Report on the 2004-5 Ontario Health Promotion Resource System Provincial Needs Assessment

by

Brian Rush, Ph.D

With the support of the OHPRS Evaluation and Needs Assessment Committee

Brian Hyndman (Chair)

Sherri Anderson

Pam Benson

Nancy Dubois

Lorna Heidenhiem

Robyn Kalda

Anne Lessio

Leslie MacElwee

Anne Meloche

Roya Rabbini

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1.0 Introduction and Background:

The Ontario Health Promotion Resource System (OHPRS) is comprised of 22 Resource Centres and Key Associates[1] that provide services and supports to health promoters around the province (see Appendix A for a list of OHPRS organizations and the web link www.ohprs.ca for more details). The Evaluation and Needs Assessment Committee (ENAC) of the OHPRS is charged with the responsibility to assess the extent to which the OHPRS network is achieving its collective goals. To date the work of the Committee has included a baseline survey of the capacity of health promoters in Ontario working in Public Health Units and Community Health Centres (Rush and Urbanoski, 2003); a complementary qualitative assessment of health promotion capacity (Rush and Andrew, 2004); as well as feedback from key representatives in the Ministry of Health and Long Term Care in terms of expectations and perceived progress in the development of a coordinated system of services and supports (OHPRS Impact Evaluation Committee, 2003). The Committee has also undertaken a baseline network analysis of the nature and extent of inter-organizational linkages across the OHPRS organizations (Rush and Urbanoski, 2003). The goals and objectives of each evaluation strategy are summarized in a comprehensive evaluation plan (Rush, 2002).

In 2004-5 ENAC supplemented its evaluative activity with a provincial needs assessment related to health promotion services and supports. Since many of the OHPRS organizations routinely engage in systematic needs assessment activity, the ENAC Committee consulted with the various organizations to identify areas where a collaborative needs assessment project would bring the most significant "added value" to them individually. This process began with an initial consultation at a Network Forum and then continued with interviews with representatives of the individual organizations. All OHPRS members were consulted using telephone interviews and a semi-structured interview guide. Their feedback was incorporated into the project workplan.

In broad terms the goal of the collaborative needs analysis was to collect information from health promoters in Ontario that would:

[1] The term "OHPRS organization" is applied to all member organizations and key associates as a matter of convenience for this report.

- Support the planning of individual OHPRS organizations by reaching a broader target group than would normally be surveyed by each organization;

- Through comparable questions and a shared approach to the data analysis identify potential areas of strategic collaboration across two or more Members which, in turn, may increase their impact on provincial health promotion capacity;

- Provide an opportunity to engage in inter-organizational collaboration and provide information to support the planning of system-level activities (e.g., communications, promotion).

2.0 Methods

2.1 Survey Questionnaires

Through the early stages of consultation with the OHPRS organizations draft survey topics and items were prepared to reflect their individual information needs and target groups. The initial vision for the project was for a core survey questionnaire that all survey participants would be asked to complete, to be supplemented by different modules of particular interest to various health promoters and OHPRS target audiences. During the initial consultation process input was also received from the OHPRS French Language Services Working Group as to needs assessment information required to better support the work of health promoters working primarily or exclusively in French. It was decided to develop a parallel version of the survey materials in order to facilitate comparisons across English language and French language health promoters. The questionnaires were subsequently revised on the basis of discussion among the ENAC members and follow-up consultation with the OHPRS organizations.

The final set of survey materials consisted of a set of core questions as well as eight supplementary modules. The core questions covered barriers to accessing information and technical support for health promotion work, including language and multicultural issues; familiarity and past use of the various organizations comprising the OHPRS; self-help/mutual aid strategies; preferred approaches to meeting education and training needs; and French language services and supports. These issues were seen as relevant to a wide cross-section of health promoters. The final section of the core questionnaire covered a range of characteristics of the respondent in order to support various sub-analyses of the

data (e.g., years of working in health promotion, region, type of organization if applicable).[2]

The eight supplementary modules to the questionnaire were finalized in close consultation with the OHPRS organizations with the major focus being their individual as opposed to system-wide information needs. In some cases one organization took the primary responsibility for the module and, in other instances, two or more organizations worked collaboratively with the project consultant to best integrate their collective information needs into one survey module. In the mailout version of the questionnaire these supplementary modules where separated from the core questionnaire, with the front page of the module printed in a different colour so as to facilitate easy identification in the survey package. In the web version of the questionnaire, after the respondent checked which modules were appropriate for them, the selected modules were the only additional parts to the questionnaire subsequently presented to them electronically. The following are the eight modules.

- Alcohol and Other Drugs
- Evaluation, Health Communication, Community Mobilization/Capacity Building
- Heart Health
- Maternal and Infant Health
- Nutrition
- Physical Activity
- School-based Health Promotion
- Tobacco Control

In addition to the survey questionnaires, the mail out survey package included a "two-pager" that briefly described the work and target audience of each OHPRS organization (Appendix A). The email invitation to participate contained the web link to the OHPRS

[2] The full questionnaire is available on the OHPRS website (www.OHPRS.ca) in a section devoted to the needs assessment project or by contacting Sheri Anderson at s.anderson@opc.on.ca

web site. All survey materials were available in English and in French. There were also separate web links for on-line completion in either of the two official languages.

2.2 Pre-testing and Translation

Pre-testing was initially undertaken with the mail out version and involved 10 health promoters identified through several of the OHPRS organizations. They were drawn from the areas of alcohol and drugs, nutrition, physical activity, and tobacco control. In addition, the ENAC group itself completed the survey materials and provided feedback. A few areas were identified for improvement. However, the questionnaire was judged overall to be easy to complete, with the core and modular design working well to direct people to the sections of most relevance to them. The main concern expressed was the instrument length and potential impact on response rates. Pre-testing showed the average completion time for the Core section was about 20-30 minutes and the various modules ranged from 5 to 15 minutes. Those pre-testers taking considerably longer had completed the word-processed version electronically via the email attachment. This was not the intention within the pre-test as the web form had yet to be set up. Following the pre-test the revised instrument was then converted to the web version and the full system tested by the project team in collaboration with the programmer of the web version. Few modifications were made from that point on.

Following the pre-testing and modification phase, the full set of instruments and supporting survey materials were translated into French. Translation was performed by the translation services within the MOHLTC. The translated version was then vetted through two Francophone members of the FLS Working Group to ensure appropriate use of terminology and language level. Several changes were made to ensure a less formal style and vocabulary in French. The fully translated version was then converted to the web format for on-line completion.

2.3 Survey Sample

The survey was targeted at past users of the services and supports provided by the OHPRS organizations as well as individuals who had not as yet accessed these organizations. An attempt was made to be inclusive in the language about the intended

target group for the survey in order to solicit participation from the wide cross-section of people for whom the comprehensive cross-section of services and supports of the OHPRS organizations are appropriate.

The following instructions were provided in the cover letter/email as well as the cover page of instructions to the core questionnaire itself.

> *"This survey is about services and support for your work as a "health promoter". We define "health promoters" quite broadly as a diverse group of professionals and volunteers working in such areas as public health, education, prevention, community development/capacity building, self-help/mutual aid, environmental issues and health service delivery. Their work may focus on any or all of the broad determinants of health, including education/literacy, income, social support networks, employment/working conditions, social and physical environments, personal health practices and coping skills, healthy child development, health services, gender and culture. Health promotion work may be paid or voluntary".*

In addition to this broad interpretation of health promotion, the survey cast a wide net in terms of the nature and scope of past use of services and supports available within the OHPRS. In the cover letter, previous use was noted as *"including, for example, a training workshop, curriculum support, consultation, newsletter, or Listserv discussion".* The survey sampling procedure was also used to ensure a broad cross-section of users by the inclusion of both intensive and less intensive service users. Finally, an item in the questionnaire (Item #6) gauged familiarity and use of each OHPRS organization. The response to this item was then used to classify respondents on the basis of their pattern of service utilization. This included identifying people who had not used any of the services of these organizations.

2.3.1 Sampling past users: Each OHPRS organization was invited to submit a list of past clients/contacts who would receive an invitation to participate. In considering potential sample size, representatives of each organization were asked to choose a number that they felt would be sufficient for subsequent analysis and interpretation of

information from users of their organization separately. Since the OHPRS organizations vary considerably in size, the number of names submitted was quite variable; in some instances representing their full client contact list, and in others a sample comprised of up to 1000 people. A general guideline was also given to each organization for them to include clients who had received some services or supports *over the past two years,* although flexibility was allowed in this regard given variation in the nature of the organizations' contact databases. Some flexibility was also allowed in the comprehensiveness of past use, for example, some elected to include newsletter distribution while others opted for a selection of only more intensive users. Some OHPRS organizations have a well-defined target audience (e.g., Heart Health Resource Centre; FOCUS Program) and this was reflected in the submission of their names for the survey.

Table 1 shows the distribution of the email and mail out lists across the various OHPRS organizations[3] as well as the resulting totals. The table also shows the total number on the list of French language health promoters submitted by the FLS Working Group[4]. Many of the submitted names were duplicated across the various lists as they had been nominated by more than one organization. The lists were first separated into those who had an email address and those who would be receiving the survey material by regular mailout. Based on this potentially duplicated list of names, a total of 4828 were designated for email distribution and 839 for the mail out, for a total of 5667.

For a variety of reasons not all OHPRS organizations submitted names of past clients/contacts for the survey. For example, a large part of the target audience of the Consumer Health Information Service (CHIS) is the general public and this sector was considered to be outside the scope of this needs assessment activity. Some of the alcohol/drug and tobacco control organizations declined on the basis of anticipated overlap with the contact list submitted by another organization, as well as the confidentiality of individuals participating in their listserv (the only source of contact

[3] Note the number here excludes those names submitted for whom no email address or full mailing address was available. Some names were also removed in consultation with the OHPRS organization if the number to be mailed out versus emailed was significantly greater than projected due to the impact on mailing costs.
[4] A mix of Francophone users and non-users of OHPRS services and supports.

names). In this event, rather than a direct email invitation to each individual, a notice about the survey and the web link to the questionnaire went out on the APOLnet listserv (est. 400 members) and to the Media Network membership (est. 300).

Table 1. Submissions and survey distribution by OHPRS organization.

	Email Distribution			Postal Distribution			Total
OHPRS Organization	**Initial submission for email**	**Email returned undelivered**	**Final email list**	**Initial list for postal mailout**	**Returned postal mail**	**Final list for postal mailout**	**Total Distributed[1]**
FOCUS	90	10	75	5	1	4	79
ODAP	12	3	9	4	-	4	13
PTCC	841	193	648	332	37	295	943
OTN	9	-	9	-	-	-	9
OPC	572	55	517	-	-	-	517
Best Start	1135	145	990	-	-	-	990
OSHnet	167	26	141	19	-	19	160
PARC	140	10	130	-	-	-	130
THCU	605	79	526	22	2	20	546
CSBHRC	-	-	-	340	11	329	329
HHRC	100	3	97	-	-	-	97
NRC	263	20	243	-	-	-	243
OHHC	533	82	451	2	-	2	454
FLS list	361	34	327	115	27	88	414
Sub-total with duplicates	4828	-	-	839	-	-	-
Unduplicated totals	4235	660	**3575**	780	78	**702**	**4277**

[1] Total of the final email list and final postal mail list combined. The grand total of 4277 is the denominator for estimating the survey return rate.

These two master lists (email and postal mail out) were then examined for duplicate entries so as to avoid a potential respondent being sent more than one survey invitation. Removal of duplicates was done in three stages – first within the list of people for whom an email address was available; second within the postal address list and finally by a cross-referencing of the email list with the postal list. After removing duplicated names the email list was comprised of 4235 people, and the mail out list had 780 entries for a total of 5015 to be mailed out by both methods combined. .

Following the email and postal distribution of the materials, a number of emails and survey packages were returned undeliverable. Accordingly, it was necessary to remove these from the email and mailout counts for purposes of estimating the response rate to the survey. With respect to the email list, there are a number of potential explanations for the email with the survey invitation to have been returned undelivered, including the recipient's mailbox being full, an incorrect address, or a block on "foreign" email by the server's security system. For these email returns the project team contacted the OHPRS organizations that had submitted the email lists to verify, to the extent possible, the accuracy of the email address that had been provided. A few were corrected in this manner (e.g., name was recognized and spelled wrong) but most were unknown. The bounced back emails were also followed up within some sectors that have an identifiable structure to their email address, for example the domain names for the public health units. A total of 20 health units and four other organizations were contacted to discuss and verify bounced back emails. In most instances the list of bounced back email was sent out and a health unit staff member went through the list to delete staff who were no longer there, or to correct spelling of the name. Bounce backs from the list of Francophone health promoters were sent to members of the FLS Working Group for a second look and correction if possible. Other email that was bounced back was corrected directly by the project team by identification of obvious errors (e.g., the domain name was spelled incorrectly). Through these processes, and over the course of three reminder emails, a number of the addresses that were initially bounced back were corrected and re-sent successfully. In total, 660 email addresses were bounced back and remained unverifiable. Thus, of the 4235 sent out, a final count of 3575 emails were considered to have been received by the intended recipient.

In addition to the email returns, a number of the *postal* mail packages were returned with "return to sender" marked on the package and often with a handwritten note "wrong address" or "no longer working here". Table 1 shows that a total of 78 mailed packages were returned, leaving 702 for further consideration in the counting process**.** In sum, and as shown in the last column of Table 1, a total of 4277 survey invitations were distributed

(3575 + 702). This number excludes the notices sent out on the APOLnet listserv and to the Tobacco Media Network.

2.3.2 Non–users: In addition to securing a list of potential survey participants identified as past contacts/clients of the OHPRS organizations, a supplementary process was implemented to solicit the participation of people who may not be familiar with, and who may not have used, the services and supports of an OHPRS organization. A brief description of the OHPRS and the project itself was prepared and contact made with a wide variety of organizations. Representatives in these organizations were asked to consider promoting the survey within their organization or community partners with whom they collaborate. Most of these organizations were recommended as a potential source of support for the survey through the consultation process with the OHPRS organizations. A total of 89 organizations were contacted and provided with an overview of the project and paper versions of the survey questionnaires. They were asked to post a notice about the survey via newsletter, website, Listserv, or other appropriate means in order to inform people about the project, the value of their input and provide the web link to the survey. Overall, 51 organizations were confirmed and followed through with the posting. After a minimum of two attempts at confirmation another 32 organizations declined and a further six organizations could not be confirmed. The list of participating organizations is included in Appendix B.

It is also important to note that the cover letter to the survey informed those receiving the invitation to participate that they should feel free to pass on the information about the survey to other colleagues *"whether or not they have used any services or supports from an OHPRS organization"*. Thus, the survey was promoted in many different ways to both users and non-users of the OHPRS services and supports.

2.4 Survey Administration

The survey was officially launched in the fall of 2004 via both email and postal distribution. Although the outgoing notice indicated three weeks for survey completion, the web site stayed open considerably longer as returns kept coming in and several people called indicating their interest if time still allowed for their participation. In order to maximize the return rate an incentive was provided for survey participation and outlined

in the survey invitation as well as the cover page of the questionnaire. The incentive was for the participant to be eligible for a random draw for conference registration and up to $500 travel support to one of four identified health promotion conferences. Also to encourage participation a series of three email reminders went out to potential participants. These were automated though the web-based survey procedure[5]. All people identified on the FLS list for postal distribution were designated for a personal telephone reminder.

In addition to the volume of bounced back emails identified above, some people had difficulty with the web instructions for creation of their User ID and password. This feature was required to allow multiple starts and stops to survey completion, a feature that several people commented on as being very helpful. New and more detailed instructions were added to the web site and the problems diminished considerably.

The study team fielded a number of email and telephone requests about the survey and the request for participation. Examples would include:

- Expressing concern about the ID number and password or having exited from the questionnaire and been unable to get back in[6];
- Stating that they didn't feel the survey was appropriate for them (e.g., retired); didn't seem to fit with job (e.g., Occupational Therapist, Child Counsellor);
- Asking for more information about the survey, about OHPRS or if they were too late to respond;
- Declining participation without explanation or saying they were sending in only one part of the package;
- Asking if they could access the survey in the other language (English of French) or by paper and pencil rather than electronically;
- Expressing confusion over the email reminder when they had done it already.

[5] The second reminder inadvertently went to some people who had already responded and this resulted in a flurry of email with enquiries about whether there questionnaire has been "lost".
[6] The web survey consultant fielded all these calls to reassure people the information was not lost and to facilitate re-entry to the site.

2.5 Survey Participation Rates

Having received either the email with the web link to the questionnaire, or the postal version itself, there were several potential levels of involvement in the survey. For example, some will have read the email invitation and not gone any further. Others will have clicked on the web link to the questionnaire and opened it up to have a look at the content. They may then have chosen to continue or to decline the offer to participate. Others will have gone part way into the questionnaire and stopped. Still others opted to complete all the core questions but then chose not to complete any of the special modules. Finally, still others completed the Core component and one or more of the modules that were most relevant to their work. In terms of the postal version, somewhat similar scenarios will have played out, although the survey returns that were received had a completed Core section in almost all instances. These various outcomes can impact the calculation of the survey participation rate and we are unable to tease out the effect of all the possible variations and nuances.

Two other factors limit our ability to determine the precise rate of return to the survey. First, the survey was promoted by several means to potential "non-users" of the OHPRS organizations and it is not possible to estimate how many people went to the web site for the survey via this method of invitation[7]. Also, since the survey procedures allowed for people receiving the questionnaire by postal mail to go to the survey web link and then complete the survey on-line, it is not possible to give a precise estimate of the survey return rate for each method of distribution. Responses through the web site were completely anonymous so can't be tracked back by survey administration method. The research team did receive a total of 71 survey returns by postal mail (66 English and 5 French[8]). Since a total of 702 were mailed out to correct addresses it is safe to say that this method did not yield a high rate of return as it is unlikely that the large majority of people receiving the package by regular mail would go to the web link for its completion.

[7] We did subsequently secure participation from a sample of "non-users". However, it is not possible to determine how many "users" were also identified via broad promotion of the web link as opposed to the OHPRS client/contact lists.

[8] Six additional surveys were returned with a note explaining their reason for not participating.

Table 2 shows the levels of participation for the total sample of survey participants. This information, obtained via automated feedback from the web survey process, shows that a total of 1367 people (1249 in English, 118 in French) opened the questionnaire to perhaps gauge the relevance of the specific content or otherwise assess their potential response. A total of 1016 people (948 in English, 68 in French) worked their way through part of the questionnaire but didn't complete the entire Core component. A total of 875 respondents completed the majority of the items in the Core component (823 completed in English and 52 completed in French). It is this group of 875 respondents that have been selected for this analysis of the main survey data. In addition, a total of 614 people (576 in English, 38 in French) completed at least one Module and are among the 875 completing the Core.

The survey feedback also showed where the respondent exited the survey questionnaire. The most common spots were the more complex matrix questions (e.g., Question #6 concerning which of OHPRS organizations had been used and the level of use). Other than this complex item for web administration there seemed to be no one problematic item. To facilitate analysis and interpretation of the data the sample of people completing the full Core have been selected for the analysis in this report (n=875). Based on these 875 survey returns, and a denominator of 4277 who received the materials either by mail or email (see Table1), we would estimate the "effective" return rate at 20.5%**.** Another approach would be to base the return rate on those respondents who completed some part of the questionnaire (1016), and this would yield an estimate of 23.8%. Our survey return rate is, therefore, estimated at 20% to 25% although, for the reasons cited above, this is considered a somewhat tenuous estimate at best.

Table 2. Type and level of survey participation by language of completion.

Type/level of participation	English	French	Total
Opened questionnaire on web site	1249	118	1367
Completed at least part of questionnaire	948	68	1016
Completed the majority of the Core items	823	52	875
Completed the Core and at least one module	576	38	614

2.6 Analysis

At the conclusion of the data collection process an SPSS system file with all the quantitative data, and a set of Excel files with the participant responses to the open-ended questions, were returned to the project consultant from the company that had been sub-contracted for the web survey (Circum Network Inc.). These files included 71 postal survey returns that had been entered into the database by the project team in order to form a unified database from both methods of survey administration. Data were analysed with Stata V.8.0. Missing values to some items arose due to appropriate skips around particular questions not relevant to the respondent, as well as the respondent's option not to answer any given question if they so chose. These missing values were appropriately verified and coded. Thus, the number of respondents to each question varies somewhat. Analyses involved review of data distributions to ensure appropriate cell sizes for interpretation, followed by frequency and cross tabulation of key variables. In addition, some summary indices were prepared to facilitate particular analyses (e.g., index of the number of OHPRS organizations used; index of familiarity).

The qualitative data were reviewed by the project consultant for themes that would lend themselves to a formal coding process and which would also build upon other evaluative work of the OHPRS (e.g., a previous breakdown of various indicators of health promotion capacity). Coding was completed by two coders, first working together to ensure consistency in the approach and interpretation, and then coding independently. One section was coded by both coders and resulted in a 90% level of agreement. All final coding was double checked by the project consultant. The French responses were coded by the project consultant to ensure consistency with the coding of the English responses but with back up provided by a Francophone member of the team to assist with those items requiring further consultation and interpretation.

The present report is based on the survey items in the Core section of the questionnaire, although subsequent reports may examine these data in relation to key findings to emerge from the analyses of the survey modules for the various OHPRS organizations.

3.0 Results

3.1 Characteristics of our Sample of Ontario's Health Promoters

In this section several tables and charts summarize key characteristics of the survey respondents. Given the non-random process for selecting and inviting people to participate in the needs assessment survey the resulting survey sample cannot be considered a representative sample of all health promoters in Ontario. Further, there is no existing provincial database of health promoters against which we can compare key characteristics of the sample to the "population" of health promoters in the province (e.g., years of working in the field; region of the province). These caveats notwithstanding, we were successful in securing participation in the survey from a large and diverse cross-section of people either working or volunteering as health promoters across Ontario. The sample size (n=875), and its diversity, give us confidence in interpreting the resulting information as reflective of provincial needs and concerns that may be addressed by the overall OHPRS network. We are also able to explore differences in the many aspects of the survey data within and across many different sub-groups of survey participants.

