Strategies for Strengthening the Health Promotion Workforce
A Practitioner Perspective

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INTRODUCTION

This "Think Piece" is written for the Health Promotion Forum (HPF) by Helen Rance and Fran Manahi. It is one of a series of 'Think Pieces' commissioned by the Ministry of Health (MoH) for the Public Health Workforce Development Plan. The focus is strategies to develop *'a well trained workforce with the skills and capability to lead Health Promotion in New Zealand at all levels'.*

The Task

Modern Health Promotion is a relatively new discipline. Recent reports indicate the workforce seems to be seeking a collective identity, a voice and visibility in both the public health and wider health sectors.

Issues affecting the Health Promotion workforce have been raised through a range of surveys, stock takes, discussions and written articles. Questions are being asked around:

- Te Tiriti O Waitangi: how to sustain and build on developments for Māori and the Māori health promotion workforce?
- How might the practice and education / training sectors be bought closer together?
- What should education / training programmes look like, and who best can deliver them?
- Who provides Health Promotion leadership and how can it be strengthened?
- How do we recognise both competent practice and cultural competence in the Health Promotion environment, and how can competence be supported and further developed?
- How can the principles of: community development, determinants of health, and reduction of inequalities be applied not only to the communities we work with, but also addressed within the capacity of the Health Promotion workforce?
- How can we improve sustainability of the sector and reduce the associated insecurities caused by the funding environment?

Underlying these issues is the important question: what is an inclusive and accurate description of the Health Promotion workforce? In its strategic plan the HPF sums it up: *"The health promotion workforce is growing and there is increasing recognition of the value of health promotion from new areas, including primary health care and local government. Many people who use, or would like to use, health promotion approaches have not been recognised as part of the health promotion workforce, often work without payment, and have had even less opportunities for learning – but can and do make a substantial contribution to improving health and well being within their communities and society."*

Not only is the workforce growing but Health Promotion is evolving. Following the signing of the Ottawa Charter aspects of health education were subsumed into a more

comprehensive Health Promotion framework. The focus has swung from lifestyle behaviours to social determinants approaches focusing on inequalities. More recently a human rights agenda has forwarded health promotion thinking with recognition that Hauora is everyone's right.

Our present task is to shape and equip the Health Promotion workforce to adapt and keep up with future trends, to be strong, credible and visible, to be inclusive and to be a rewarding career for both paid and unpaid practitioners.

The Brief

The brief for this paper from the Ministry of Health requested a Health Promotion practitioner perspective and suggested strategies. It is impossible for any one practitioner to represent the diversity of views in the workforce. This paper represents what we found from our own existing knowledge and a rapid (but limited) consultation across the country and a range of work environments, about major issues and priorities for the workforce. Consultation encompassed the HPF Council, Māori, Pacific and Academic Reference Groups and Operations Team, the Think Tank of Te Waipounamu Health Promotion Coalition (TWHPC), and selected senior practitioners.

The brief asked for strategies to address eight questions.

THE EIGHT QUESTIONS

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

Politically driven health structures have resulted in fragmentation and competition in both Health Promotion services and education / training provision. Whilst the demand for education is growing, qualifications among the workforce vary from nothing to post graduate degrees.

Change is needed to focus on the development of the Health Promotion workforce. The time for competitive approaches is past; the future lies in strategic partnerships and collaborations.

When considering workforce development and training three useful distinctions can be made: 'learning for work', 'learning at work', and 'learning through work'.

- **Learning for work:** a person first gains a formal qualification before seeking work as a practitioner.

  Learning for work is normal procedure in most health related professions e.g. nursing but is not yet common practice in the Health Promotion workforce. A growing range of qualifications equip people to work in the field: e.g. University of Otago *Certificate in Health Promotion*, and Auckland University of Technology *BHSc in Health Promotion*, but more training opportunities are needed if 'learning for work' is to become widespread.

Internships, cadetships and work placements can supplement qualifications and strengthen links between the education and practice sectors while easing the transition from qualification to practice competence.

- **Learning at work:** a practitioner with or without prior training or experience 'learns on the job.'

  Mentoring, coaching and professional supervision develop and use a range of learning and teaching methods, techniques, devices, and resources that build on and make use of previous experience. The aim is to enable supervisees to achieve and develop knowledge, understanding and skills. To ensure ongoing education and professional development we suggest professional supervision become a requirement of all job descriptions and that urgent attention is given to the development of a pool of skilled mentors, coaches and professional supervisors.

