Aotearoa Dec 2002 – Feb 2003-08-07

Informal Feedback
At times informal feedback from members of the workforce was captured.

Competencies Workshops 2001
Collated Issues arising

Key Informants / Focus Groups
All key informants listed in the methodology for health promotion standards were asked for comments and a review section included in all Focus Groups

Critique of Ethics
A brief critique has been done by Andrew Moore Lecturer in Philosophy, Otago University Medical School.

Appendix 4

Three Samples of Standards

1. UK - National Standards for Specialist Practice in Public Health

In November 2001, National Standards for Specialist Practice in Public Health were published (National Standards for Specialist Practice in Public Health: An Overview) Approved version Nov 2001.

The standards show ten areas and sub areas. This is followed by the detailed standards and associated descriptions of knowledge, understanding and skill. Specialists in public health will have provided performance and knowledge evidence against each of the ten areas by the point of qualification. Subsequently they will have to demonstrate ongoing competency, often at a higher level than the standards, in a more limited number of areas, and baseline competency in the remainder.
The ten areas are:

1. Surveillance and assessment of the population's health and wellbeing
2. Promoting and protecting the population's health and wellbeing
3. Developing quality and risk management within an evaluative culture
4. Collaborative working for health and wellbeing
5. Developing health programmes and services and reducing inequalities
6. Policy and strategy development and implementation to improve health and wellbeing
7. Working with and for communities to improve health and wellbeing
8. Strategic leadership for health and wellbeing
9. Research and development to improve health and wellbeing
10. Ethically managing self, people and resources to improve health and wellbeing.

National Standards for Specialist Practice in Public Health contain

- **Performance criteria** – these describe good practice in that area of work ie the expectations of any individual when they are practising in that area of work
- **The context** to which the performance criteria apply (column 2) – a competent practitioner should be able to apply the criteria in column 1 to each of the areas in column 2.
- **Descriptions** of the knowledge, understanding and skills that individuals will need to possess in order that they can achieve these performance criteria across the contexts.

The UK has set up a voluntary registration scheme in subscribing to the standards for public health specialists. This is seen as a precursor to statutory registration in the future.

2. NZQA Unit Standard – Sexual and Reproductive Health

Because of space limitations only two out of four elements are shown.

Sexual and Reproductive Health

Level 6

12855 15 Credits Provide health promotion models and strategies in sexual and reproductive health.

element 3

Plan and evaluate a health promotion programme in sexual and reproductive health.

performance criteria

3.1 The plan's features are responsive to the identified needs of the client group.

Range: features include but are not limited to - aims, goals, objectives, activities, information, resources, timeframes, needs analysis, evaluation.

3.2 Plan identifies how the programme will be delivered to a group to meet the need of that group.

3.3 Evaluation of feedback identifies quality of programme's content and delivery and identifies areas requiring modification.

element 4

Implement a sexual and reproductive health promotion programme.

performance criteria

4.1 Provision of sexual and reproductive health information to the community group uses delivery methods in accordance with their specific needs, and models of health promotion.

Range: includes but is not limited to - written, audiovisual, one to one, interactive, group.

4.2 Context of health promotion services provided is relevant to the needs of the community.

Range: contexts may include but are not limited to - screening services, safer sex information, reorientation of health services to meet the needs of the community (for example, one stop shop adolescent health services), support groups, self esteem, advocacy, personal skill development.

3. Te Wana Quality Programme

The following is a sample from the Guide to the Standards and Indicators.

NB: Te Tiriti o Waitangi standard is written in two perspectives, - Maori and Tauiwi. Services choose which of these perspectives they wish to use, - they do not do both perspectives.

COR SECTION A
Te Tiriti o Waitangi – Maori perspective

Whai wahitanga

STANDARD COR A.1:
Te Tiriti o Waitangi is the whariki upon which services are provided in a manner that is consistent with the principle of participation.

Indicators

COR A.1.1	Participation by whanau and hapu is included in the policy of the service.
COR A.1.2	The strategic direction of the service reflects the commitment to participation within Te Tiriti o Waitangi.
COR A.1.3	Whanau and hapu participate in all aspects of the service, and at all levels of the service.

Tino Rangatiratanga

STANDARD COR A.2:
The service has power of authority over its own destiny.

Indicators

COR A.2.1	The service operates with a mandate from whanau and hapu.
COR A.2.2	The service has the power to make decisions that enhance health outcomes.
COR A.2.3	Tino Rangatiratanga strengthens, and is strengthened by, partnership, protection and participation.

COR SECTION B
Te Tiriti o Waitangi – Tauiwi perspective

Whai wahitanga

STANDARD COR B.1:
Te Tiriti o Waitangi is the whariki upon which services are provided in a manner
that is consistent with the principle of participation.

Indicators

COR B.1.1	Participation by whanau and hapu is included in the policy of the service.
COR B.1.2	Whanau and hapu participate in all aspects of the service, and at all levels of the service.
COR B.1.3	Consultation with whanau and hapu is recognised in policy and processes of Te Tiriti o Waitangi and monitored and evaluated.

COR B.1.4. The strategic direction of the service reflects the commitment to participation within Te Tiriti o Waitangi.

Tino Rangatiratanga

STANDARD COR B.2:
The service supports tangata whenua to exercise authority over their own destiny.

Indicators

COR B.2.1 The service actively supports 'by Maori for Maori' initiatives.

COR B.2.2 The service supports Maori staff to take part in Maori caucus opportunities both internally and externally.

COR B.2.3 Tangata whenua cultural practices are incorporated into the provision of health services.