In terms of the geographic focus of their work the large majority of our survey participants worked in Ontario (97.7%), with the remainder drawn from other provinces/territories (about 1%), or outside Canada (less than .5%). For those working in Ontario we asked which region of the province most accurately reflected the area they served. *Figure 1* shows the excellent balance obtained in the survey sample across the various regions. Just over 8% indicated they served "the province as a whole".

The survey participants reported working in a wide variety of geographic contexts: 43% indicated "a combination of urban and rural areas" and 31.8% indicated "a large urban area" (*Figure 2*). When probed further about the geographic focus of their work, 58.1% indicated "local" and 28.4% "regional" (*Figure 3*). There was probably some variation in the interpretation of these terms. The small balance reported a provincial, national or international focus. Thus, our sample is comprised of a large group of health promoters across Ontario who are working primarily in their community context.

Figure 1. Region of Ontario most accurately reflecting the area the respondent serves (n=845)

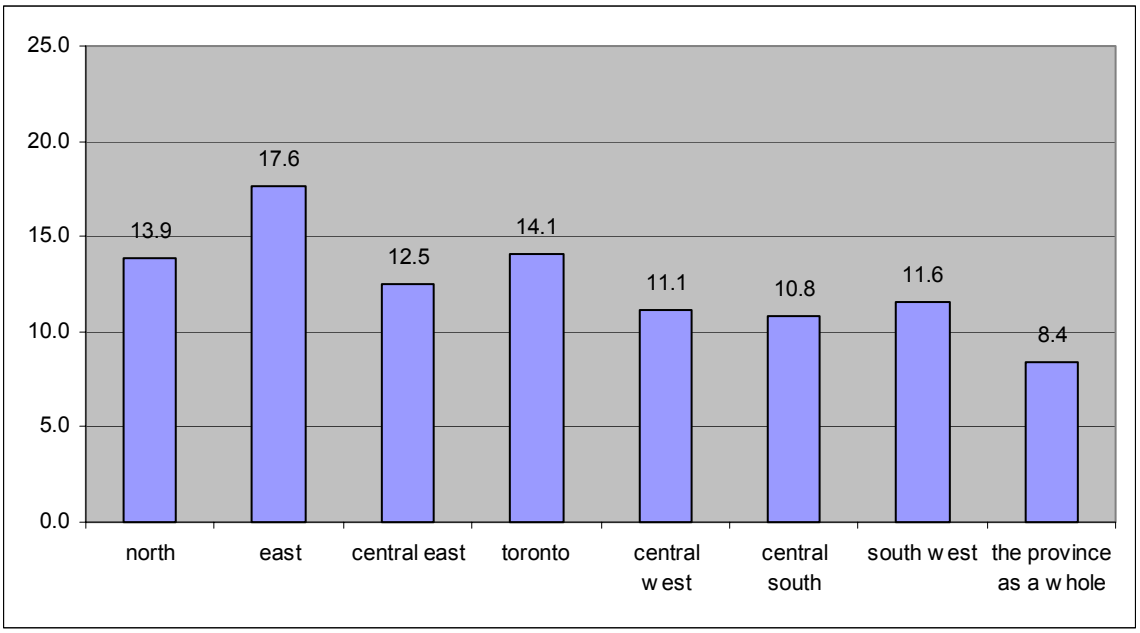


Figure 2. Type of work jurisdiction (n=858)

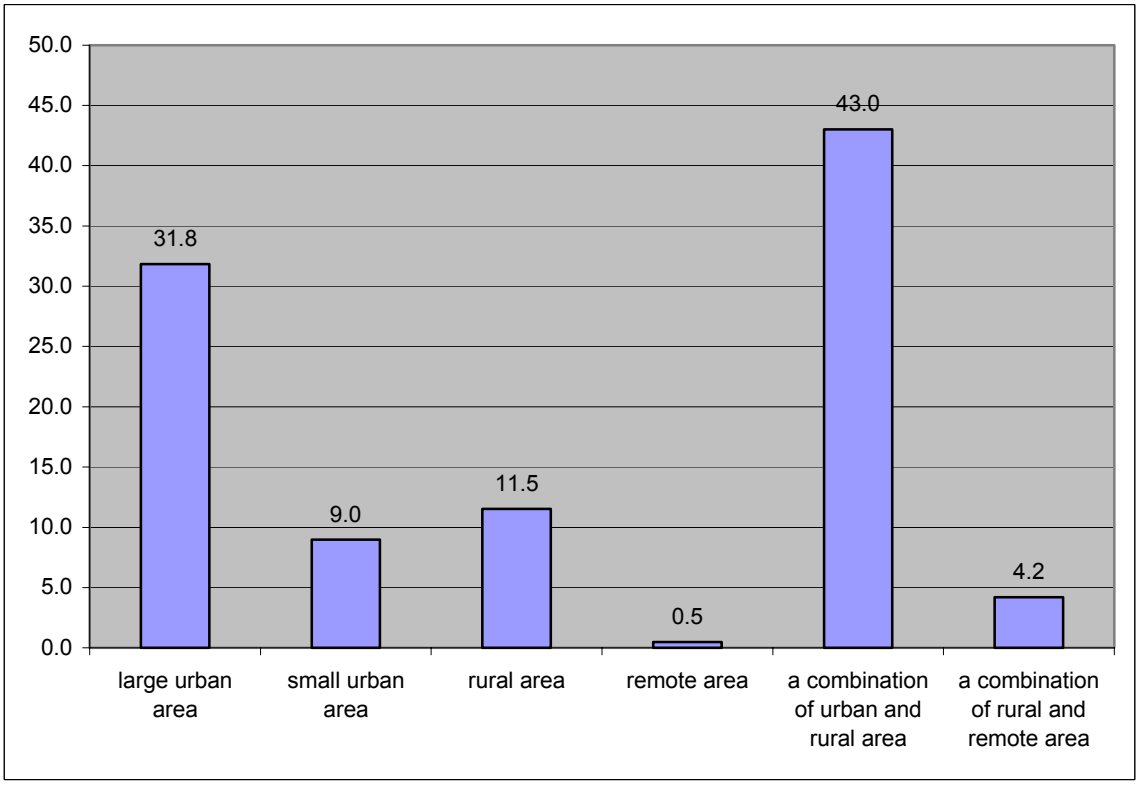
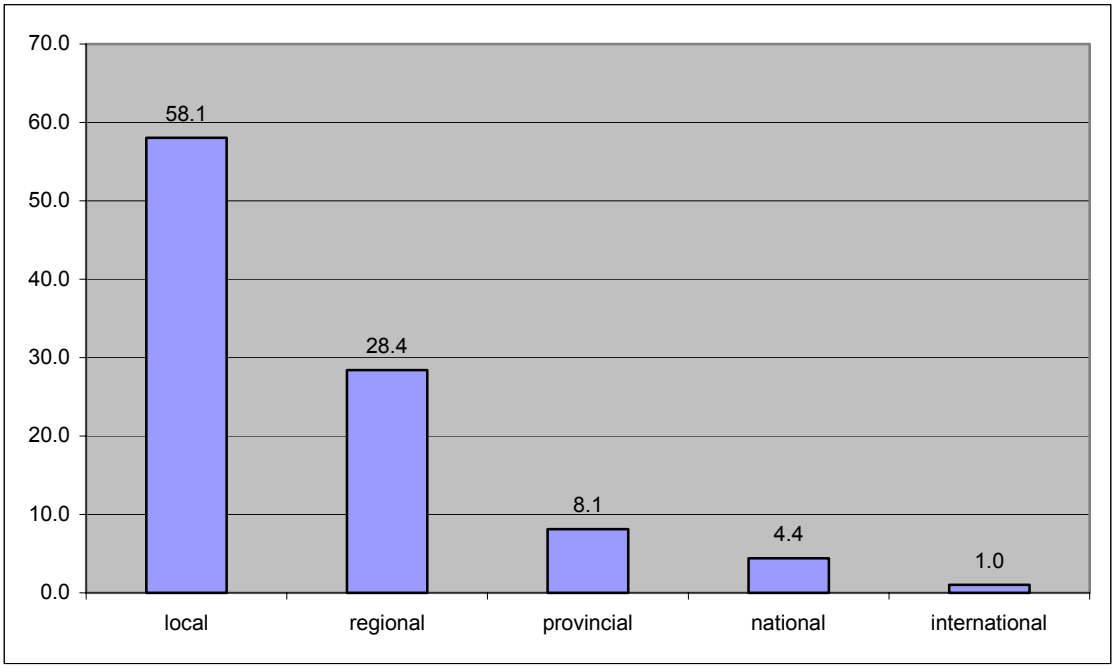


Figure 3. Geographic focus of respondents' health promotion work (n=863)



Many health promoters in Ontario work in areas with a significant Francophone population and several parts of our survey probed issues associated with needs related to the provision of services and supports in French. In terms of background information about the respondent we found that almost half of our respondents did not work with the Francophone community and about another 40% engaged in up to 25% of their work with this community (*Figure 4*). Smaller percentages of respondents were engaged with the Francophone community on a more frequent basis and 2% worked exclusively with this population.

Figure 4. Percentage of respondent's work with Francophone community (n =847)

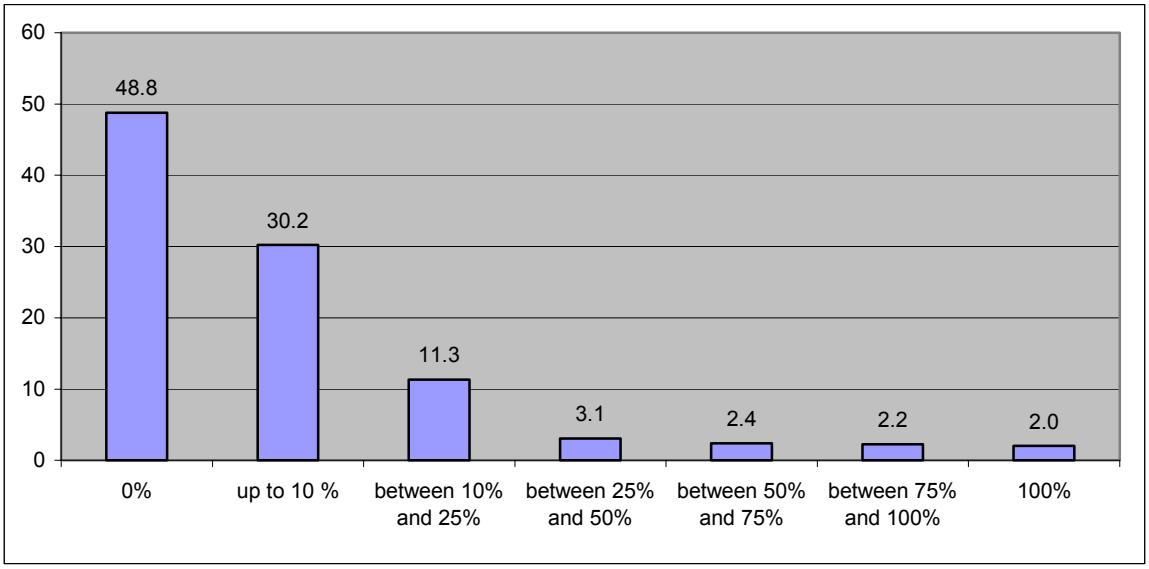
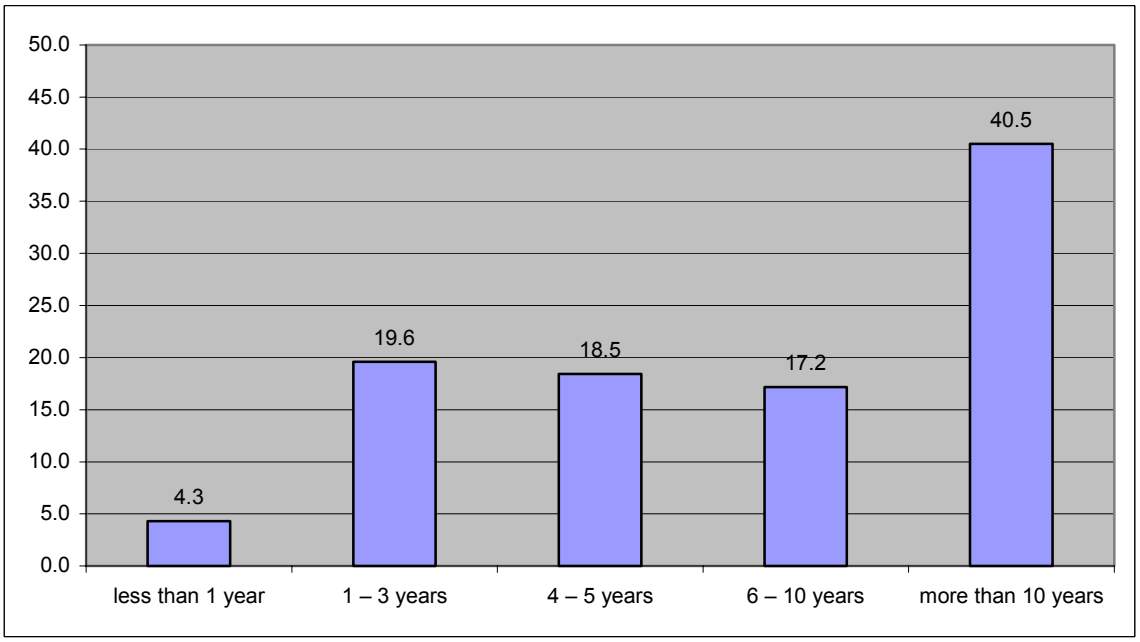


Figure 5. Years involved in health promotion (n=862)



In terms of years of involvement in health promotion, about 40% reported more than 10 years of engagement in the field, with the balance of respondents spread across the other categories (*Figure 5*). Only 4.3% had been working for less than one year. 90.1% of respondents were currently working as paid employees, 5.7% were self-employed and 4.2% were volunteers. Of the paid employees, 74% worked full-time and 26% part-time.

Also, for those working as paid employees, we inquired about the type of organization in which they worked (*Table 3*). A large part of our sample was drawn from the local Public Health Units/Departments (39.2%) as well as Community Health Centres (13.2%). These are undoubtedly "core customers" of many of the OHPRS organizations. However, the overall survey sample, which was identified largely from the contact lists, attests to the diversity of organizations involved in health promotion in Ontario. About 10% were working in hospitals, 5% in schools (clearly under-represented in this survey) and smaller percentages from the many other categories shown in *Table 3*. The "other" category for these respondents was comprised mainly of people working in health or social service agencies (45 or 43.3% of the "other" category), other local non-profits (18 or 17.3%) and private industry (9 or 8.6%)[9].

Job titles also varied considerably (*Table 4*). One fifth of respondents (20.1%) reported their job position as "public health nurse". A further 18.4% were working in a managerial type of position and in this group we included a small number of "chairpersons" of local coalitions or committees. About 12% of respondents identified themselves as being in a "Coordinator" position, sometimes qualified as "project coordinator", "health promotion coordinator" or another coordinator role, and a further 11.9% gave a job position as "health promoter". Other health professional designations such as dietician, midwife, or nutritionist were cited by 8.9%. Table 4 shows the smaller percentages reported in several other categories, for example, community workers/animators, teachers and principals/superintendents and analysts/evaluators and researchers.

Within this same group of paid employees, and for those able to estimate, we found quite a range in the size of the organization in which they work (*Figure 6*). Results showed as many as 24.1% working in organizations with over 500 employees, and about the same number (21.1%) working in organizations with less than 25 people.

[9] See Table Core29c in Appendix C for a complete set of coded open-ended responses to the "other" category for this question on organizational affiliation.

Table 3. Type of workplace for those health promoters working in an organizational context (n = 753)

	n	%
Public Health Unit/Dept.	295	39.2
Community Health Centre	99	13.2
Hospital[1]	73	9.7
School/other primary or secondary	37	4.9
Municipal government	29	3.8
National NGO	23	3.1
University/college	22	2.9
Provincial NGO	15	2.0
Federal government	11	1.5
Community centre	11	1.5
Multicultural organization	8	1.1
Health promotion resource centre	6	<1
Research organization	4	<1
Social planning council	4	<1
Parks and recreation	2	<1
Environmental organization	1	<1
Other	113	15.0
Total	**753**	**100.0**

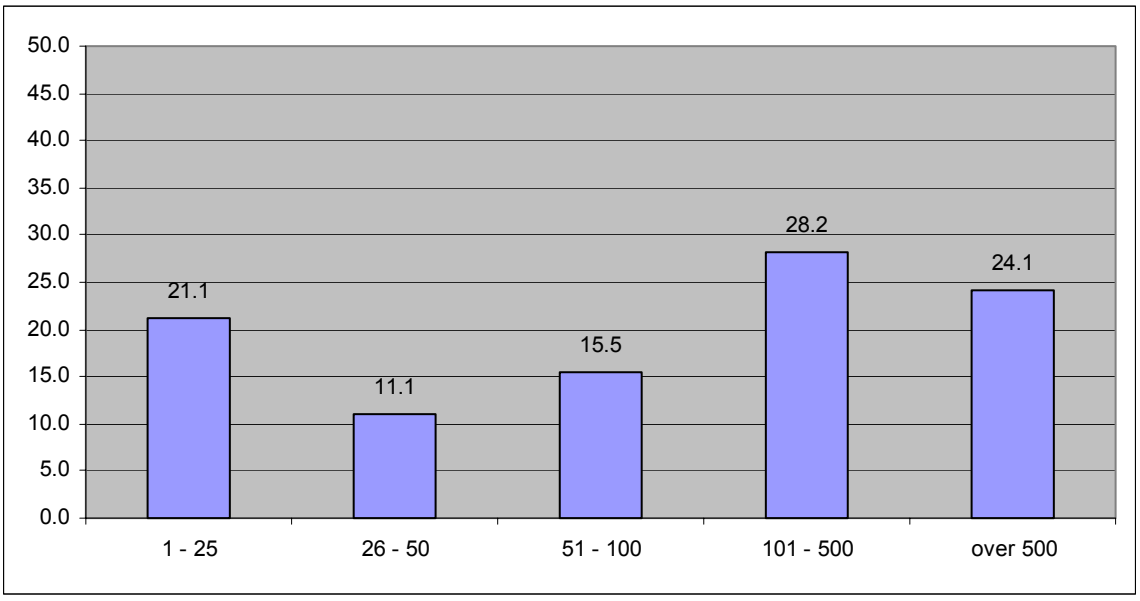
[1] includes the Centre for Addiction and Mental Health. Although CAMH is a hospital it also provides a diverse range of research, education, community development and health promotion and prevention functions. This is undoubtedly true of several other hospitals in this category.

Using both an open-ended question, as well as questions employing fixed categories, we also inquired about the type of work the respondent was engaged in. For the structured questions we asked both about the topic areas in which the respondent was currently engaged (*Figure 7*), and the types of strategies and activities that had been implemented (*Figure 8*). These categories were developed from a comprehensive health promotion framework used by OHPRS in the qualitative assessment of health promotion capacity (Rush and Andrew, 2004), as well as prior work of the Ontario Prevention Clearinghouse.

Table 4. Title of respondent's position (n=706)

	n	%
Public health nurse	142	20.1
Manager/executive director/ /supervisor	130	18.4
Program or project coordinator/other coordinator position	87	12.3
Health promoter	84	11.9
Other profession (e.g. dietician, nutritionist)	63	8.9
Community worker, animator, case manager	39	5.5
Teacher/instructor/educator/lecturer	34	4.8
Program consultant	31	4.4
Other nursing	30	4.3
Analyst/evaluator/researcher/evaluation	19	2.7
Project officer	14	2.0
Principal/superintendent	7	1.0
Planner	7	1.0
Other	14	2.0
Total	**706**	**100.0**

Figure 6. Size of respondent's organization (n=730)



In interpreting these data it is important to reiterate that the percentage of health promoters reported here as being involved in various topic areas and activities/strategies is influenced by the process through which our sample was identified. Since the vast majority of respondents were identified from the contact lists of the various OHPRS organizations, and since the number sampled was not directly proportionate to the size of their client base, some of the topic-specific OHPRS organizations contributed more than others to the final sample. Best Start and PTCC would be two examples contributing comparatively large numbers of survey participants working in the areas of maternal and infant health, and tobacco control, respectively. The data are also open to varied interpretation of the terms used by the respondent. Terms such as "self help peer support", "chronic disease prevention", "advocacy" and "community mobilization/capacity building" are probably not interpreted uniformly among health promoters.

It is also important to note that virtually all respondents endorsed multiple topic areas and activities/strategies. Thus, more detailed statistical analyses will be possible in future reports to show the *clustering* of topic areas and strategies/activities in which selected sub-groups of health promoters are engaged. Of particular value to the present project, however, is the wide cross-section of topic areas and activities/strategies/ endorsed. Again, this gives us confidence in painting a provincial picture of needs and issues within the health promotion field as currently practiced in Ontario.

In terms of topic areas (*Figure 7*), many topics that were frequently endorsed map onto risk factors or target populations that are the focal areas of several of the OHPRS members. This includes physical activity (46.6%), nutrition (45.7%), school-based health promotion (39%), alcohol and other drugs (36.9%), heart health (38.6%), maternal and child health (36%), and self-help/mutual aid (35.9%). Other topic areas engaged in are more broad-based such as community mobilization/capacity building (46.6%), chronic disease prevention (45.1%), determinants of health such as poverty/income/housing/employment (30.3%), and multicultural issues and topics (27%). Three other topic areas were endorsed by about a quarter to one third of respondents and

which have no clearly designated focal point in the OHPRS network – mental health (36%), injury prevention (31.2%) and violence (24.7%).