  The opportunity arises to create strong linkages, strategic alliances and secondments between Public Health and Health Promotion providers including Non Governmental Organisations (NGOs) and Primary Health Organisations (PHOs) to share mentors, coaches and supervisors.

- **Learning through work:** a practitioner already in work obtains recognition for their experience in the field and is supported to enhance their practice through formally recognised training.

  Recognition of Prior Learning, work place assessment**,** and cross crediting are flexible assessment tools to acknowledge and validate experience and skills learnt in the field. Although much work will be required to establish the necessary procedures these pathways provide for people to turn their experiential learning into formal qualifications.

  TEC or NZQA recognition of training and education is important so the individual can supplement their working knowledge and experience, as well as lifting the professional profile of health promotion.

  Currently courses such as the MIT Certificate of Achievement in Introducing Health Promotion, postgraduate health promotion diplomas, public health diplomas and masters, and other qualifications are also available to practitioners already in the field.

  When the *'learning through work'* content of practitioner's study arises from their work, that knowledge and skill is bought back to the workplace.

We suggest:

- **A co-ordinated approach** to Public Health and Health Promotion education and training is urgently needed. Stakeholders include the Ministry of Education (MoEd), Tertiary Education Commission (TEC), New Zealand Qualifications Authority (NZQA), tertiary institutions and adult learning providers.

  Co-ordination will enable each institution to ascertain their area of expertise, and provide for a specific segment of the market.

Co-ordination has the potential to staircase education to provide stepping stones to advanced training in other institutions and enable those with limited education to progress on the qualification ladder.

Co-ordination will help meet the diverse needs of the workforce.

- **An Advisory group** which encompasses both practice and education sectors to advise directions and coordination pathways, encourage education, with the potential to develop standards, and promote visionary strategies.

  The HPF recently established an Academic Reference Group to advise their own programmes and direction – does this group have the potential to include others in the workforce and develop into an advisory body?

- **Exploration and development** of the elements outlined through the "learning for/at/through work" model. That is:
  - Work with tertiary institutions and health promotion providers to develop internships, cadetships and work placements to supplement formal qualifications.
  - Establish professional supervision as a requirement of all health promotion job descriptions, and urgently develop a pool of skilled mentors/coaches/professional supervisors.
  - Explore and develop with consultation a formal process to "recognize prior learning" for those in the workforce without formal training.
  - Ensure current training opportunities are expanded and recognized as part of a career pathway.

Barriers

Until barriers around training are addressed there will be inconsistency in the knowledge base of the workforce. Access to education and training needs to be addressed from many perspectives including quality, progression, location and resources.

- **Quality and Progression** - *Nga Kaiakatanaga Hauora mō Aotearoa - Health Promotion Competencies for Aotearoa-New Zealand* already establish a guide for curriculum development (allowing that culturally specific competencies are still to be achieved) and has potential to be expanded into quality standards for both practice and education / training.

  Programmes need to be flexible and inclusive so all practitioners can engage with an appropriate level of education and progress.

  Strategies are yet to be devised to reach and increase capacity of those doing the work but not identifying as Health Promotion workforce.

- **Location -** The same practitioners, namely those from regional, rural, southern locations and small providers, are constantly disadvantaged by limited education and training locations. To be able to plan future education and career development practitioners need clear career pathways, early notification of courses and affordable opportunities.

Regional consultation and prioritization are suggested to determine where education and training will be best located.

- **Resources** - Time allocation, funding and workforce capacity are essential elements to make education and training more accessible. Funders can demonstrate the value of training by ensuring contracts require employers to resource and enable workers to take up the opportunities.

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

A number of recent reports have noted the need for Public Health Leadership development and within this focus is a need to strengthen Health Promotion leadership, especially the need to nurture leadership in Māori and Pacific Health Promotion and primary health care.

Constant change and restructuring within the health sector and provider organisations tends to inhibit leadership, and furthermore, some practitioners indicate their work is constrained by limited health promotion knowledge and purpose in organisational managers. The Leadership Development Centre (LDC) website *"What is Leadership"* differentiates management as a role while leadership is a behaviour. Therefore good management will include leadership, whilst experienced Health Promotion practitioners can also provide leadership (but not necessarily management) in a range of roles and organisational structures.

Strong and diverse leadership will be best developed through a range of strategies, no single solution covers the diversity of scenarios or workforce.