Figure 7. Health promotion topic areas in which respondents were engaged (n=875)

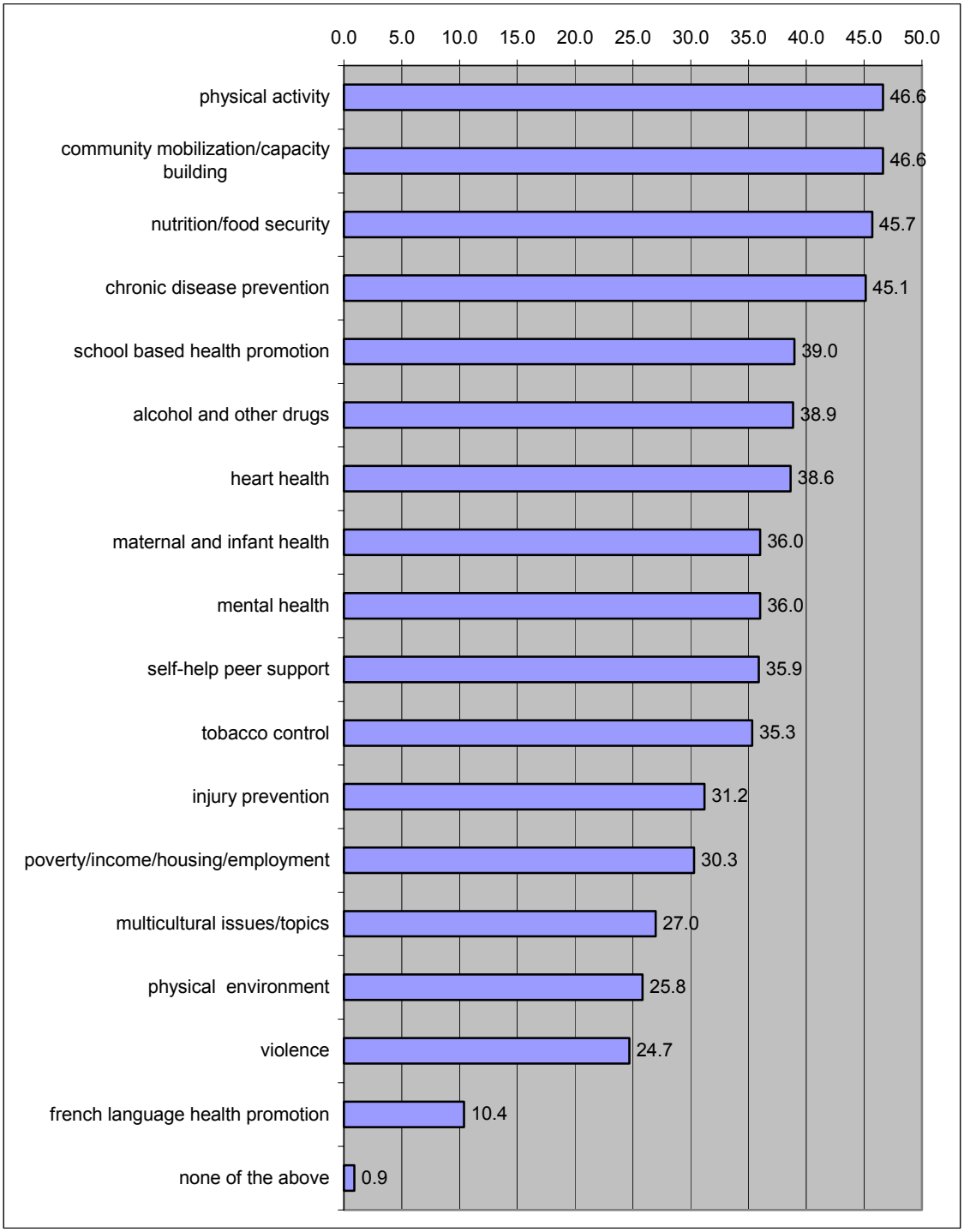
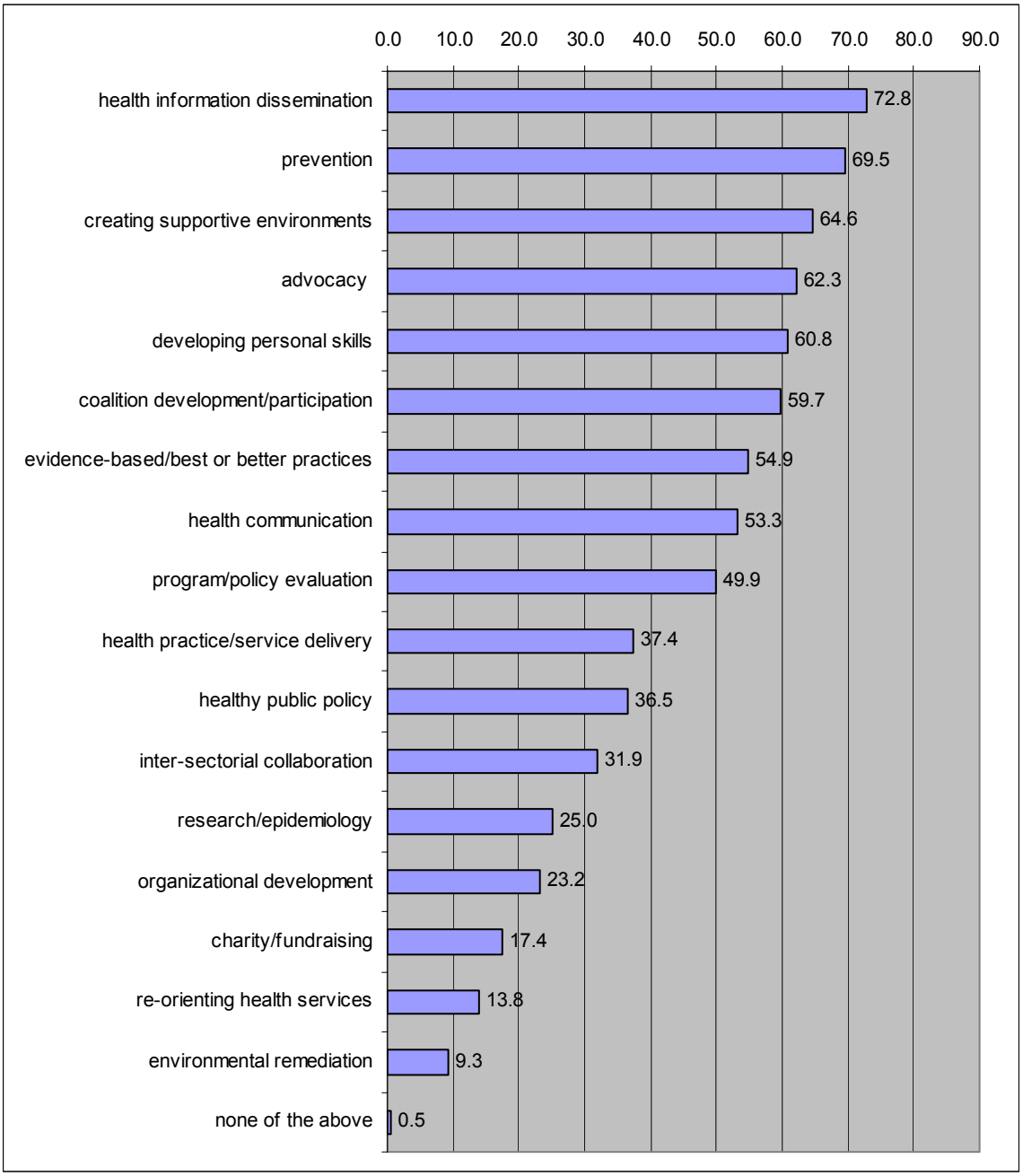


Figure 8. Health promotion related strategies/activities respondent has implemented (n = 875)



With respect to the types of strategies and activities implemented by respondents we observed a broad and comprehensive range of activities, as one might expect based on research concerning the nature and scope of health promotion (*Figure 8*). For example, we see a high percentage engaging in the dissemination of health information and developing personal skills, two strategies derived from a traditional health education

paradigm. We also see, however, a real commitment to a broader ecological approach as seen by the significant involvement in creating supportive environments (64.6%) advocacy (62.3%), and healthy public policy (36.5%). A significant percentage of respondents were actively working with their communities and in a partnership model as reflected in the endorsement of coalition development/participation (59.7%), and inter-sector collaboration (31.9%). The high endorsement given to evidence-based best or better practices is also noteworthy (54.9%), as is the significant proportion that have implemented program or policy evaluation (49.9%). Only 9.3% had been involved in "environmental remediation (e.g., air quality), and only 13.8% reported involvement in "re-orienting health services". The latter is an important but typically neglected aspect of a comprehensive approach to health promotion as stated in the Ottawa Charter many years ago.

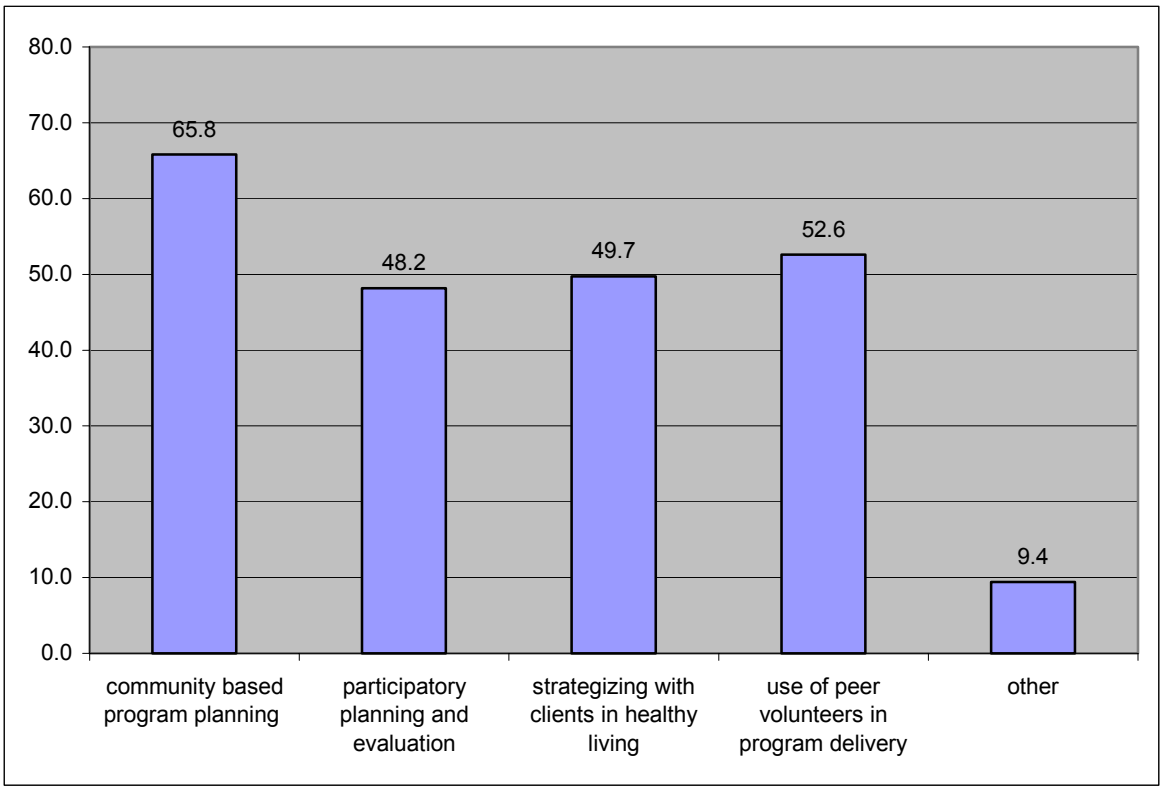
Lastly, in terms of respondent background information, we probed somewhat deeper into the area of self-help mutual aid as a health promotion topic or strategy in which they may be engaged. Respondents were asked if they had used self-help/mutual aid strategies in their health promotion work in the past two years. Several examples were offered with this survey item to help respondents frame their response (support groups, peer mentoring, participatory action planning, client-drive initiatives). 756 participants responded to the question and, of these, 521 or 68.9% replied in the affirmative that they had used one or more self-help/mutual aid strategies. When asked what types of strategies they had used, the responses were consistent with the few examples given in the initial structured part of the question with around 50% to 65% of the group endorsing each option (Figure 9). 9.4% also cited "other" strategies - support/chat groups (13 or 27.1% of the "other" group); named a program or community resource as an example of their self-help work (6 or 12.5%); involve peer volunteers in some capacity, including a paid capacity (5 or 10.4%) or they cited individual/group work or skills training (also 5 or 10.4%)[10].

We also examined whether the use of self-help/mutual aid strategies differed for those working in different organizational contexts. Those working in Community Health

[10] (see Table Core10 in Appendix C for more detailed categorization of the open-ended responses).

Centres were more likely to report using these strategies (84.2%) compared to respondents working in Public Health Units/Departments (68.0%) or other types of organizations combined (64.8%).

Figure 9. Types of reported self-help strategies in past two years (n=521)



The preceding charts and tables provide an overview of the characteristics of the survey sample in terms of involvement in health promotion and the nature of their work. To close this introductory section, which has described our survey respondents and their health promotion work, we offer a few of the open-ended responses to the question about the nature of their work in order to bring some of the people "alive" for the reader and to illustrate the multi-dimensional nature of their work We then turn to their feedback on accessing the information and supports needed to effectively undertake this work.

Ontario's Health Promoters Describe Their Work

Our organization works with perinatal health care providers in hospitals, health units, and community service agencies. Our mission is to improve the quality of perinatal care and we do this through three areas of evidence-based work: professional development, community support, and health status work using a perinatal database.

I am a Community Programs Manager, serving a target population of adolescents & at-risk homeless. Operating out of a community health centre & satellite sites targeting at-risk population of both youth & adults. Risk factors for adolescents include STDs, pregnancy and birth control. With the homeless we focus on general overall health care i.e. infection, cuts, mental health & hygiene.

As a community dietician, the health promotion I do is related mainly to diet and lifestyle issues. My goal is to help delay or prevent chronic diseases.

Assessing level of (alcohol) use among individuals of aboriginal ancestry; utilization harm reduction strategies; provide information/education re: responsible use of alcohol.

I plan, develop, implement and evaluate dental health promotion strategies, using a combination of risk-based and population health approaches. Primary target group is school-aged children to improve their oral health, important secondary targets are parents, teachers and child care providers, as well as other human service providers. I work with schools, child care centers and other health professionals.

I co-ordinate a diabetes awareness project working with members of the Caribbean, Vietnamese, Polish and Spanish speaking communities. We aim to raise awareness in the communities about diabetes, risk factors, ways to prevent it, and the importance of being tested for diabetes. We are using community animators from the four communities to engage the community through a communications campaign which uses community media, health fairs, community events and meetings with community leaders.

Raising awareness of sources of early childhood lead exposure. At risk groups include children 90-6 yrs living in pre-1950's housing. Poverty is another risk factor.

Physical education teacher for students in kindergarten to grade 5. I work with 550 students, primarily the physical activities and skills portion of the curriculum but we are always discussing health practices.

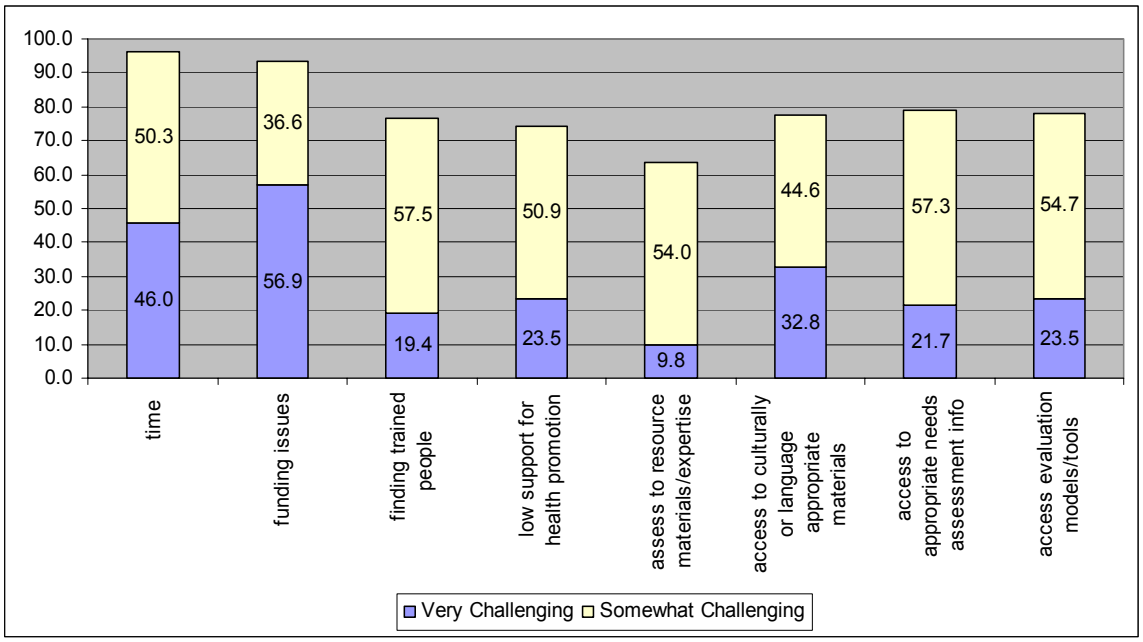
I am a public health nurse in a small town health unit. My program areas are tobacco use prevention (youth) protection (community, children) cessation (adult), early detection of cancer (female adults) and skin cancer prevention (community). My primary strategies are health education, supportive environments and healthy public policy.

3.2 Accessing information and supports for health promotion work

3.2.1 Perceived Difficulties and Challenges

We asked about the challenges in planning and implementing health promotion programs. *Figure 10* shows the percentage reporting various issues as "very challenging" (lower part of bar graph) or "somewhat challenging" (upper part of bar graph). Resource-related issues appear to be particularly challenging and were expressed as either *funding* (56.9% - very challenging; 36.6% - challenging) and *time* (46.0% - very challenging; 50.3% - challenging) or *finding trained people* (19.4% - very challenging; 57.5% - challenging). Access to *appropriate needs assessment information* as well as *access to evaluation models/tools* were also endorsed as significant barriers (21.7% and 23.5% very challenging, respectively), as was access to *cultural and language appropriate* materials and expertise (32.8%). Many respondents indicated that they experienced *low support for health promotion* as a very significant (23.5%) or somewhat significant (50.9%) challenge in their work. Although the *access to resources and expertise* is the least challenging issue faced by respondents (9.8% - very challenging; 54% - challenging) this is still an issue for a significant segment of the sample. Overall, the data paint a picture of the very challenging nature of working in health promotion in Ontario.

Figure 10. Challenges experienced planning/implementing health promotion activities



The open-ended probe for additional challenges reflected many of these same response categories. Of 216 replies, we found low support for, and difficulty making, the business case for health promotion to be most common (17.1%). This was followed by challenges accessing relevant resource material and expertise (16.7%). Other salient issues were the lack of internal organization support for health promotion or their topic area (10.6%); funding issues (8.3%), lack of coordination/duplication of effort (8.3%) and time (8.3%)[11].

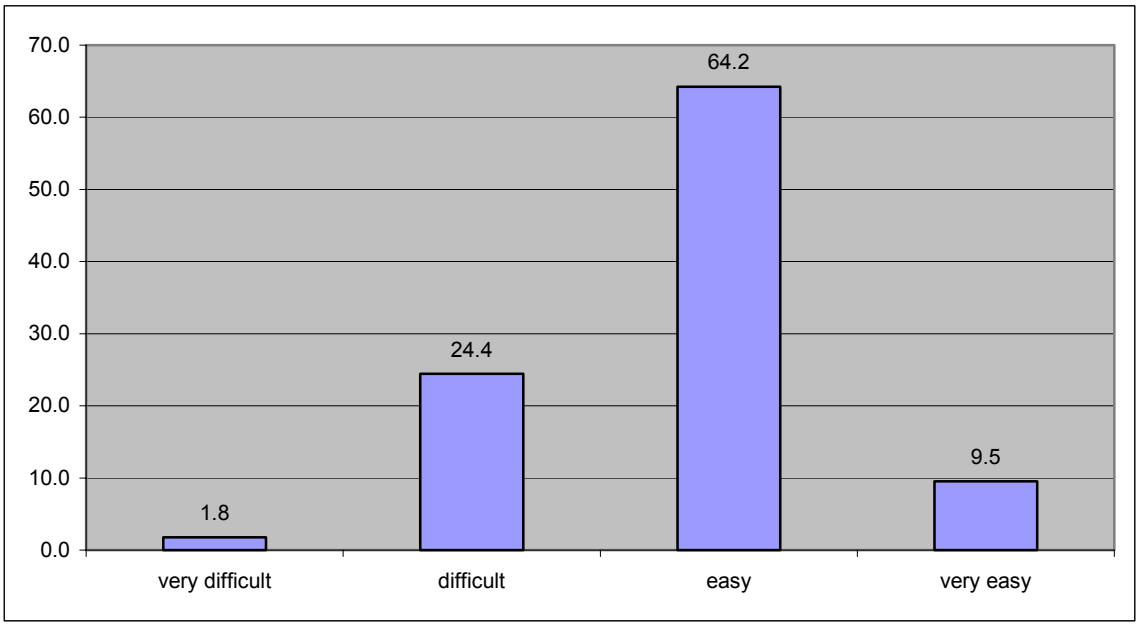
> *"Trying to do true health promotion work (community-based, consensus-building) while trying to meet the province's mandatory (prescriptive) guidelines."*

> *"A challenge is that the broader community understanding of health promotion is that it is education only"*

When asked how easy it has been to get the information needed for their work (Figure 11) about 25% of the health promoters reported it to be difficult (24.4%) or very difficult (1.8%). Although the majority reported "easy" (64.2%) or "very easy" (9.5%) access to information, further analyses provide more insight into these data.