We suggest:

- **The leadership and co-ordination roles** of organisations such as the HPF, Te Waipounamu Health Promotion Coalition (TWHPC) and Public Health Association (PHA) be strengthened and the development of a collective workforce structure be pursued.

- **Strategic partnerships** between providers with workforce development roles to share expertise, leadership skills and roles.

- **Address leadership gaps**. High staff turn over and inconsistent Health Promotion expertise in MoH and District Health Board (DHB) Funding and Planning departments often results in a lack of consistency in Health Promotion contracts. There is some concern that recent MoH contracting processes with DHBs may have sidelined Public Health Unit (PHU) expertise. Leadership could be demonstrated through contracting processes by utilising PHU expertise and including inequalities and determinants approaches.

- **Regional networks** establish frameworks to strengthen expertise and develop leadership across providers especially at the PHU, NGO and Primary Health Organisation (PHO) interfaces.

- **Specialised training** and mentoring programmes will nurture and develop leaders. Career pathways that reward specialised leadership skills and positions will support and encourage leadership.

Future Directions
Health Promoters have the ability to respond to opportunities to provide leadership and influence in achieving public health outcomes from a Health Promotion perspective. The ability to seek change is a valid Health Promotion strategy.

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

"*In 1977 Mattesich and Monsey wrote that, with strong community capacity, members of a community can work together to develop and sustain strong relationships, solve problems, and make group decisions, and collaborate effectively to identify goals and get work done." (Hands on Health Promotion, Rob Moodie and Alana Hulme. IP communications 2004).*

Health Promotion practitioners in this country need to develop a strong sense of community in order to develop Health Promotion capacity. Some regional and issues based networks provide a little cohesion within limited parameters, but the prevailing sense is of competition and fragmentation. Feedback from the workforce indicates that networking and collaboration are still considered as luxuries by many managers and funders. Training and funding for community development is given little or no priority and the time needed to implement these approaches is frequently underestimated.

Networking within and between groups working in communities is a fundamental building block of community development and should be a requirement of all service provision.

We propose that:

- **At a local level** - Health Promotion development best happens through sharing, exchange and seeding ideas via networking, collaborations and joint ventures. Networking should be made explicit and visible in all contracts and be an integral part of each practitioner's job description. After its purpose and contribution to a particular public health outcome has been identified networking must then be validated and supported with time allocations.

- **At a regional level** - Regional services are ideally placed to be a base for co-operative and collaborative models allowing for regional diversity of health promotion functions, roles and perspectives.

  Te Waipounamu Health Promotion Coalition (TWHPC) is a South Island model of the potential of regional networks in providing opportunities for workforce development. It provides a meeting point where people can come together to share skills and resources to achieve outcomes that are not possible without co-operation. Similar regional networks could form the base for the development of mentoring and professional and cultural supervision.

- **At a national level** - The Health Promotion workforce needs a focal point from which to develop its own community capacity and collective identity. Experienced Health

Promotion capacity within the MoH Public Health Directorate would ensure a clearer understanding of Health Promotion workforce development issues. Realizing the potential within the Health Promotion workforce will require resourcing to enable participation in and the development of a collective structure. Current disparities and inequalities throughout the workforce mean industry funding is not practical at this point in time.

- Feedback from some in the workforce suggests this focal point for a health promotion collective identity might/could be a professional body with agreed practice standards and other processes.

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

To strengthen the focus on determinants of health and the reduction of inequalities two intertwined approaches must be implemented in parallel. Contracts must support both approaches by clear identification of inequalities and provision of time to address the issues.

Firstly - if we recognise that Hauora is everyone's right, then addressing inequities as a breach of Te Tiriti O Waitangi and the reduction of inequalities must be prioritised in Health Promotion services and work.

Government's key health goals tend to constrain Health Promotion funding criteria to reflect specific disease and risk factors often with a focus on health education, events, and tied to specific projects or issues, thus supporting competitive, fragmented and short term contracts. If we are to make a real difference, Health Promotion contracts must address inequalities and focus on determinants of health while resourcing networking, linkages and joint ventures. Realistic contract time frames are needed to enable strategic planning and implementation of cohesive approaches.

Secondly - is the need to apply Health Promotion approaches to the reduction of disparities and inequalities within the workforce:

- **Te Tiriti o Waitangi**: We uphold Māori rights to the resources and support to develop approaches that address disparities.

- **Education and Training**: Many issues require attention to ensure quality training is accessible to all practitioners: e.g. access to education and training needs to be addressed from many perspectives including quality, progression, location and resources.

  Inclusive orientations for new practitioners and managers that cover essential topics such as inequalities and the determinants of health will help to underpin understanding of disparities.

- **Career pathways** and pay systems must recognise both skills and qualifications. National career and pay pathways will support consistent practice and transferability when changing employers.

- **Māori, Pacific** and other practitioners who work in specific settings bring specialised approaches and skills to their Health Promotion practice. Developing nationally consistent pay and qualification processes that recognise and reward these approaches and skills will be an essential component to reduce inequalities.

- **Strategic alliances** and joint ventures have potential to strengthen the capacity of organisations, improve quality of practice and help reduce inequalities in the workforce.

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

Health Promotion is both a science and an art. Until Health Promotion is recognised as a discipline with a wide-ranging set of skills and its own internal rigour many will continue to see it solely as an art and it will struggle to gain credibility.

- **Continuing growth** of Health Promotion contracts in PHOs has added a relatively new dimension to the workforce. The rigour of Health Promotion needs to be actively strengthened in order to gain credibility and maximize the opportunities available in the primary care context.

- **Health promotion training** and understanding should be a requirement for everyone who governs, leads, manages or implements a health promotion contract. This could be achieved by funders requiring a minimum budget to be set aside for a basic level of organisational training. Capacity of the education sector to provide training will need further exploration and development.

- **Hui and workshops** to explore issues and resolve ways forward will strengthen links between the sectors and ensure that Health Promotion activity is both effective and supported.

- **Co-ordination** and networking for Health Promoters working in PHOs will provide a solid basis of support, especially in organisations where the core focus is health care, and will enable a sharing of ideas and directions.

  Health promoters with dedicated roles in PHUs and leading NGOs have potential to link with and support leadership in PHOs.

- **Co-ordination between diverse providers** will add to the critical mass of practitioners and go some way to strengthen the Health Promotion voice while reducing fragmentation of services.

- **Generic Public Health Competencies** (presently being consulted) will offer opportunities to strengthen the Health Promotion voice. **Is the Health Promotion workforce ready to seize the opportunities?**

- **Access to information** about other organisations also contracted to provide Health Promotion services will facilitate sharing of expertise, networking, joint planning and many opportunities for Health Promotion to be heard in other forums. However this

data is not readily available and the Ministry of Health is the only source of the information.

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

The health promotion workforce still has to be clearly identified and whilst this work is progressing, an accurate answer is still someway of. It is relatively easy to identify the formal workforce working within Public Health Units, plus others funded by MoH, DHB, or PHO contracts. However this description covers only a portion of the workforce. Many more exist outside these parameters. They use health promotion skills and competencies, and population health approaches but may not even identify their work as Health Promotion.

Building competence in the workforce will only be achieved through a range of solutions that reflect workforce diversity, the range of roles and the reality of those who don't fit into the formal structures.

Strategies to build competence could include:

- **Health Promotion competencies** - these are still to be developed into standards with implementation pathways. Possible pathways range from voluntary implementation, to credentialing, to membership of a professional body.

- **Culturally specific competencies** are needed alongside mainstream competencies to support safe practice whilst acknowledging the diversity of the workforce and the communities we work with. Implementation pathways also need to be culturally appropriate.

- **Wide consultation** and gentle steps towards competency implementation to ensure that practitioners who are least advantaged are not further marginalized.

- **A strategic human resources plan**. Whilst recent work supported by the MoH provides some insight into the composition of the current workforce, there is still much more work to be done. Until we have an understanding of future needs and possible makeup of the workforce, planning will be less than adequate. A strategic human resources plan places greater importance and urgency on further development of competencies frameworks.

- **Strategic alliances** to share networking, mentoring and supervision will maximize and share expertise between organisations, especially those too small to engage a range of expertise within their own workforce. Mentoring should become part of career pathways and encourage mature skilled practitioners to remain in the workforce, maintaining a pool of expertise while reducing some capacity issues.

Health Promotion and Te Tiriti O Waitangi

Te Tiriti O Waitangi places obligations on the Crown to ensure that there is "meaningful Māori participation at all levels of health promotion including decision-making, prioritizing,

purchasing, planning policy, implementing and evaluating health promotion services . . .It is about creating and resourcing opportunities for Māori to exercise tino rangatiratanga, control, authority and responsibility over Māori health. This [includes] resourcing and sustaining the ongoing development of Māori health promotion funders, providers and workforce. . . [It means] an immediate goal us to reduce the health disparities that exist between Māori and non- Māori. (TUHA-NZ, 2002)."