> *"Finding evidence based materials that are clear and specific, so someone can just pick it up and run with it, rather then having to spend a lot of time figuring out how to implement a program quickly"*

Figure 11. Reported ease of access to information for health promotion related work. (n=839).



[11] Table Core5 in Appendix C provides additional and more detailed coded data.

There was no difference across region in terms of reported ease of access to information. Access to information was, however, more difficult for health promoters working in CHC's, as well as those with less than three years experience. Reported ease of access to information was also related to the topic areas in which respondents were engaged. Those working in tobacco control, heart health and chronic disease prevention generally reported better access to information, and the number of such respondents in the database weight the data considerably. Reported access was also marginally better for several other topics specific to some of the resource centres, for example, school-based health promotion, nutrition, physical activity, and alcohol and other drugs. In *Figure 12* we highlight those topic areas that stood out among survey respondents as being more difficult to locate required information. In *Figure 11* we showed that, across all survey respondents, 26.2% reported "very difficult" or "difficult" access, if we combine these two categories. The horizontal line in Figure 12 shows the average percentage reporting "difficult" or "very difficult" access to information among those topic areas with a percentage below this sample "norm". The topic areas falling at or above the normative level of 26.2% included: poverty/income/housing/employment (31.0%); French language health promotion (30.3%); community mobilization/capacity building (29.1%); multicultural issues/topics (28.4%); maternal and infant health (28%); mental health ((27.1%) self-help peer support (26.7%) and violence (26.2%).

Those reporting access to information to be "difficult" or "very difficult" were asked with an open-ended question to describe the access issues they had encountered. The coded responses from 204 participants are shown in *Table 5*. We coded up to two responses for each person offering comments resulting in 281 coded answers as shown in *Table 5*. A variety of access issues were evident and any attempt to summarize these to a small number of key issues runs the risk of discounting important issues faced by a small percentage of respondents working in unique and perhaps very trying circumstances. That said, the most frequent response

"I would really like to see more accurate and consistent statistics nationally and Provincial/Territorial regarding breastfeeding exclusivity and duration. There are more stats coming from other countries but little consistent stats and research in Canada around breastfeeding rates"

"Upstream evidence to support physical activity in adulthood will decrease the likelihood of falls in the elderly"

concerned a lack of information that was specific to their particular topic area of focus (22.1%), for example, breastfeeding, dental health promotion, smoking cessation among youth, tuberculosis and prevention/health promotion. In some of these instances this was couched in terms of lacking best/better practice evidence in their area, while in other instances it was a more general concern reflecting lack of information. Concerns about *local* barriers and challenges to accessing information and resource people were expressed in 11.4% of the comments. Another 11% of the comments reflected the difficulty finding what is out there as a result of time or other resource constraints and another 9.3% concerned a more general difficulty with knowing where to look or who has what information available. Other access issues were cost related (e.g., for materials/shipping, general costs concerns) (7.8%) or language and culture–specific (6.4% Francophone and 7.5 % other languages or cultures). A lack of research information or synthesized information on best/better practices was reflected in 5% of the comments and another 5% decried the lack of local information for their jurisdiction. The "other" comments (18.3%) are further sub-categorized in Appendix C[12].

"It is difficult to find resources tailored to unique populations. Often it is difficult to try and tailor certain resources to fit the population group I am working with."

" No access to on-line lit searches; no library at public health unit"

"Reduced funding of health promotion programs due to city deficits and urgent priorities such as homelessness, poverty issues. Reduced staff - less time to explore available resources"

"Unequal access to services and lack of understanding in cultural specific health practice"

The follow-up question on *additional* needs with respect to access to appropriate resources materials and expertise was answered by a large number of respondents (n = 526) and resulted in 556 codeable responses[13]. The same coding scheme was used as for *Table 5* above, which was specific to information needs and only for those reporting "difficult" of "very difficult" access. The most salient issues for this larger group of

[12] See Table Core4b in Appendix C.
[13] An additional 83 responses were not codeable since no additional needs were reported (e.g., none/nothing mentioned). See Table Core4c in Appendix C for the full set of these coded data.

respondents were similar to those emerging in that sub-group. Specifically, 20.5% noted poor access to information specific to a topic of interest and a further 12.0% reflected on poor local access to information and resource people. Other issues related to "finding what is out there" also predominated, for example, the need for "more centralized source of contacts and information" (9.0%); specific concerns about lack of time and resources to find what they need (6.7%); "don't know where to look, who has what, too much info" (6.3%), and also cost related issues "finding free materials, shipping costs" (5.2%).

Figure 12. Percentage reporting access to information to be "difficult" or "very difficult" according to health promotion topic area worked in (vertical bar equals sample average across all topic areas).

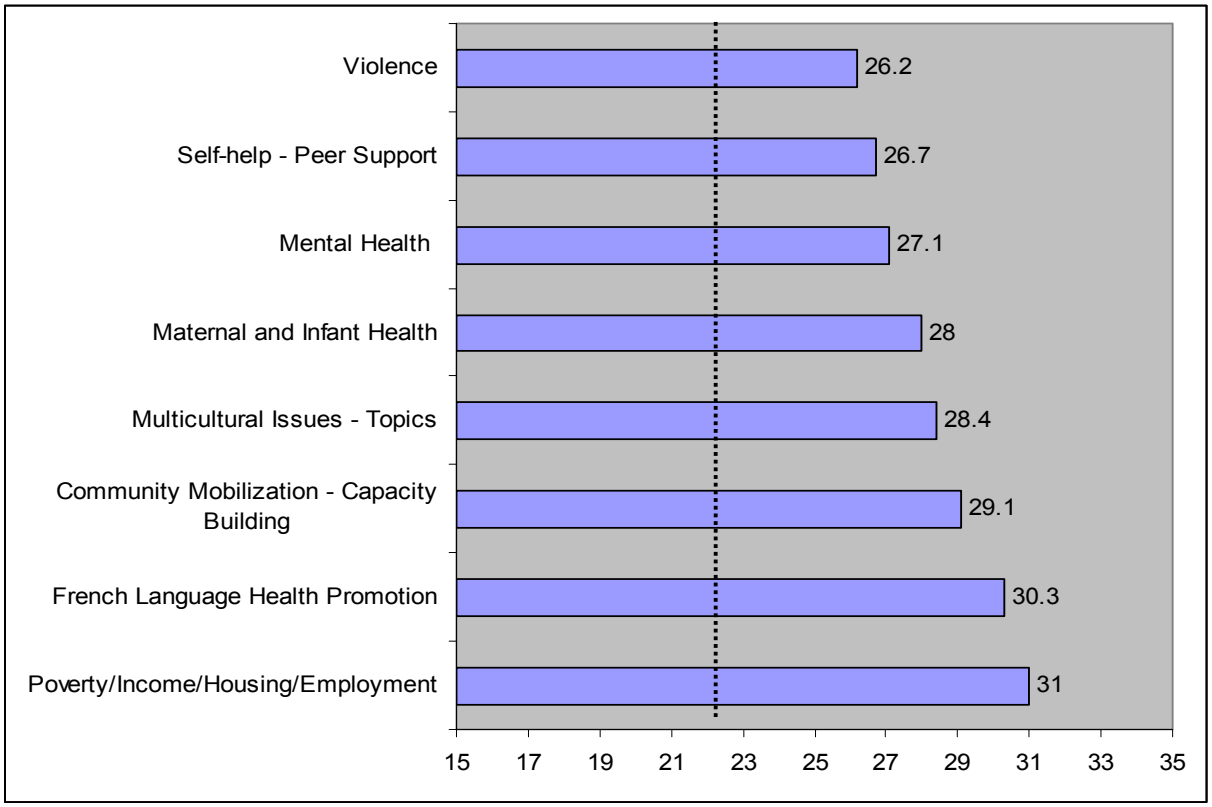


Table 5. Access issues cited by those indicating "difficult" or "very difficult" access

	n	%
Topic specific – e.g. not enough on specific topic of interest, incl. lack of best practice information on that topic	62	22.1
Generally poor local access to information/ resource people; need to find/go through less than ideal local channels	32	11.4
Finding out what is out there –specific concerns about lack of time or resources	31	11.0
Finding out what is out there – general concerns with not knowing know where to look or who to ask, too much info, don't know web search terms	26	9.3
Cost – finding free materials, shipping, general costs	22	7.8
Access issue is language or culture-related	21	7.5
Francophone specific concerns such as access to materials, translation, experts	18	6.4
General concern about lack of evidence-based practice recommendations	14	5.0
Access issue is jurisdiction specific - not enough local information	14	5.0
Other	58	18.3
Total	**281**	**100.0**

3.2.2 Multicultural Issues and Challenges

We asked whether respondents had experienced barriers to accessing health promotion materials with respect to the cultural groups worked with. A total of 775 participants considered the question applicable to their work and, of these, 449 or 61.9% indicated such barriers existed for them. This would represent 51.3% of the total survey sample. Given the variation in cultural diversity across Ontario it is of interest to also examine regional differences in the percentage agreeing that cultural barriers impact their health promotion work. Regional differences are evident (e.g., Toronto was the highest at 80.2% agreement compared to Central East Region at 41.4%). This variation aside, five of the eight regions reported percentages over 60%. Thus, the language and cultural barriers to health promotion in Ontario are far from Toronto–specific issues.

Table 6 shows the coded responses to an open-ended item that went on to ask for a description of barriers in working with different cultural groups. Of 477 codeable responses the most frequent was a general expression of need for translated or otherwise culturally appropriate materials (35.8%). Other specific comments were offered by the respondent in terms of their own limitations in languages other than English, or needing to find people who speak the language or know the culture (12.8%). We coded separately all comments specific to the need for translated materials in French or access to Francophones for support. This accounted for another 10.1% of responses. Several other languages, however, were also cited such as Chinese, Punjabi, Hindi, Ukrainian, Finnish, Portuguese, Italian, Tamil, German Mennonite, Urdu, Spanish, Arabic, and many others (10.1%). Another 9.4% commented specifically on the need for material to support their work with First Nations/Aboriginal people. Other comments included concerns about literacy issues in English (7.8%) and lack of information or needs assessment data in different cultural groups (6.3%). A small number of other comments also fell outside this coding structure (6.3%).

"Very multi-cultural community, many communities with great need and limited materials available in multiple languages"

"Getting resources in the appropriate language that are culturally relevant--not just translated. Getting detailed information about difference cultural groups living in Canada."

"Many materials are not translated into French (as many projects don't have money for this). Some do not have contact info for asking questions and some require a fee to be paid"

"Native, Chinese, Italian, Ukrainian populations- limited resources in other languages besides English and French."

"Very little about how main stream/best practices cases work with culturally different populations"

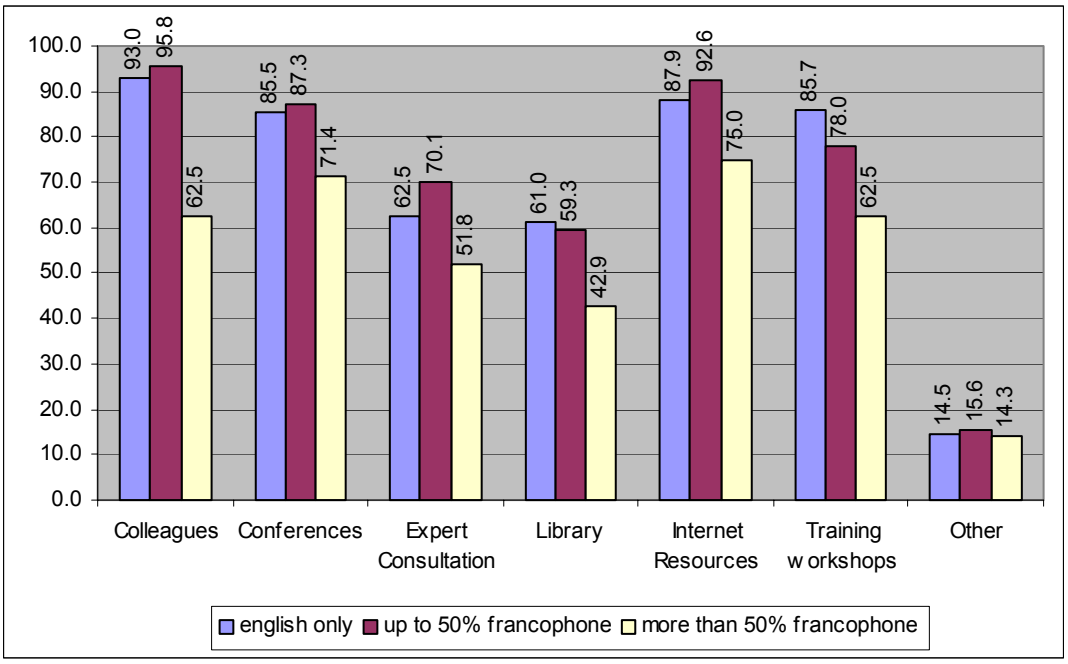
Table 6. Barriers to access with respect to cultural groups worked with

	n	%
Need translated/cultural specific materials – general statement	171	35.8
Need people who speak the language/know the culture	61	12.8
Need translated/cultural specific materials – Francophone specific	48	10.1
Need translated/cultural specific materials – other specific languages/cultures stated	48	10.1
Translated/cultural specific materials needed – Aboriginal needs	45	9.4
Readability level of (e.g. English) materials is too high – literacy issues	37	7.8
Lack of information/need assessment data on different cultural groups	30	6.3
Lack of time/resources to secure what is available, or to get advice	7	1.5
Other	30	6.3
Total	**477**	**100.0**

3.2.3 Current Sources of Information and Support for Health Promotion

We were also interested in exploring the sources and types of health promotion services and supports that were being accessed by health promoters in Ontario. In that regard we first asked which of several formal and informal sources had been accessed in the past two years. Because the questionnaire separated the response options for both English and French language services and supports it is most appropriate to summarize the responses according to the percentage of the respondent's work they reported with the Francophone community. For this purpose we created three groups: those not working with the Francophone community at all; those working with this community up to 50% of the time and those reporting between 50% and 100% of their work with the Francophone community. The resulting data are summarized in *Figure 13* (sources of English language information and support) and *Figure 14* (sources of French language information and support).

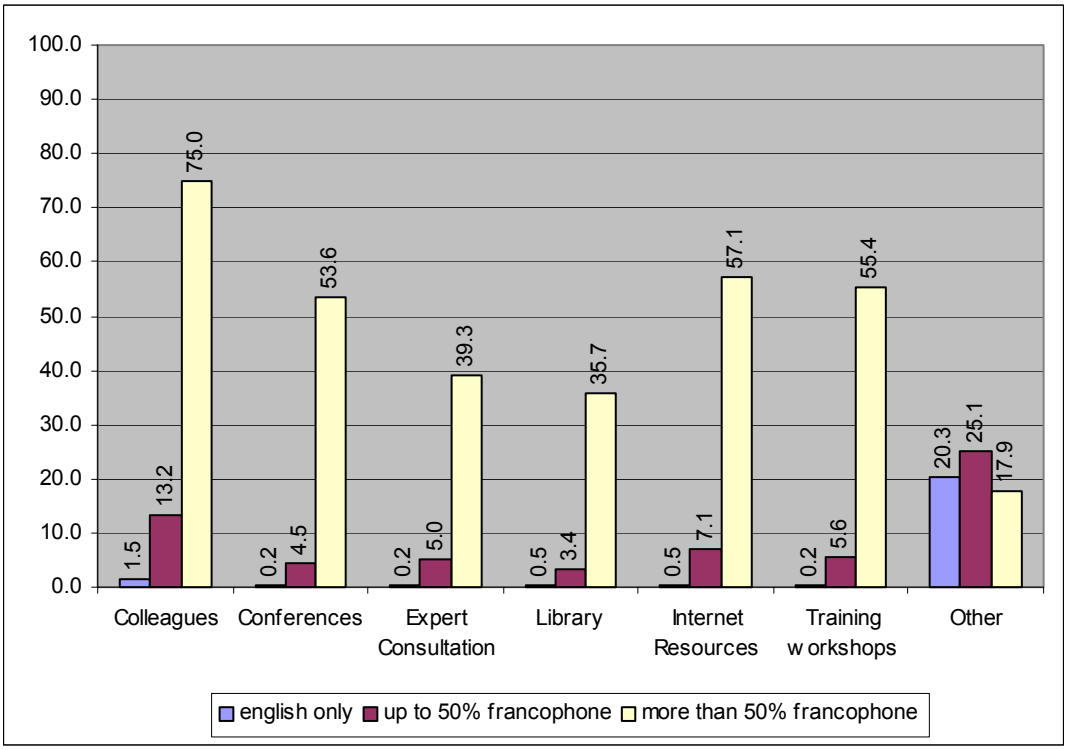
Figure 13. Sources of English language information and support in past two years according to percentage of work with Anglophone/Francophone community



Looking first across the various sources of information and support, and regardless of the language issue, one can see the important role played by informal contact with respondents, the Internet, as well as both conferences and training workshops. Expert consultation as well as accessing library reference material were also important categories. The sources of information and support mentioned in the "other" category tended to be other community agencies/sources (15.3%), courses or university (14.0%), consumers/client groups (13.4%); or colleagues/professional networks (10.8%). Public health was cited by 12 or 7.6% of respondents. Another 12.1% cited a *type* of information rather than a source of information, admittedly a somewhat blurry distinction.[14]

[14] See Table Core3a in Appendix C for more detailed coded information.

Figure 14. Sources of French language information and support in past two years according to percentage of work with Anglophone/Francophone community.



There were, however, important differences in the survey findings across our sub-categorization by percentage of work with the Francophone community. For those working over 50% time with the Francophone community, and in terms of their accessing *French language supports,* the pattern of results across the categories of sources of support is the same as their "English-only counterparts. However, the percentages accessing virtually all sources of support in the French language are marginally lower. For example, 93% of the English-only group sought out English-speaking colleagues (*Figure 13*) compared to 75% of the over 50% Francophone group (*Figure 14*); and 87.9% of the English-only group accessed information in English over the Internet (*Figure 13*) compared to 57.1% of the group working predominantly with the French community (*Figure 14*)[15]. This probably reflects the relative isolation of some Francophone health promoters from other health promoters working in their language, as well as difficulties accessing French-language materials. Both of these issues came

[15] Only 8 comments were provided here for French language source and this is too few for comparative purposes. Four of the 8 comments provided concerned other community agencies

through more clearly in subsequent parts of the questionnaire. *Figures 13* and *14*, however, also suggest these issues may be particularly challenging for those working with the Francophone community but in less than 50% of their work. Here we see very little reported access to French-language colleagues (13.2%), or any of the formal sources of information and support (*Figure 14*). Clearly this group is seeking support predominantly from English-speaking colleagues and other sources of material in the English language.

In *Figures 15* and *16*, we use the same approach to analysing the survey responses with respect to the *types* of resource material used in the past two years for planning, implementing and/or evaluating health promotion programs. The most frequently accessed materials were research articles and books. Best/better practice documents were accessed by between 10% and 15% of respondents, regardless of the sub-category reflecting the percentage of their work with the Francophone community. Comparatively few people reported using newsletters. This may have reflected respondents' interpretation of the word "use" as undoubtedly many respondents will be on the mailing list for various newsletters (e.g., OHPE Bulletin, Heart Health newsletter).

A large percentage of respondents cited "other" kinds of resource material being used: 66% with respect to other types of English materials; about 5% of the total sample with respect to other types of French language material. Of 248 responses, just over 50% cited a *source* of information, again confusing the source and type of information. Our coding of the responses tried with varying degrees of success to make subtle distinctions between what might be referred to as a "resource kit" (e.g., CAMH Promoting Community Awareness materials; campaigns such as Quit Smoking and Breathing Spaces), and other types of materials such as reports, documents, and evaluation tools. We also coded specific references to OHPRS organizations, although this was typically a generic comment and not necessarily concerning a particular product (e.g., "THCU training workshops", "Internet- Ophea/Active Ontario"). The detailed results of the coding is presented in *Table Core3b* in Appendix C. Whereas a very small percentage cited what we interpreted to be "resource kits" (4.0%), another 12.1% of the responses concerned various other materials and products such as "evaluation scales from Health Canada",

"government guidelines", "project reports", "mailouts from public health". A further 13.7% cited research and/or needs assessment information, often collected by the respondent and colleagues. 5.6% made a generic reference to an OHPRS organization but it wasn't clear precisely what material they were referring to.

Figure 15. Types of English language resource material used in the past two years by percentage of work with Anglophone/Francophone community

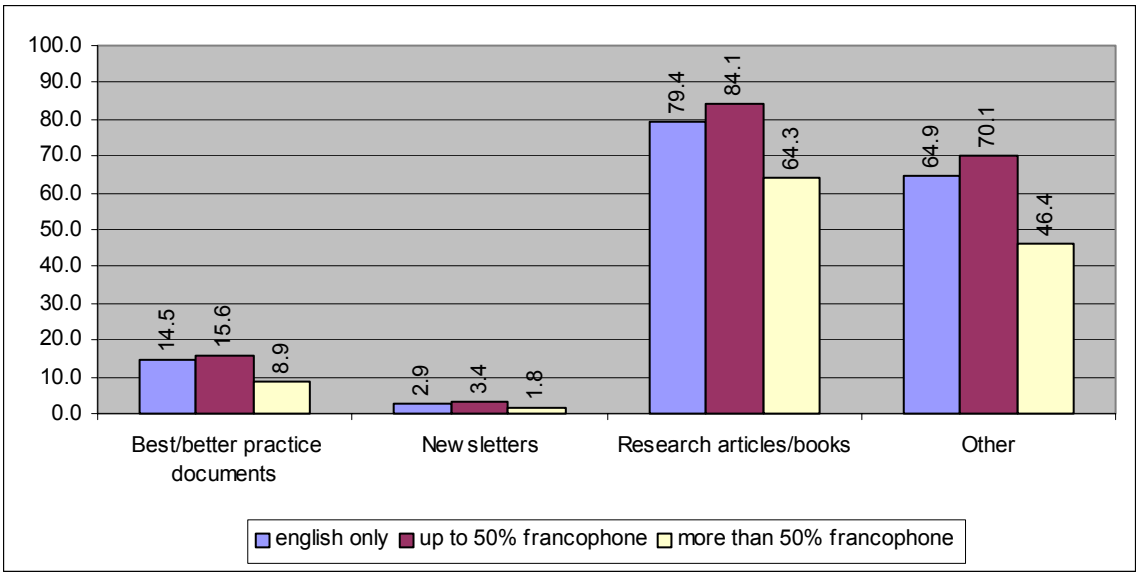
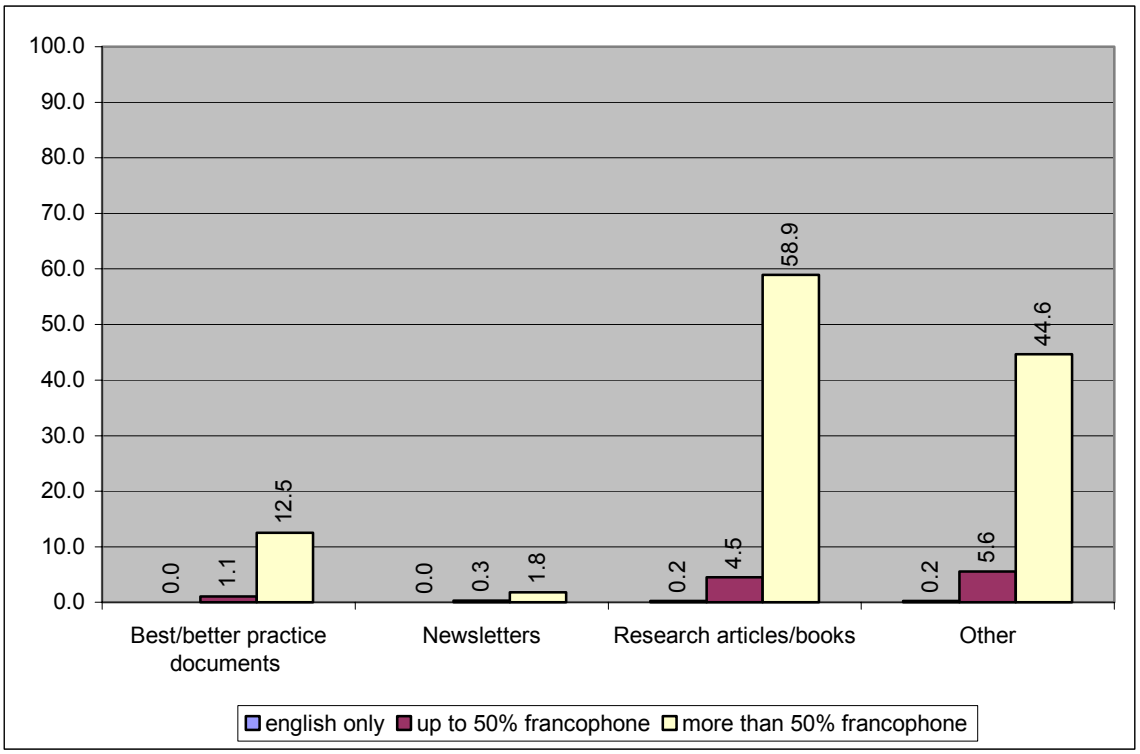


Figure 16. Types of French language resource material used in the past two years by percentage of work with Anglophone/Francophone community



3.2.4 Familiarity and Use of the OHPRS Network

Figure 17 shows the level of familiarity of respondents with each of the OHPRS organizations, with the lower part of the bar chart representing the percentage "very familiar" and the upper part showing those "somewhat familiar". The chart is organized in such a way as to group the six OHPRS organizations focused on alcohol and other drugs at the top of the chart, followed by the six tobacco control-related organizations. The remaining organizations are then listed in alphabetical order. In interpreting the data it is important to keep in mind that the familiarity ratings for some organizations will be higher because more survey participants were solicited from the client lists of some organizations compared to others. For this reason it is of more interest to note the relatively high familiarity ratings *across the overall group of organizations* rather than the ratings for any one organization specifically. In other words, irrespective of the

specific OHPRS list from which respondents were drawn, most respondents were familiar to some degree with many of the other organizations.[16]

This same pattern is found in the data from the question asking about "ever use" of the various OHPRS organizations (*Figure 18*). Again we see substantial variability in the percentage ever using each of the specific organizations, and some of this variability is no doubt related to the size of the sample drawn from each organization for this project. The bar chart in *Figure 19* then shows the percentage of the "ever used" group who have used the services of the organization in the past two years at an "intensive " or "less intensive" level. Examples of "intensive use" given in the questionnaire included: consultation service; regular workshop/event attendance; regular web site access; program/project involvement. Examples of "less intensive use" included: newsletter/e-bulletin; occasional brief inquiry; occasional workshop/event attendance; and occasional web site access. At first glance at *Figure 19* it seems like more of the sample are likely to be "less intensive users" since the percentages tend to be higher than for "intensive use". However, this belies a more complex pattern of utilization namely, that the large majority of health promoters are contacts or clients of more than one OHPRS organization, and with varying levels of intensity across these multiple contacts.

Figure 20 shows the proportion of respondents accessing the information, services and/or supports of more than one of the organizations. Over 43% reported, "ever use" of six or more organizations, and 32.6%, reported some use (intensive and non-intensive combined" in the past two years. We also see from these two charts that our survey was successful in its objectives to include some non-users of the OHPRS system – 51 individuals or 5.8% in terms of "ever use", and 78 or 8.9% in terms of use in the past two years. Those respondents who had never used any of the OHPRS organizations were more likely to work outside either the Public Health Units/Departments or Community Health Centres. The non-user group was also more likely to be working part-time versus full-time, and to report less years of experience working in health promotion. In terms of topic areas, the non-user group were *less* likely to be working in the areas connected to

[16] We use these data in subsequent analyses by computing a "familiarity index" which is essentially an additive scale combining the ratings across all the organizations (very familiar being scored = 3; somewhat familiar = 2; and not familiar at all = 1).

chronic disease prevention, heart health and tobacco-control, and were *more* likely to work in the area of mental health.

When the group of non-users was queried as to the reasons for their not having used the services and supports of any of the OHPRS organizations (which had been listed in the preceding item), 40 responses were offered by way of explanation. 22 or 55.5% of these responses indicated they didn't know what was available or what the organizations do. 22.5% indicated that they didn't feel they needed to access these services and 19% felt their topic area didn't fit with the services and supports offered by the various organizations. We also asked if the respondent had learned more about the OHPRS as a result of completing the survey. Of 840 respondents to the item, 81.4% replied that they had learned more. When asked if they might now consider accessing one or more of the organizations they may not have used before, 89.2% of 790 respondents replied in the affirmative.

"I am relatively new to business and was not aware of these organizations. The list is impressive"

"Did not know that they existed OR do not know what resources that they have available. Also--other local resources are used and are very accessible."

"Not being familiar with them. Also, seem to have a wealth of organizations and material that we are having difficulty finding the time to sift through it all."

Figure 17. Percentage of respondents familiar with each of the OHPRS organizations.

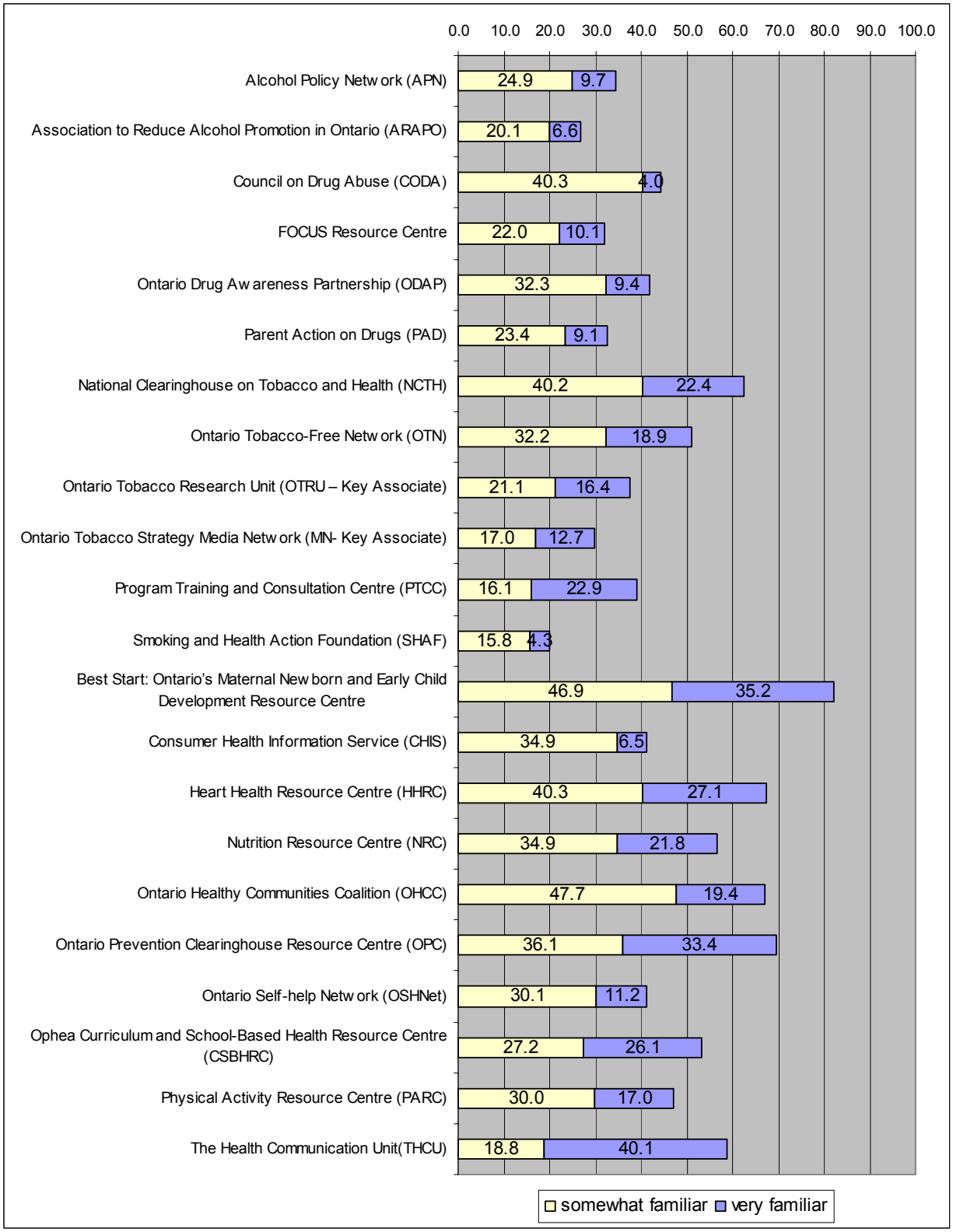


Figure 18. Percentage of respondents reported "ever using" each of the OHPRS organizations

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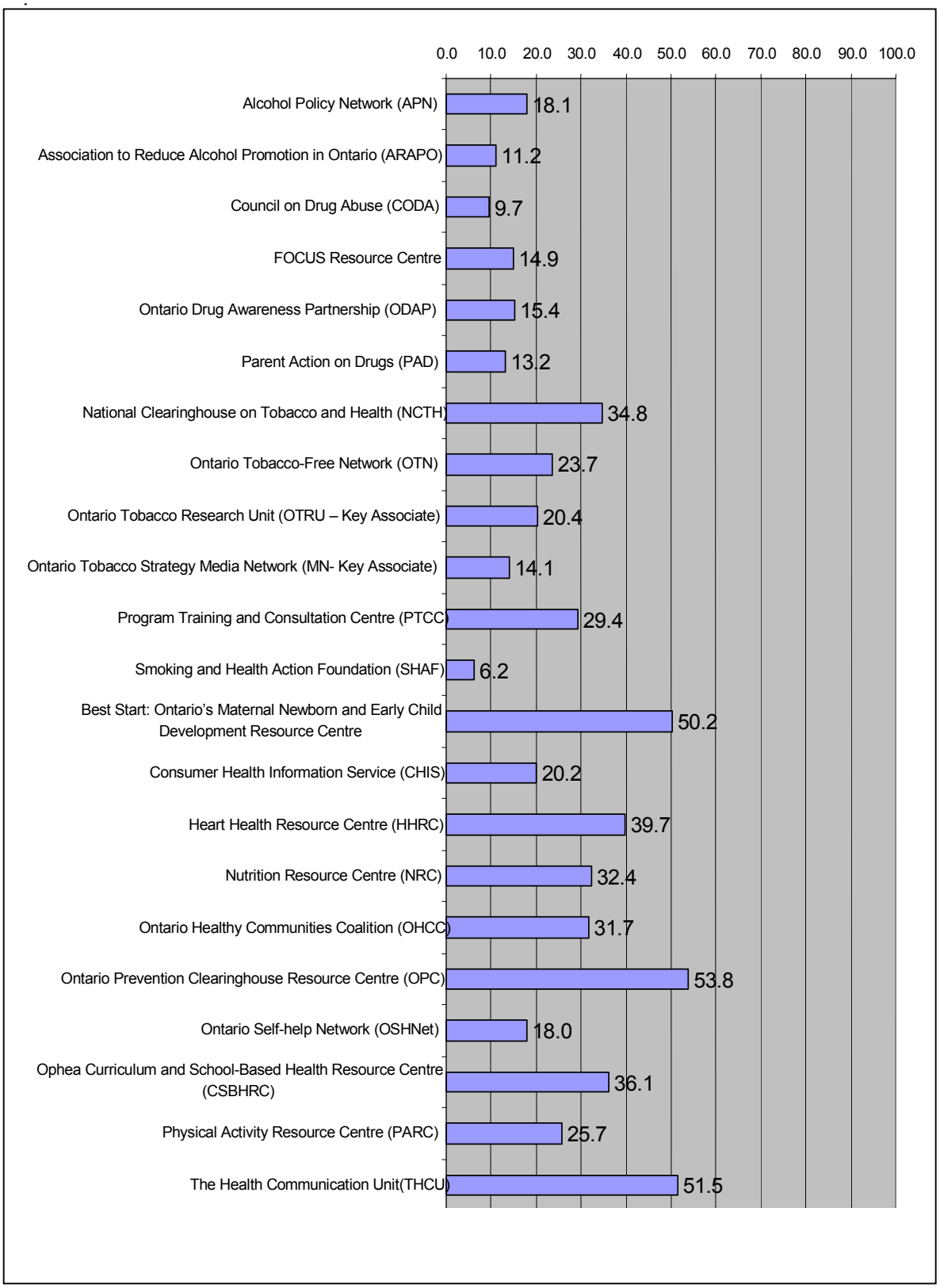


Figure 19. Percentage of "ever users" who reported either "intensive" or "less intensive" use of each OHPRS organization in the past two years.

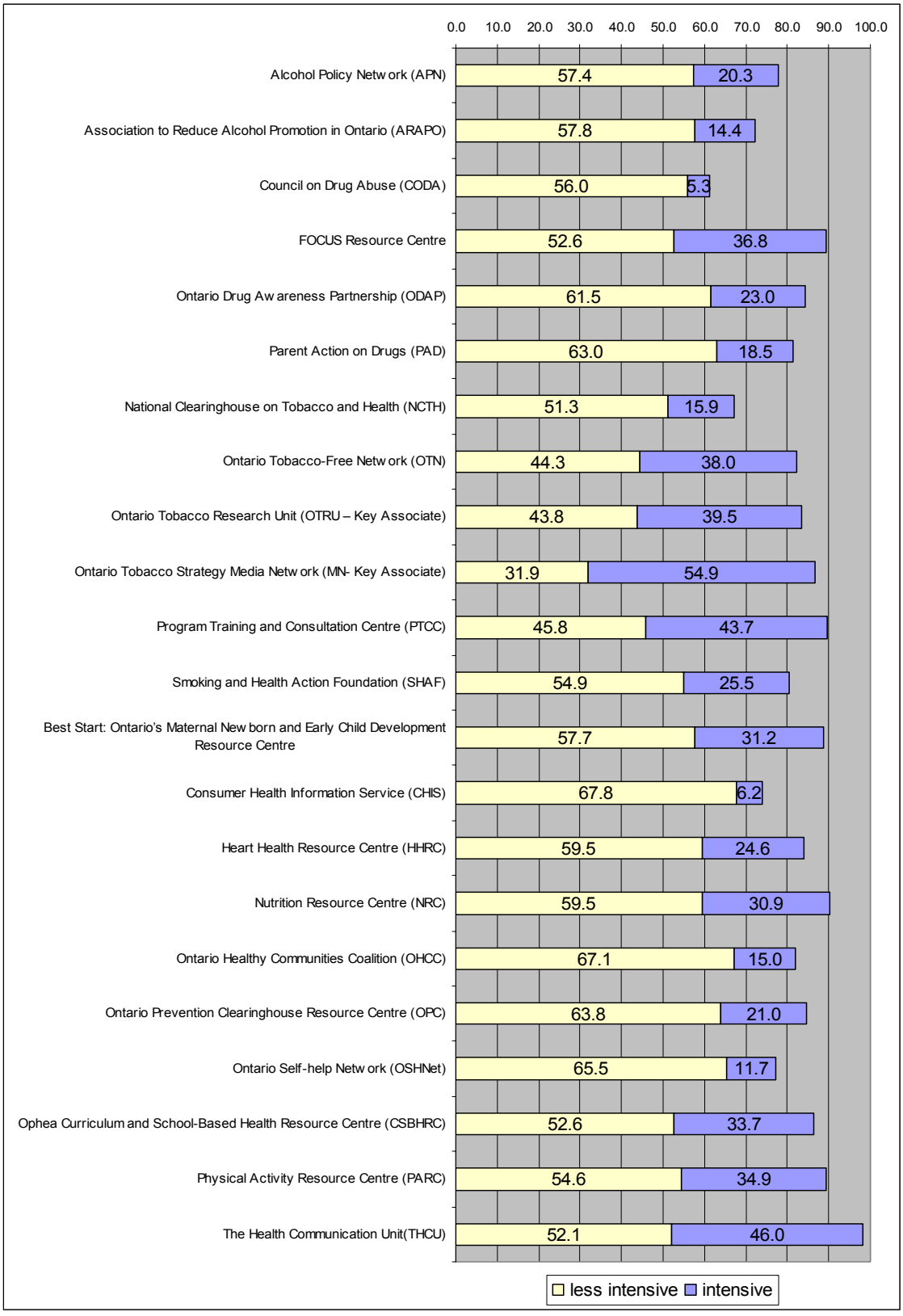
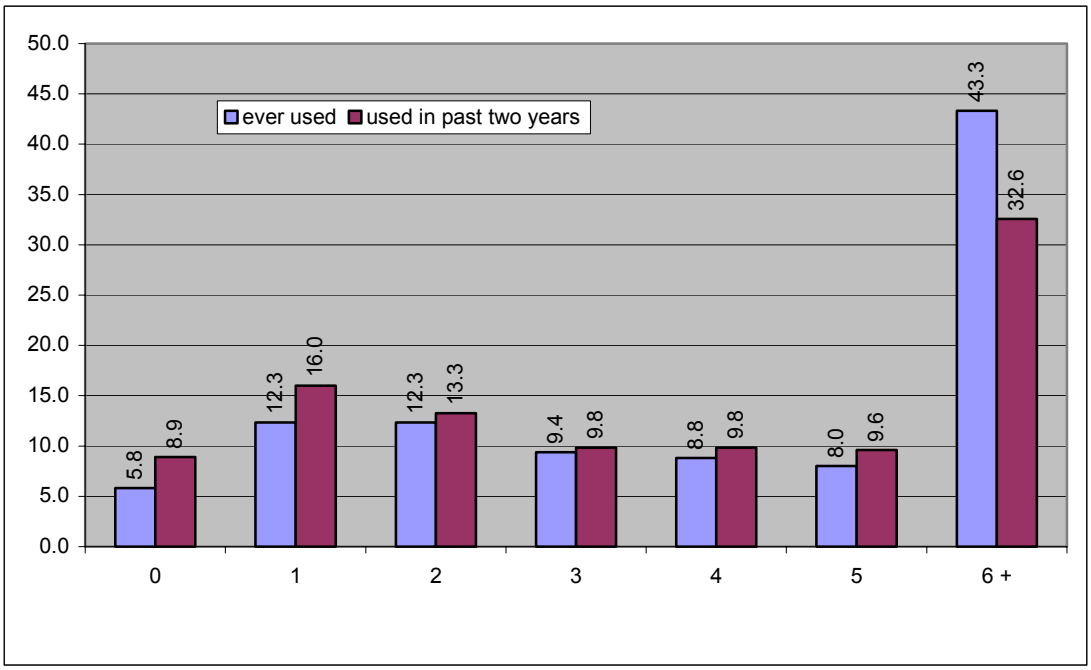


Figure 20. Number of OHPRS organizations "ever used" and "used past two years" (n = 875)



Finally, with respect to use of the OHPRS organizations, we employed an additive scale "number used in past two years" to explore the association between multiple contact with the OHPRS and several other respondent characteristics and survey responses.[17] These data are shown in *Table 7*.

There was no significant difference in the number of OHPRS organizations used in the past two years across the different regions of Ontario, although there was a tendency for somewhat more use of OHPRS by those in the South West region. Health promoters employed full-time versus part-time accessed more of the OHPRS organizations, as did those from mid-sized organizations and those working in Public Health Units/Departments. These two latter characteristics were closely related as people from the health units predominated in the group of respondents from organizations between 101 and 500 employees. Years of experience in health promotion showed a marginally significant trend for accessing more of the organizations among those with more years of working in the field. These data, however, are influenced by the less frequent use of

[17] The "used in past two years" index was very highly correlated with the familiarity index as well as "ever use". We selected this index as it was the least likely to be influenced by years of working in the field.