Recommendations to the International Union on Health Promotion and Education (IUHPE) from the 2004 Māori Health Promotion Gateway Hui on indigenous health included an "expectation that health promotion for indigenous peoples will be led and controlled by indigenous peoples , that IUHPE recognizes (and therefore advocates for) the recognition of the validity of indigenous health promotion frameworks, models and practices . . . IUHPE gives priority to indigenous people's health promotion (and) . . . IUHPE should pay particular attention to supporting capacity building for indigenous health promoters and that these initiatives are indigenous-led". These recommendations have been adopted by IUHPE and set an international expectation of what is best practice in the development of the New Zealand Health Promotion workforce should support priority being given to Māori health promotion, understanding and use of Māori frameworks, models and practices, and support for Māori i-led capacity building of the Māori workforce.

He Korowai Oranga, the MOH Māori health strategy, recognizes that Māori workforce development "needs acceleration and greater co-ordination . . . Māori community health and voluntary workers, many of whom are Māori women, have a pivotal role in improving the health of Māori whanau. This needs to be recognized with the development of mechanisms to encourage community workers, public health workers, and voluntary workers into professional training."

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

- **Māori** Those working with and for Māori health need to be culturally safe. There is potential for cultural competencies to support safe practice. But the competencies approach can also carry problems. There has been considerable debate and discussion among Māori about the development of competencies. Ngā Kaiakatanga Hauora mō Aotearoa / Health Promotion Competencies for Aotearoa-New Zealand developed by the Forum in 2000 does not adequately identify Māori values, ethics, skills and knowledge, approaches and models required to work for and with tangata whenua. This discussion has continued through the process of developing core public health competencies, and influenced the consultation document

- **Pacific Peoples** For Pacific peoples, there are also a range of underlying issues. "Cultural competency is an essential component of the core body of knowledge, skill, and attributes of the health promoter in order to be effective in working with Pacific peoples. Cultural competency for Pacific people can be best built and ensured when it is developed at both individual and institutional levels, and based on an accurate understanding of the special relationship that the Government has with Pacific people. The special relationship manifests itself in a need to protect and foster Pacific cultures and identities, and a need to recognise that Pacific people should have the

same socio-economic opportunities as non-Pacific people." (Ministry of Justice [September 2000]. *Pacific Peoples Constitution Report).*

- **Other Cultures** Developing cultural competency in the health promotion workforce also means recognition of the importance of culture to the wellbeing of Asian peoples, women, children, youth, refugees and new migrants, people with disabilities, people living in various communities, and those experiencing other discrimination. The importance of cultural competency in working with and for these groups should not be overlooked.

Anecdotal evidence suggests the high turn over of health promoters sits alongside a trend (driven by contracts) away from community development. As fewer health promoters are able to focus on community development Māori and Pacific communities at all levels may be missing out.

This illustrates the importance of recognising Māori and Pacific models of health and the need to be more inclusive of the diversity of the population.

These are priority areas for further research and development.

8 Are there any other strategies you would recommend to support the development of a well trained workforce for Health Promotion?

To protect marginalized sectors of the workforce, to reduce inequalities; to strengthen Health Promotion and to develop a well trained workforce Health Promoters must work together. It is only through a collective identity, collegiality and a sense of responsibility towards each other and the shared body of knowledge that we can serve those who are least advantaged.

We propose that the HPF should be funded to:

- Explore how health promoters at all levels might establish a national collective identity and develop both formal and informal mechanisms to support this identity.

- Develop an Advisory group for supportive, progressive and accessible training. Representation in this group could be inclusive of the present HPF Academic Reference Group and diverse representation from the workforce.

- Explore the development of regional networks throughout the North Island and continue the partnership with TWHPC to support the ongoing development of Health Promotion.

The HPF is the best placed organisation from which to establish a national focal point for the Health Promotion workforce. HPF has a national overview, with established expert reference groups, and access to expertise through its operations team and strategic alliances with other organisations. Their membership provides extensive stake-holder and workforce networks from which to seek further mandate.

It is only through a collective identity and a national focal point that Health Promotion can be a strong voice, credible, accountable and effective when faced by the challenges the future.

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