Table 7. Average number of OHPRS organizations "used in past two years" according to various respondent characteristics

	Ave. # Organizations Used Past 2 yrs.	n
Region		
North	4.4	117
East	4.5	149
Central east	4.3	106
Toronto	3.9	119
Central West	3.9	94
Central South	4.5	91
South West	5.3	98
Province as a whole	5.0	71
Employment Status		
Full Time	5.0	533
Part Time	3.6	187
Work with Francophone Community		
0% Francophone community	4.3	413
Up to 50% Francophone community	4.8	378
50% - 100% Francophone community	3.4	56
Organization size		
1-25	3.6	154
26-50	3.7	61
51-100	5.2	113
101-500	5.5	206
Over 500	4.4	176
Years of Experience		
Less than 1 year	2.9	37
1 to 3 years	3.9	169
4 to5 years	4.3	159
6 to 10 years	4.5	148
More than 10 years	4.9	349
Type of Organization		
Public Health Unit/Health Dept.	5.9	295
Community Health Centre	3.6	99
Other	3.8	359
Access to Needed information		
Difficult/very difficult	3.8	220
Easy	4.7	539
Very easy	4.7	80

OHPRS by the two sub-groups "less than 1 year" and "between 1 and 3 years" since we asked about their use in the past two years. We also compared the average number of organizations used across those respondents working in the various topic areas and engaged in various health promotion strategies and activities (Question 2). While we found no consistent pattern across these many categories (data not shown), future

multivariate analyses may identify trends of interest in these data as these topic areas and strategies are highly inter-related.

Lastly, we also correlated respondents' rating of their ease of access to information for their health promotion work to the average number of OHPRS organizations used in the past two years. On average, those rating their access as "difficult" or "very difficult" reported using fewer of the OHPRS organizations.

3.2.5 Use of Services and Supports Outside the OHPRS

In the process of planning this provincial needs assessment it was clearly acknowledged that the OHPRS organizations are not the only organizations devoted to the provision of information, services and other supports to health promoters in Ontario. No information exists, however, on the full range of options being accessed across the province by health promoters. Just over 80% of the survey sample responded to the question on services accessed outside the OHPRS[18] and, of these, 500 or 68.5 % reported having done so. These affirmative respondents were then asked to provide the names of up to three of these organizations.

A total of 1087 organizations were cited. In addition, 101 people cited an OHPRS organization or one of its programs/products. Nine people responded but then said "none". Several others cited an organization that could not be coded due to the use of an unidentifiable acronym[19]. A comprehensive coding scheme was applied to these data in anticipation of future analyses of interest to specific OHPRS organizations or sectors. We captured the distinction between Canadian and US sources and, within Canada, between Ontario, other provinces, local organizations, and organizations for which the jurisdiction was unknown or not codeable. We also distinguished between organizations, associations, networks/coalitions and government departments. Finally, the detailed coding scheme captured several individual organizations, or types of organizations,

[18] Those indicating "not sure", those who skipped the question and those who did not actually identify an outside organization in their response were coded as missing. In total there were 725 people giving an answer clear enough to be coded.

[19] We were, however, able to identify many of the organizations identified only by acronym through a web search.

because they were frequently mentioned sources of support (e.g., local Public Health Units/Departments, Lung Association, Heart and Stroke Foundation, Cancer Society or Cancer Care Ontario), or because they have offer unique services of potential importance to some key stakeholders who may ultimately be using these needs assessment data (e.g., PHRED, Dieticians of Canada, SMART Risk, Canadian Centre on Substance Abuse; Centre for Addiction and Mental Health). The detailed data are shown in *Table Core 9b* in Appendix C.

For summary purposes here we highlight only the most frequently cited sources, these being Public Health Units (9.5%) and other local organizations (6.8%). Interestingly both are *local* sources of information and support, to which we might add local networks or coalitions for another 2.6%. As a group, Canadian national associations also stood out with 4.8% of mentions. Examples would include, the Canadian Intramural Recreation Association, Canadian Association of School Health, Canadian Medical Association, Canadian Council on Social Development, and the Federation of Canadian Municipalities. Provincial associations such as Dairy Farmers of Ontario, the Ontario Federation of Sport and Fitness Sciences, and the Federation of Community Mental Health and Addiction Programs accounted for another 2.9%. Some specific organizations of note would be the Heart and Stroke Foundation (4.2%), Centre for Addiction and Mental Health (3.8%), Cancer Care Society (2.6%), Canadian Mental Health Association (2.3%), Centre for Disease Control in the United States (2.1%) and the Diabetes Association (1.9%). Health Canada factored into 3.2% of the responses. We also note the important role of various organizations that have a strong web-based component to the services (e.g., Motherrisk (1.7%). The remaining categories that were coded were cited less than 2% of the time but cumulatively account for well over half of the mentions. This in and of itself is a good indicator of the complexity and comprehensiveness of the "system" of services and supports available to health promoters in Ontario and outside of OHPRS specifically.

3.3. Needs and Related Issues Concerning Training and Education

3.3.1 Past Experiences and Current Preferences

The survey inquired about various approaches that had been used in the past two years for training and education in health promotion (*Figure 21*), as well as the extent to which each approach had met their needs (*Figure 22*). Most notable was the high percentage that had attended conferences/other events (85.1%) and one-day face-to-face workshops (75.3%). Importantly, however, the three next highest categories were all Internet-based alternatives and included "self-directed learning through Internet" (75.3%); "listserv or virtual community" (55.7%); and "email expert consultation (49.7%). "Peer-based learning" and "teleconferences" were also notable (48.2% and 48% respectively). "Formal coaching or mentoring", which are innovative yet intensive forms of training and education, was cited by as many as 17%, although there may have been a wide interpretation of these terms. The least frequently endorsed options were chat rooms (7.5%), CD-ROM-based courses (12.2%), and video-conferencing (15.5%).

In *Figure 22* we take these data one step further and show, for those using each training and education approach, what percentage reported their needs being "met" (lower part of the bar graph) or "partly met" (upper part of the bar graph). By subtraction one can also determine the percentage whose needs were not met, the third response category to the item. The more intensive of these various training activities received the highest ratings in terms of meeting the person's needs, for example, formal coaching or mentoring with about 75% stating needs met, followed by all the various sub-categories of expert consultation (77% to 70%) and workshops (70% to 74%). Conferences/events were rated by 66.8% as meeting their needs, followed by peer-based learning (65.1%). The virtual options via the Internet and other technology-based alternatives such as the CD-ROM courses, on-line courses, and teleconferences and videoconferences received the lowest ratings in comparison to the others. However, they still achieved respectable ratings in absolute terms and when the met and partly met categories are combined.

Figure 21. Approaches used in past two years for education and training for health promotion

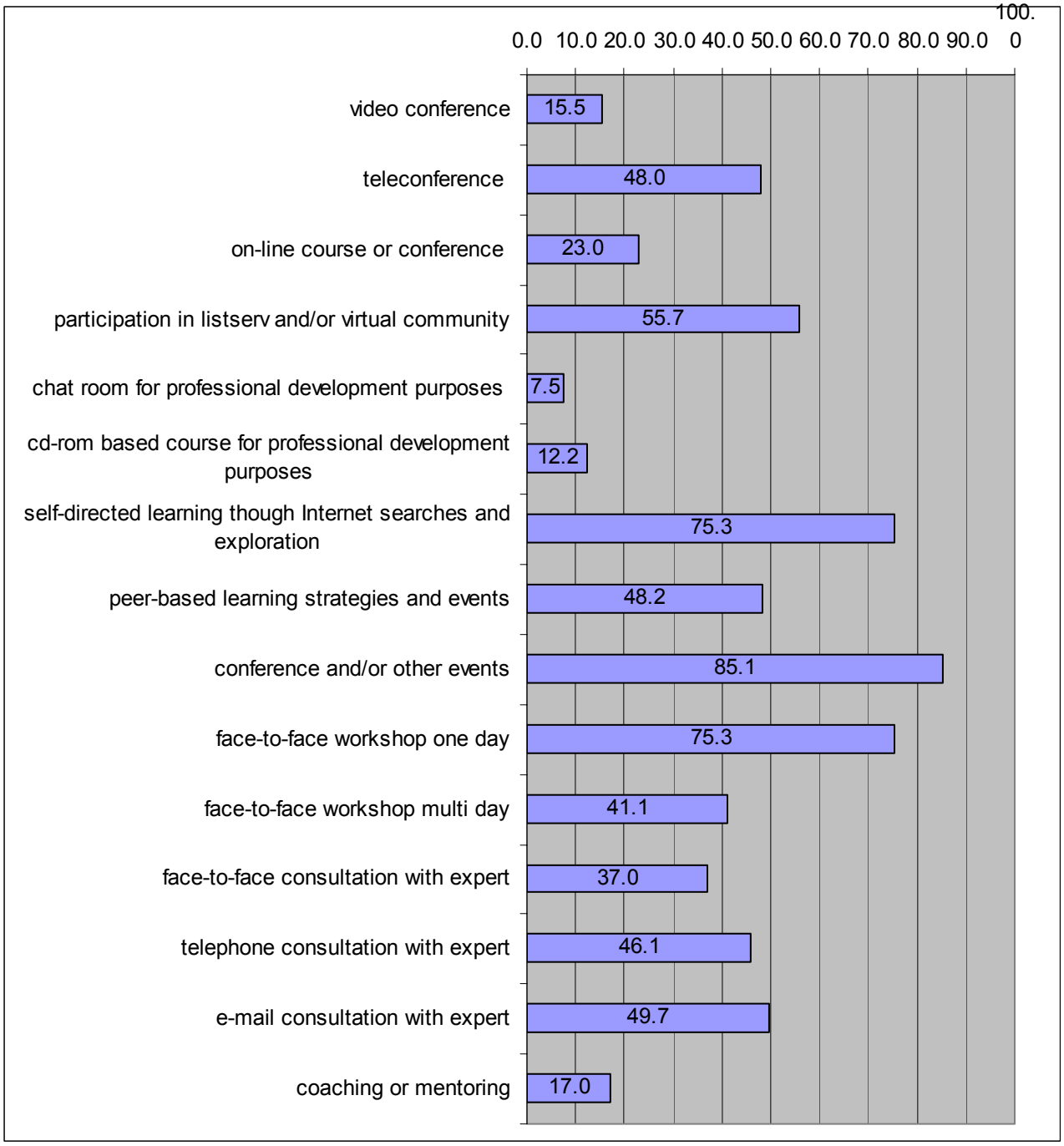
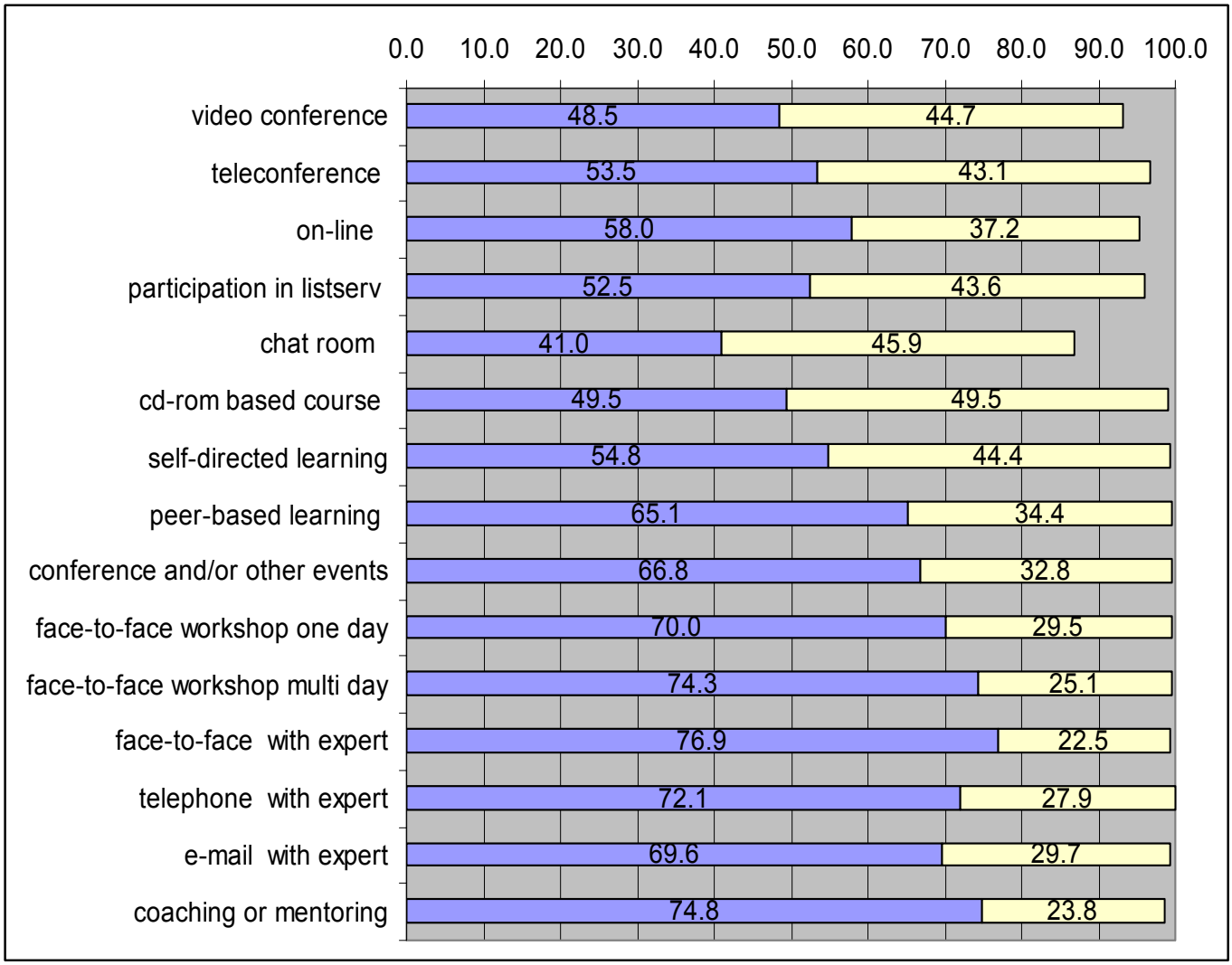


Figure 22. Extent to which needs were "partly met" or "met" according to the various approaches used for education and training for health promotion[1]



[1] Percentages are based on those respondents using each option in the past two years (see Figure 20)

In addition to the above options that were presented to the respondent for consideration, we also asked if there were other training and support approaches used in the past two years. 123 respondents or about 16% of all respondents answered in the affirmative. Responses clear enough to be coded were provided by 114 respondents and these are summarized in *Table 8*. A variety of self-study alternatives were most frequently mentioned (39.1%) (e.g., journals, library, newsletters & pamphlets, video, audio, TV, surfing the web) followed by various educational options (23.5%) such as dedicated

leave, professional assignment, getting a degree, taking a course/training. Another 20% cited networking opportunities such as teleconferencing and in-service presentations.

Table 8. Other types of training and education approaches used in past two years

	n	%
Self-study journals/library//newsletters & pamphlets/video/audio/TV or surfing the web	45	39.1
Dedicated leave/professional assignment/getting a degree/taking a course/training	27	23.5
Networking/resource sharing/teleconferencing with colleagues/in-service presentation	23	20.0
Passive/interactive observations/learn by experience	12	4.3
It's a combination of approaches and depends on topic	5	2.6
Other – too general to code/not sure	3	10.4
Total	**114**	**100.0**

To gain another perspective on the *relative preference* for different training and education alternatives we posed a question that asked the respondent to divide up a hypothetical 100 points among five optional formats. These five options were categories condensed from the many alternatives presented in *Figures 21* and *22*. We then calculated the average number of points allocated to each alternative as a measure of preference. We also calculated the standard deviation, which is a measure of variability around the averages, as well as the maximum and minimum responses. The results are shown in Table 9. The total sample size for these analyses was 875. Results show, on average, the preference for workshops (average=24.8), closely followed by conferences/events (22.9). The remaining options were close to each other and around average scores of 16 to 18. Interestingly, the score for mentoring and coaching is the lowest in contrast to the positive ratings given to it by those who have used it (*Figure 22*). This may indicate a lack of familiarity with this fairly intensive training and education option.

It is important, however, to also note the relatively high standard deviations, as well as the high ranges in the minimum and maximum scores given. These data indicate the variability across participants' preferences. In other words, there are those who strongly prefer each of the options, and those who feel much less positive about others, at least in comparative terms.

Table 9. Preferred options for training and education formats

Alternative Format	Ave. Score	SD[1]	Min.	Max.
Workshops	24.8	11.7	0	80
Conferences/events	22.9	12.2	0	90
Expert consultation	18.5	12.7	0	100
Web based or other distance education	17.5	14.1	0	85
Coaching or mentoring	16.3	11.4	0	80

[1]SD: Standard Deviation

We also asked about preferences for group versus individual formats and the results clearly favoured the group format, with 70% endorsing this option. We then inquired about preferences for *local* versus *regional* versus *provincial* learning opportunities. The least preferred option was the provincial format (18.1%) with the local and regional options being about evenly split at 43.1% and 38.8%, respectively.

Using a similar approach as described above for different training and education approaches we also asked respondents to divide up 100 hypothetical points to reflect their preference for getting information via the Internet/email or by receiving paper copies. We also broke the options down according to summary versus full-length documents. Sample size was 875. *Table 10* shows, on average, a clear preference for the Internet/email option and no obvious preference for summary versus full-length documents. As before it is important to note the wide range in preferences as shown in the standard deviation and the minimum and maximum scores (basically the full range). This suggests that although the results favour the electronic options at present they would not meet the needs of all people concerned.

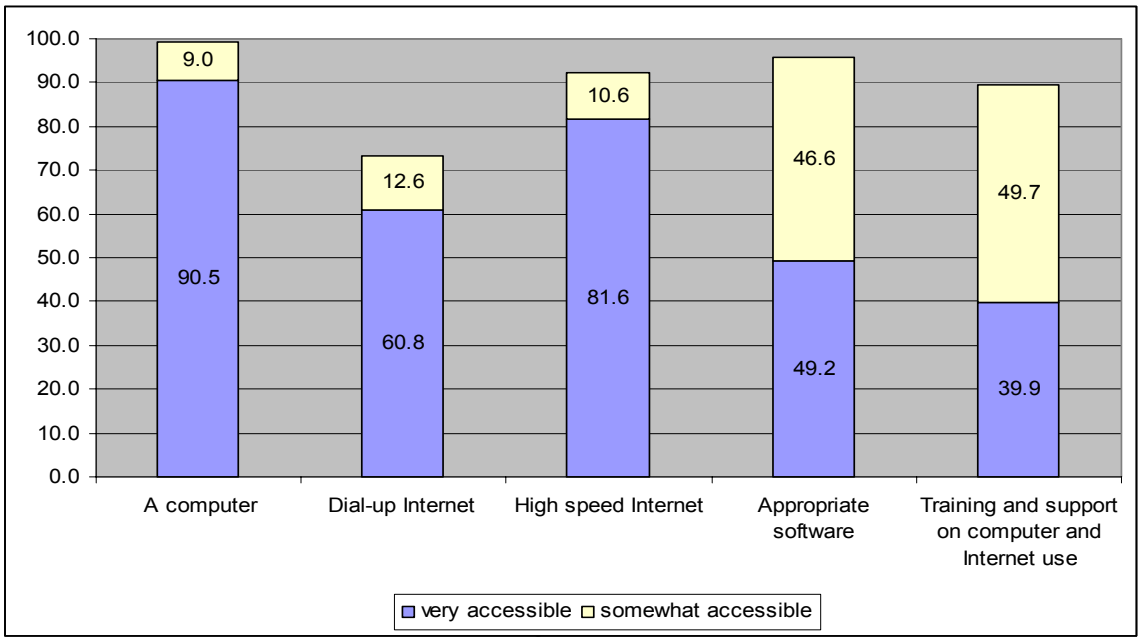
Table 10. Preferred methods for accessing/retrieving documents

Alternative Methods of Access	Ave. Score	SD[1]	Min.	Max.
Downloading from Internet or e-mail (summary documents)	34.3	18.8	0	100
Downloading from Internet or e-mail (full length documents)	33.4	21.6	0	100
Receiving paper copies (full length)	16.9	16.2	0	100
Receiving paper copies (summaries)	15.4	15.7	0	100

[1]SD: Standard Deviation

To supplement this question about accessing/retrieving documents we asked about the accessibility of information technology to support electronic distribution of documents, including training materials. Results are shown below in *Figure 23*. Almost all respondents had some access to a computer, and most also had high speed Internet access (81.6% "very accessible" and 10.6% "somewhat accessible"). However, the availability of appropriate software and training and support was less assured. Less than half the respondents reported that appropriate software and training and support on computer and Internet use were "very accessible".

Figure 23. Accessibility of computer and other IT resources when needed for work



3.3.2 Interests and Expressed Needs Regarding Various Topic Areas

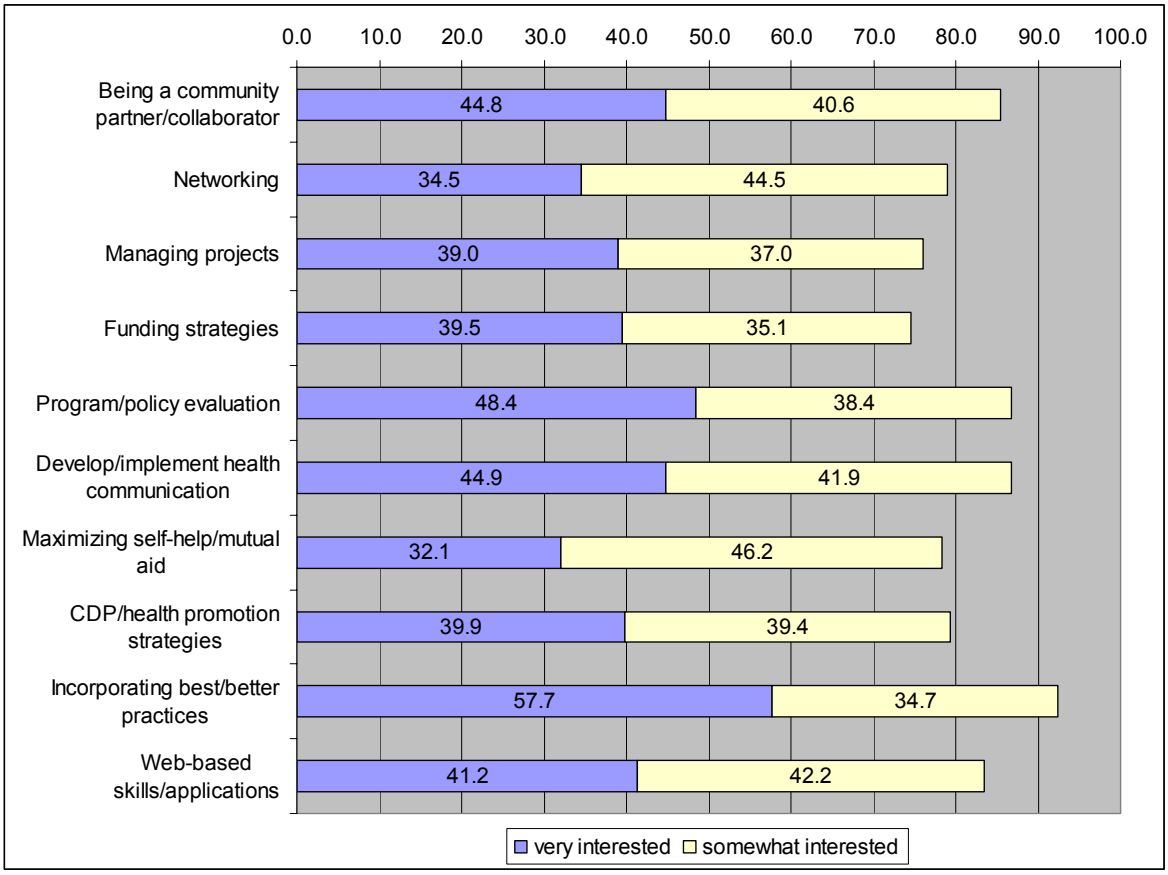
We probed respondents' perceived needs with respect to training and education topic areas, with both closed ended questions that gave the respondent several choices to endorse, as well as open-ended questions. The open-ended questions touched on topics the respondent believed had been omitted from the list of categories offered and also inquired about needs for more advanced training in health promotion.

Figure 24 shows a list of topic areas that is surprisingly well balanced in terms of level of interest, with most of the topic areas enlisting a "very interested" endorsement in the range of 40% to 55%. Focusing on the "very interested" rating as a key indicator, the topic of incorporating best/better practices was given the highest endorsement (57.7%). Several others followed, namely, program/policy evaluation (48.4%), health communication (44.9%), and being a community partner/collaborator (44.8%). Interestingly, web-based skills and applications was also of high interest to 41.2% of respondents, an indication of the importance of these skills for engaging in health promotion as well as the need for support in this area. This is also consistent with the previous information in *Figure 23.* Further it is noteworthy that no one particular area stood out as being a *low priority* for additional training. This suggests there is substantive breadth and depth to the unmet needs for capacity building among health promoters across the province. Future analyses will be able to identify sub-groups in the survey sample which might have higher or lower needs in particular areas, as well as preferences for how these needs might best be met. These additional analyses will also be of high relevance to the individual OHPRS organizations in terms of future programs and support activities.

When asked if they needed more advanced training and technical support in health promotion than is currently available through the OHPRS organizations, 137 respondents or 15.7% of the total sample answered in the affirmative. A wide range of needs were evident in the responses to the subsequent open-ended question asking them to describe these "advanced" support needs[20]. Given the high level of detail in our coding scheme the

[20] See Table Core14b in Appendix C for the detailed coding.

Figure 24. Respondents' interest in various training and education topics



percentages are not high for each coded category. We focus here on the "top 10" issues identified with respect to the "advanced" support needs. At the top of a list of 169 responses was 7.1% citing the need for a more advanced course/degree or a certification/ credentialing process for health promotion, followed by the expressed need for resources just to bring people together more often for training (6.5%). In terms of topic areas we found maternal health, including child health and developmental issues (6.5%); general statements about evaluation (6.5%); computer literacy/use of the Internet (5.9%); issues related to multi-cultural diversity (4.1%); community development services/building relationships/coalition building (4.1%);

"A lot of the courses are at the beginner to intermediate level. More intermediate to senior level would be welcome"

"College Counsellor Certification."

"I would like to be able to access information more easily on the internet and to become aware of some of the resources but my skills are somewhat limited."

Best Practice applications (3.6%); and health communication/media work (3.0). Also in the "top ten" for advanced supports was the need to know what is available/how to access information and support, including OHPRS (3.6%).

"Intermediate to advanced methods course in program evaluation"

"More regional conferences and workshops. More access to experts via telephone or e-mail"

Going beyond these expressed needs for advanced health promotion supports we used another open-ended item to ask about the topics for which the respondent would be interested in having any additional training and education. *Table Core15b* in Appendix C provides the results of the detailed coding of these responses.

"Assistance in accessing all of the Health Promotion Services not known to our agency"

Table 11. Training needs coded in open-ended question according to topic and health promotion capacity areas.

Training and Education Needs Identified	**n**	**%**
Specific Topic Area or Population	170	29.6
Health Promotion Capacity Area		
Implementation	192	33.4
Needs assessment and Planning	83	14.4
Program Evaluation	21	3.7
Sustainability	5	.9
"Cross-cutting" Capacity Areas		
Multicultural issues	23	4.0
Computer literacy/use of Internet	12	2.1
Government relations/dealing with government	7	1.2
Dealing with literacy issues	3	.5
Training in how to train/teach others	26	4.5
General training and education needs and issues	13	2.3
Other	28	4.9
Total mentions	**575**	**100.0**

[1]An additional 36 responses were made to this question but insufficient information was given to code the response or they just said "no needs" or "none"

A large percentage of responses concerned a specific topic area or population (29.6%), and examples would include maternal and child health (3.5%); mental health issues such as stress management (3.8%); and nutrition/food security (1.7%).

"Effective coalitions. Collaborative school-based strategies with parent driven projects"

"The practical application of community development. Effective advocacy. Writing clearly, and artistically to be appealing to the community to read"

"Workshop on doing needs assessments, how to design workshops or health promotion activities to meet the needs of diversity (i.e., cultural, ethnic, gender, sexual orientation, etc.)"

"Using logic models and health promotion models effectively (not just nice to have but really useful)"

"Knowledge of techniques of an effective communicator who works off the beaten track, i.e. native and remote communities"

"Training to effectively participate in online lists and incorporate electronic services into organizational structures and service provision"

A large number of responses fell into a set of categories we developed using a categorization scheme drawn from the 2000 OHPRS capacity survey and which reflect different dimensions of health promotion capacity. A total of 192 responses (33.4%) related to issues connected to the implementation of health promotion projects and activities, such as community development and coordinating with others in the community (8.9%); advocacy or working with advocacy groups (4.5%); policy-related topics (3.8%); managing projects (3.1%); involving the community and building partnerships (3.0%); and health communication, marketing or using the media (3.0%). Compared to topics connected to project implementation we found a smaller percentage cited training and education needs related to the needs assessment and planning phase (14.4%) with examples being applying or translating best practice to their community (6.1%); proposal development/writing skills (4.0%) and finding and using supporting information on community needs (2.8%). Needs related to program evaluation were reflected in 3.7% of the citations and included either general comments about evaluation of comments related more specifically to project implementation/tracking and outcome evaluation indicators. Interestingly, a very small number of responses connected to the issue of project sustainability (less than 1%).

Our coding strategy also captured a small number of what we called "cross-cutting" capacity areas, that is topics that are important at any stage of the process of planning, implementing and evaluating a health promotion project or activity. The more salient topics in this broad category were multicultural issues (4.0%) and issues related to computer literacy or using the Internet (e.g., web searches) (2.1%).

> *"Public speaking & health promotion"*

Lastly, in terms of broad categories, we found 4.5% of responses were related to a perceived need around training or teaching others (e.g., using plain language and presentation skills (1.9%); training methods (1.0%); coaching and mentoring others (.5%). In the category of more general training and education needs (2.3%) we captured, for example, needs concerned with resources for bringing people together (1.2%).

> *"How to communicate about the work that is being done by our project and how to develop key messages for clients. Too many channels and paper work to process for approval."*

3.3.3 Needs and Suggestions Regarding Conferences/Events

Based on the data summarized above with respect to preferred training and education approaches it is not surprising to see a high interest in, and attendance at, various conferences and events (*Figure 25*). It is important to note that the absolute numbers and percentages of the sample going to any one of the events listed in the questionnaire will be influenced by the sampling procedure and the resulting make up of the group of survey participants. For example, the percentage going to Best Start Conference will be related to the size of the sample that was drawn from the Best Start organization. This caveat aside, a higher percentage of respondents obviously consider going to health promotion related events than are actually able to attend. This is particularly evident for the Canadian Public Health Association meeting, the Ontario Public Health Association meeting and the Health Promotion Summer School.

In addition to those conferences endorsed and shown in *Figure 25* several others were mentioned and coded (n = 234). Up to two conferences were coded per respondent. *Table 11* shows that this included a range of other Canadian events (34.9%) as well as

non-Canadian events (11.2%). Several OHPRS events were listed (26.7%) and a wide variety of local events and workshops (11.2%).

Figure 25. Percentage of respondents considering and those actually attending health promotion related conferences/events in the past two years.

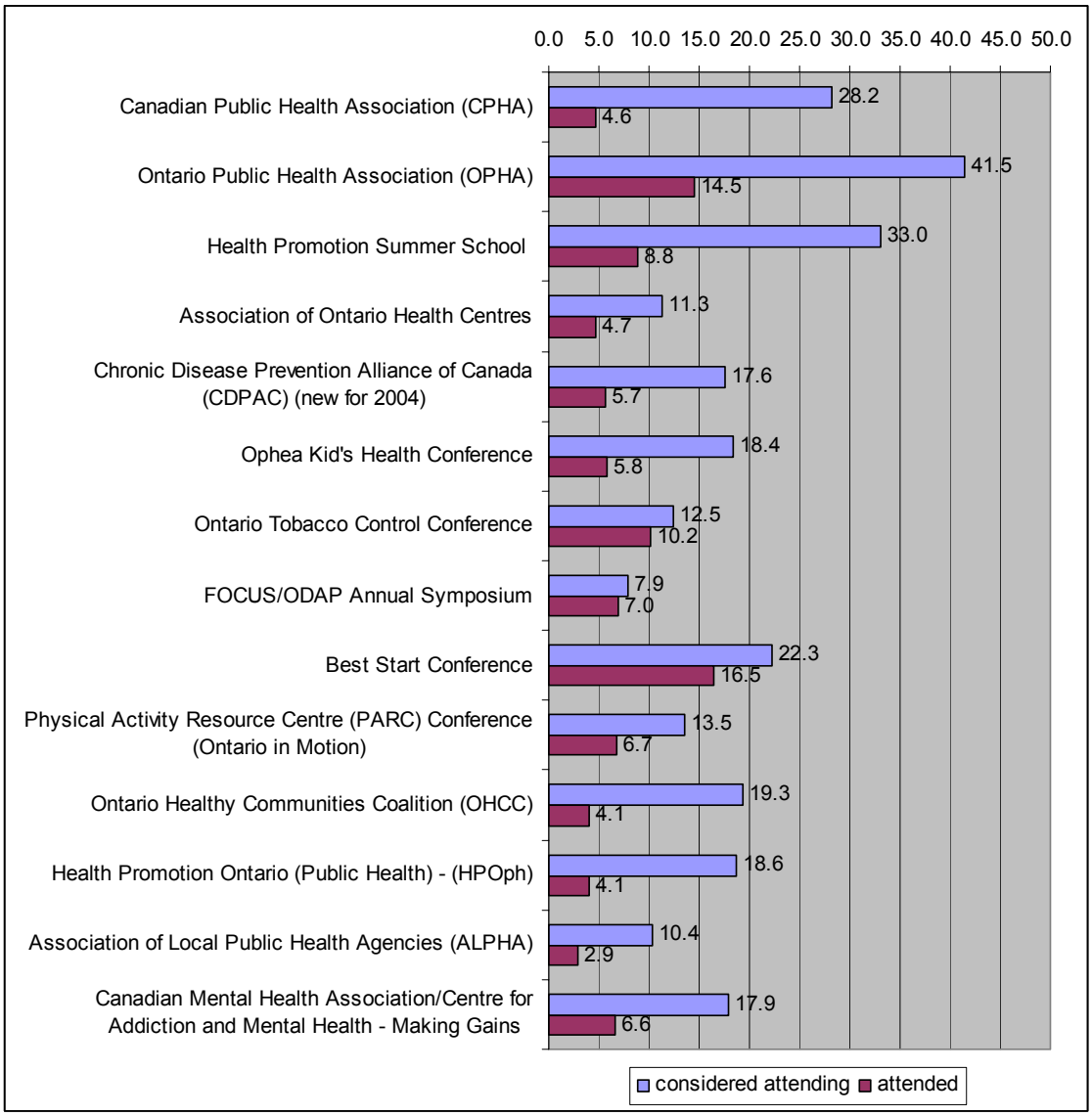


Table 11. Other conferences /events attended

	n	%
Canadian event (National, Provincial, Regional)	113	48.1
Local event/workshop if identifiable (e.g. Falls Prevention-Peterborough)	33	14.1
OHPRS – related events (THCU, HHRC workshop, including. OHHN)	30	12.8
Non-Canadian event (U.S., other country, world)	26	11.1
General – no one specific conference/event listed – (e.g. "conferences in topic area")	13	5.6
Other event/workshop but not codeable in above categories	10	4.3
Comments offered but no conference or conference topics offered	9	3.8
Total	**234**	**100**

Although conference participation seems to play a major role in the training and ongoing education of Ontario health promoters it is not without significant challenges and barriers. When asked directly if they experienced barriers or challenges in making their optimum selection for a conference/event to attend, 75.2% of those responding to the item (n=827) said they did experience such barriers and challenges. Figure 26 provides a breakdown of responses to various kinds of barriers provided as options in a follow-up question. Financial concerns about the cost of the conference registration (56%), or travel costs (50.2%), dominated the responses. Another 40.5% noted they did not have enough time to attend the conferences they wanted to, and 20.3% felt they did not have managerial support. The remaining options were selected by around 10% of the group and 12.2% endorsed the "other" category.

"Too many channels and paper work to process for approval"

The responses to this "other" category, as well as a final open-ended question about conferences/events, yielded similar information as that elicited using the response categories shown in *Figure 25*. These open-ended data, however, also provide additional nuances around the issue of conferences and other events (*Table 12*). Barriers and challenges included organizational policies (25.2%) and issues related to distance to travel (24.4%), the latter

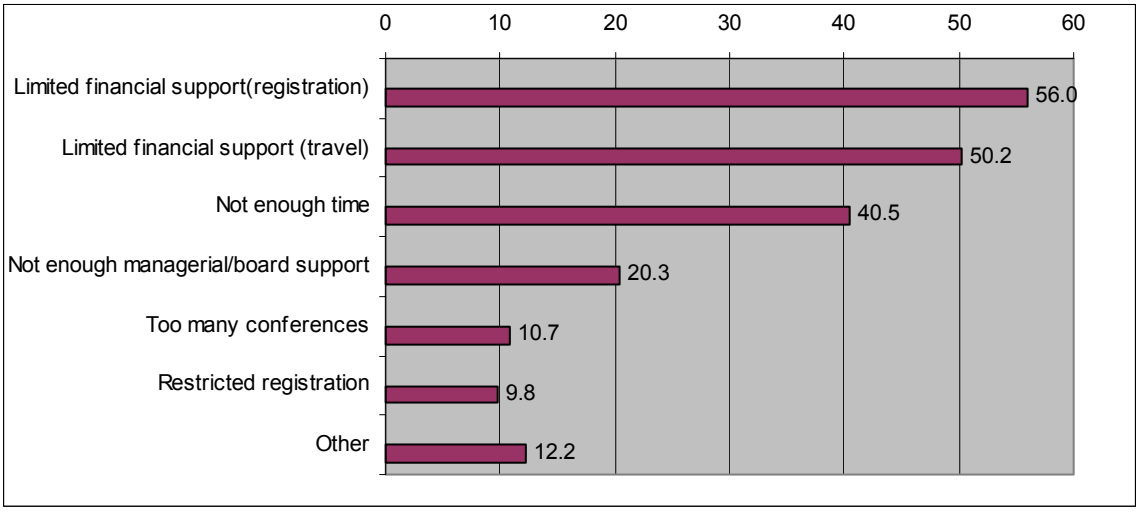
"Not enough support for professional development"

sometimes connected to issues of cost and family responsibilities. A further 14.6% made comments concerning the amount of time away from work and home and several also commented about insufficient information or notice of the event 14.6% of the time. *Table 12* shows additional comments made by lower percentages of respondents.

> *"We have support to attend; however, our workload is such that conferences make too much work"*

> *"Location too far from home/family"*

Figure 26. Barriers or challenges experienced concerning conferences and events



> *"Not knowing about the conferences"*

> *"Most conferences occur in southern Ontario and not enough money and time to go"*

Other comments provided in the final question about conferences also reiterated the financial issues (25%); issues related to the need for local events and to reduce travel time and costs (16.5%), and the need to broaden the reach of the conference through strategies such as web casting or sending out disk copies of materials after the event (8.5%)[21].

[21] Table Core18 in Appendix C provides the more detailed breakdown of comments.

Table 12. Other challenges experienced making choices for conferences/events

	n	%
Organization policies (no coverage, only one can go; lack of manager support)	26	25.2
Too far to travel/poor location (Toronto, South) – sometimes connected with family/cost	25	24.3
Not enough notice and/or info about conferences or associations	15	14.6
Other responsibilities (family, work); bad timing / no time/too much time away	15	14.6
Lack of conferences/events in topic area / content not appropriate	8	7.8
General concern re: cost – doing it in the budget	5	4.9
Event was full, they fill up quickly	3	2.9
Personal health reasons (e.g. allergy; disability)	2	1.9
Conferences should collaborate/redundant	2	1.9
Benefits to organization not clear	1	1.0
Other – don't fit above, not codeable	1	1.0
Total	**103**	**100.0**

3.4 French Language Health Promotion Needs and Related Issues

A series of questions probed issues related to the provision of services and supports for people working with Francophone communities. We report the information here organized by the two sub-categories of respondents "up to 50% of work with Francophones" and "50% or more of work with Francophones"[22].

When asked about the balance of their work with the Francophone community that was "proactive" versus "reactive" we found that those working over 50% of the time with the Francophone community were more likely to be in a proactive mode (32.7%). It is of interest to note, however, the frequency of the reactive response across all sub-categories, for example, 61.7% of those working less than 50% of the time with Francophone community reporting a more reactive than proactive stance.

[22] Those working exclusively with non-Francophone communities did not answer these questions

Figure 27. Approach to working with Francophone community

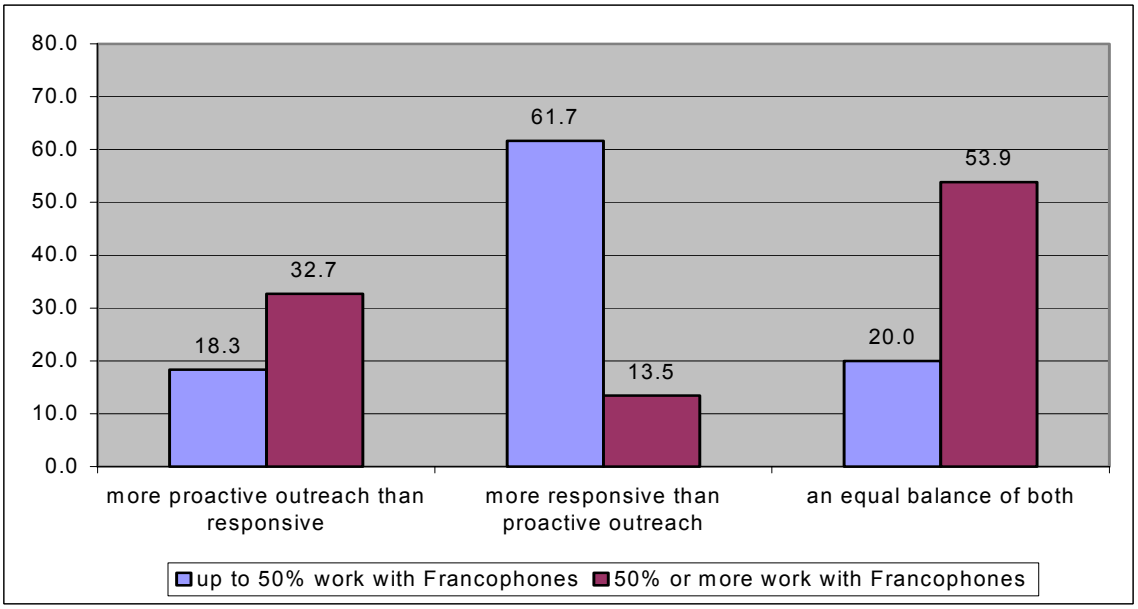
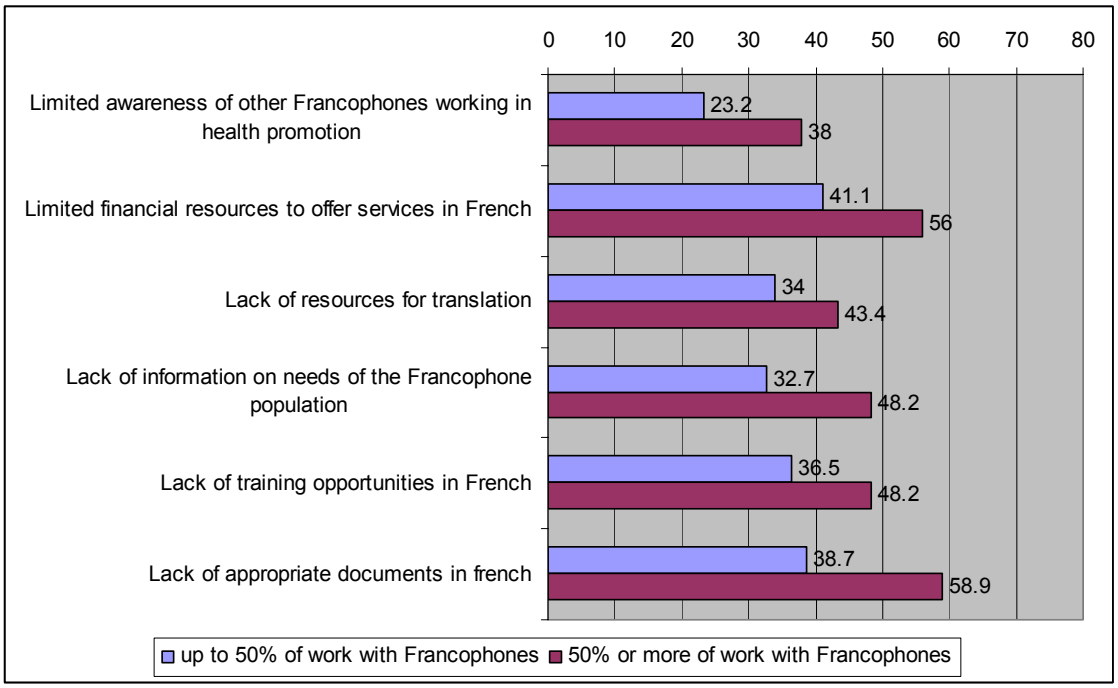


Figure 28. Percentage reporting various information or resource needs as "very challenging" when working with the Francophone community



When asked about the challenges working with the Francophone community, a wide range of responses was endorsed (*Figure 28*). Most notable were the high percentages agreeing that limited financial resources were available to offer services in French and the lack of appropriate documents in French. For those working over 50% time with the

Francophone community, virtually all categories were seen as important barriers, with between 40% and 60% endorsed all but one of the categories. Just less than 40% of those respondents, and 23.3% of those working less than 50% of the time with the Francophone community, found their limited awareness of Francophone health promoters to be very challenging.

Many of these same themes were reiterated in an additional open-ended probe on other challenges working with the Francophone population (*Table 13*), for example, the lack of French speaking health promoters (25.4%) and lack of resources/services in French (8.5%). However, we also see, for some health promoters answering this item (27.1%), the lower demand for French services and supports compared to other languages and cultures in their communities. This again reflects the multicultural diversity of Ontario.

> *"Finding the appropriate staff who have the knowledge and language competency. Also for us, there are issues of cultural competency since many of our French speaking clients are from outside of Canada and French may be their most dominant second language (i.e., Vietnamese, African, etc.)"*

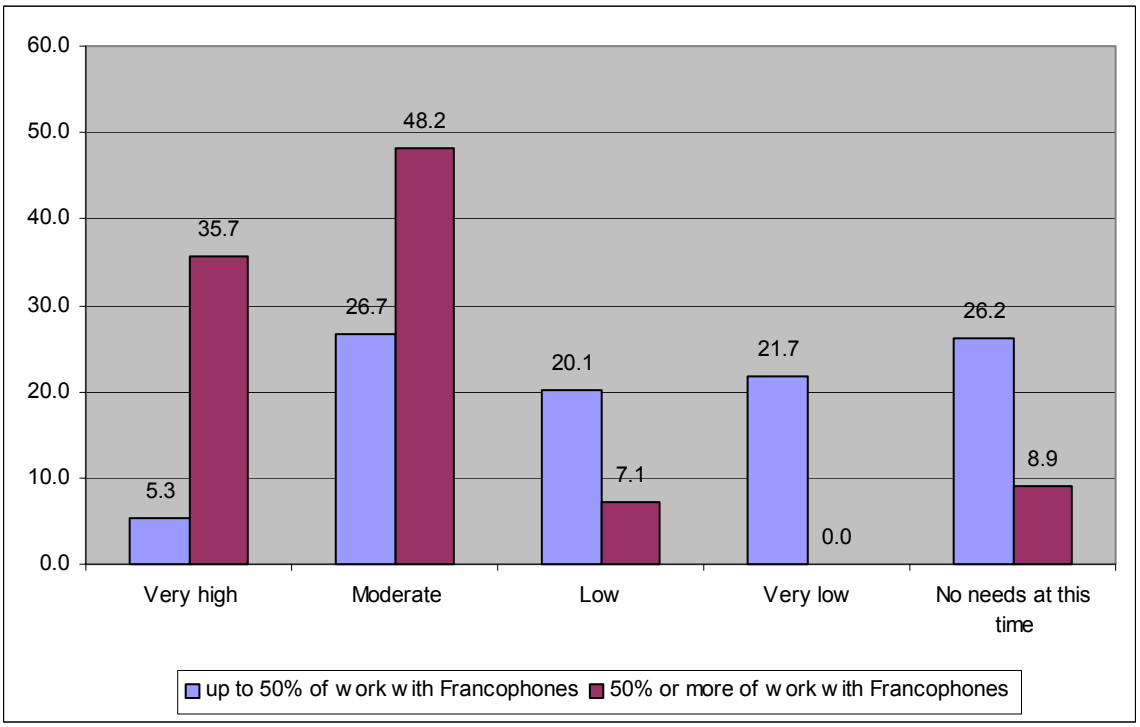
> *"Recruiting and retaining professional Francophone staff to provide services"*

Table 13. Other challenges faced working with Francophone community

	n	%
Limited need/demand for French/more need or demand in other languages or cultures	16	27.1
Don't speak the language; not enough Francophone health promoters	15	25.4
Not enough interaction locally with French lead – isolated / difficult to work with or reach	7	11.9
Lack of resources (videos, general)/lack of services	5	8.5
Difficult recruiting Francophone participants/volunteers	4	6.8
French needed or provided only for French immersion classes/schools	3	5.1
Translation services slow – not accurate – no resources to verify	1	1.7
Limited time and resources for adapting French components, or reaching out to Francophone community	1	1.7
Other – don't fit above	7	11.9
Total	**59**	**100.0**

Training and information needs for working with the Francophone community were rated and, as one might expect, the perceived level of need was higher for those working over 50% of the time with this community (*Figure 29*). In that sub-group, almost 50% rated their needs as "moderate" and 35.7% rated their needs as "very high". In terms of the detailed types of needs they have, a wide range of items were endorsed (*Figure 30*). We again see the higher level of needs for the group working over 50% of time with the Francophone community, with between 60% and 75% of this group endorsing all items as high priority (e.g., resource material created in French (74.5%); timely low cost translation services (68.8%); workshops and training events in French (68.8%). However, among those working less often with the Francophone community about one third of respondents also endorsed all the items as high priority.

Figure 29. Level of training or information needs when working with the Francophone community.



Finally, we enquired about respondents' interest in specific networking opportunities with other health promoters working with Francophone communities. In the sub-group working 50% of the time or more with the Francophone community, 100% said they would be interested in such networking opportunities. The percentage expressing an

interest in networking opportunities among those working less than 50% of the time with the Francophone community was 35.1%. In total, this represents 110 health promoters in the survey sample.

Of those health promoters expressing an interest in networking opportunities the most frequently endorsed option was for conferences/events and workshops (*Figure 31*). About 50% were also "very interested" in establishing more informal networks.

Figure 30. Percentage rating various Francophone related needs as high priority

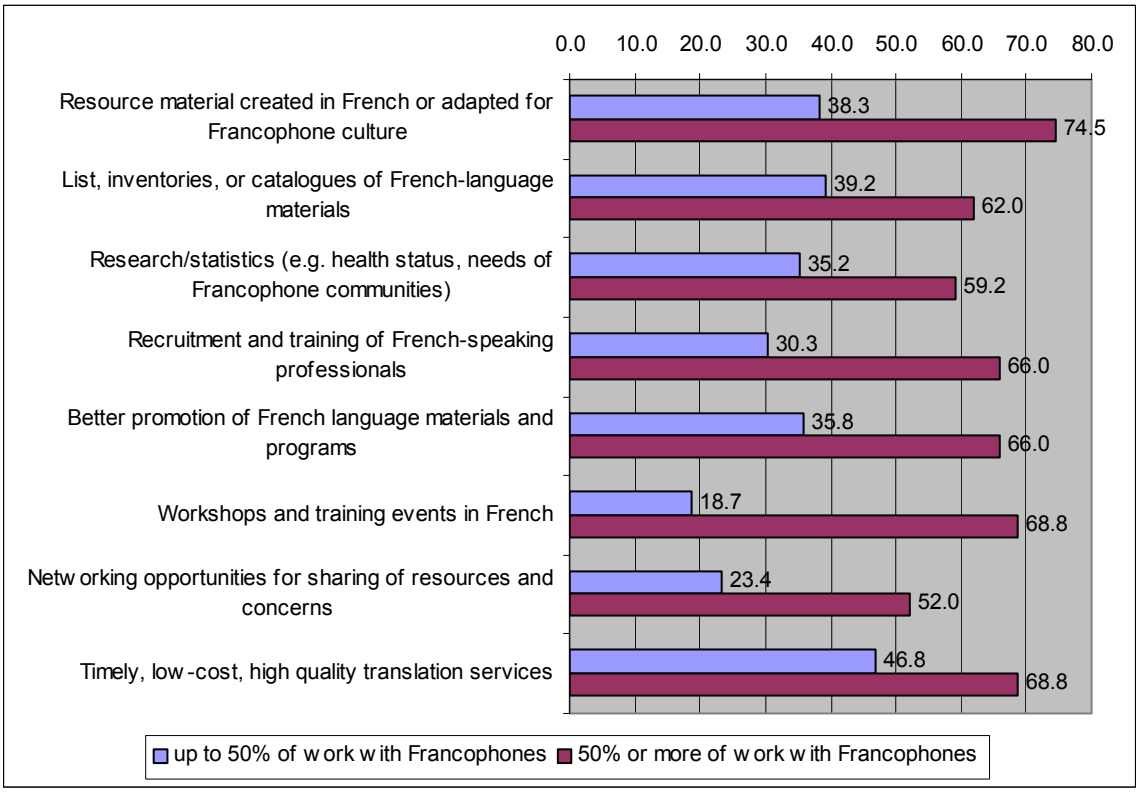
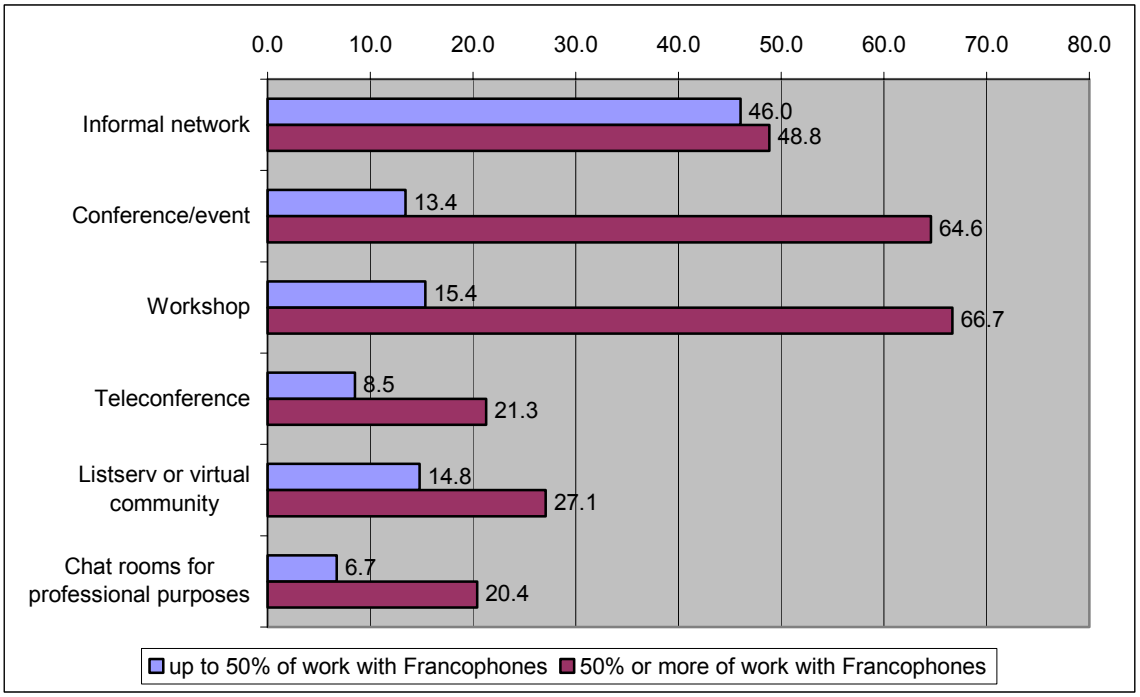


Figure 31. Percentage "very interested" in participating in specific networking opportunities for health promoters working with Francophone communities.



To conclude this section we present a summary profile of the group of Ontario health promoters working more than 50% of their time with the Francophone community. Given their more intensive work with this community it is important to profile their work, their needs and their challenges. Importantly, about 75% of this group responded to the survey questionnaire itself in the French language.

People that spent more than 50% time working with the Francophone community:

- Worked mainly in Eastern and Northern Ontario. They worked as much in urban as in rural areas and over 75% have worked less than 10 years in the field of health promotion. About half worked in organizations other than Public Health Units/Departments or CHC's. About one-third worked in organizations with between 1001-500 employees;

- Reported their top five health promotion topics areas to be: French language health promotion, school-based health promotion, community mobilization/capacity building, nutrition/food security and physical activity;

- Reported their top five health promotion strategies to be: health information dissemination, prevention, developing personal skills, evidence-based best/better practices and coalition development/community participation;

Compared to all other respondents, people that spent more than 50% time working with the Francophone community:

- Were more likely than all other respondents to rate their access to information for their health promotion work as "very difficult" or "difficult";
- Reported less use of the OHPRS organizations;
- Were more likely to access services and supports outside of the OHPRS network;
- Were more likely to prefer group versus individual-based training events;
- Were more likely to say they needed advanced health promotion training and technical support;
- Reported a higher percentage as being "very interested" in five of the 10 special topics presented to respondents for training ideas:
  - How to develop and implement a funding strategy;
  - How to partner effectively;
  - How to network with others;
  - How to manage projects;
  - How to develop/implement a health communication strategy;
- Were more likely to experience barriers or challenges making an optimum selection of conferences/events to attend (e.g., financial support for registration).

Compared to survey respondents working 50% time or less with the Francophone community, those that did so more than 50% time:

- Had less years experience working in health promotion;
- Provided more proactive outreach to the community;
- More frequently endorsed a broad range of barriers to their work such as lack of documents in French, information on the Francophone population;
- Were more likely to cite their need for training and information as "very high";
- More frequently endorsed a broad range of needs such as resource material created in French or adapted to the Francophone culture; recruitment and training of French-speaking health promoters; workshops and training events in French; and networking opportunities;
- Were more interested in networking opportunities such as conferences/events, workshops, and electronic-based options such as listservs, chat rooms and teleconferences.

4. 0 Discussion

The Evaluation and Needs Assessment Committee embarked on this provincial needs assessment for health promotion with three objectives in mind:

- Support the planning of individual OHPRS organizations by reaching a broader target group than would normally be surveyed by each organization;

- Through comparable questions and a shared approach to the data analysis identify potential areas of strategic collaboration across two or more Members which, in turn, may increase their impact on provincial health promotion capacity;

- Provide an opportunity to engage in inter-organizational collaboration and provide information to support the planning of system-level activities (e.g., communications, promotion).

With these objectives in mind it is clear that this report constitutes only one step along the way to the achievement of these objectives since the report, additional analyses and the survey data itself are now being turned over to the individual OHPRS organizations and the network as a whole for them to develop the specific implications for their work. This process of analysis and synthesis will continue for some months ahead, recognizing as well that many of the OHPRS organizations also contributed special modules to the survey questionnaire that have not been reported upon here. In this main report of the survey findings the committee saw its main goal as being to highlight the main trends in the core survey data and to draw attention to salient issues and challenges that the system as whole should consider as it moves forward with more inclusive strategic planning processes. We also present the main survey findings as a model for supplementary analyses within specific sectors and subgroups of interest. In this spirit we do not conclude our report with recommendations *per se*, as we feel additional input is needed from the overall OHPRS network in the crafting of actionable recommendations from the data at both a systems and organization level.

In this closing section of the report we highlight the following issues and challenges.

(1) *Complexity of the work and the needs:* The survey was successful in capturing a large, diverse group of "health promoters" and showing the multi-dimensional nature of

their work in many topic areas, and which includes a comprehensive range of strategies and activities. The respondents' endorsements of so many dimensions to their work is consistent with the field's current efforts to "unbundle" the concept of health promotion capacity in an effort to target required training and support activities. Our findings in this regard are also consistent with the results from the OHPRS quantitative and qualitative assessments of health promotion "capacity" (Rush & Urbanoski, 2003; Rush & Andrew, 2004). Since the work is complex and multi-dimensional, health promoters' needs for information and support are also complex and multi-dimensional. To a large extent many expressed needs of health promoters are also specific to their unique backgrounds, as well as the unique needs of the communities in which they work. This complexity supports the need for a varied and multi-dimensional system of services and supports that they can draw upon to maximize the impact of their health promotion programs and activities.

(2) *Key challenges*: Health promoters experience a wide range of challenges in planning and implementing health promotion activities. Consistent with findings from the OHPRS qualitative capacity assessment (Rush &Andrew, 2004) significant challenges are encountered with respect to funding and funding processes, as well as limited time and other resources. These types of challenges are largely outside the scope of the services and supports of the OHPRS, other than through the provision of evaluative information illustrating the effectiveness and cost-benefit for health promotion generally. Other important challenges such as access to resource material and expertise; access to cultural/language specific materials; access to needs assessment and evaluation tools and information are clearly within the scope and mandate of the OHPRS system of services and supports.

(3) *Coverage of OHPRS:* In terms of topic areas, the OHPRS organizations provide a broad coverage of most of the topic areas in which Ontario health promoters are engaged, for example, nutrition, tobacco control, alcohol and other drugs, school-based health promotion, and physical activity to name only a few. That said, there were several topic areas frequently endorsed by respondents that do not have a clear "home" within the OHPRS network of services and supports. These are mental health, injury prevention[23],

[23] Smartrisk, which has a focus on injury prevention, has recently joined the OHPRS.

violence, multicultural topics, French language health promotion; work related to determinants of health such as poverty/income/housing/employment, lastly, topics related to the physical environment. While these may well be cross-cutting, thematic areas of high relevance to many of the OHPRS organizations it would be of value for the system as a whole to consider how the needs of health promoters working in these areas are currently being supported. Importantly, the topic areas mentioned above represent five of the eight topic areas for which respondents cited the most difficulty accessing information in support of their work. While these topic areas may not need a specialized "resource centre" they may need a strategy to ensure that a coordinated, accessible and effective system of supports is available.

(4) *The language of self-help/mutual aid*: Health promoters are more engaged in the use of self-help mutual aid strategies than were anticipated going into the survey, as exemplified by their reported use of one or more of the following self-help strategies offered to them in a survey question on this topic: community based program planning, participatory planning and evaluation, strategizing with clients, and using peers as volunteers or paid staff. Thus, our survey question linked these strategies to self-help/mutual, recognizing they are not exclusive to self-help *per se*, but are also consistent with other strategies of community involvement and capacity building. In our open-ended questions on training and education needs, the terms "self-help" or "mutual aid" were rarely mentioned by respondents. Rather their needs were expressed in terms of community participation, partnership building, adult education, etc. - terms which may fit into the respondent's frame of reference for self-help only when prompted to think about it that way. This suggests the need for more clarity and specificity in the language around "self-help" and "mutual aid" and such clarification may help build some bridges across the self-help movement and that of community capacity building generally. Training and educational activities aimed at more effectively integrating self-help and mutual aid strategies into health promotion should address these language and conceptual barriers and show the consistency across much of the current work in health promotion with many of the fundamental principles and practices of self-help and mutual aid.

(5) *Accessing information*: About 25% of respondents indicated that their access to information for their health promotion work was "difficult" or " very difficult". That this represents a minority of health promoters is not cause for complacency. Responses to this question were related to the topic areas in which the health promoter was working, with the most difficult access being experienced by those working with broad determinants of health such as poverty, income, housing and employment. Furthermore, a large majority of survey participants cited specific challenges to accessing the information they needed. These challenges included whether the required information was available on specific topics; was relevant for certain cultural groups and in the appropriate language; or available for their jurisdiction. The findings suggest the OHPRS look further into these topic areas and key challenges and consider ways within its mandate to improve assess to health promotion information.

(6) *Promoting more awareness of OHPRS*: About 10% of those finding access to information to be "difficult" or "very difficult", commented on the challenge of knowing what information was available to them and from whom. This also echoed findings from the OHPRS qualitative assessment of health promotion capacity that more streamlined, centralized access to information would be extremely helpful. A related thread in the data was that about 6% of respondents had not used any of the OHPRS organizations, most typically as a result of lack of familiarity with what they have to offer. The survey itself prompted about 90% of all respondents to indicate they may now consider accessing one or more of the organizations that they may not have accessed before. Together, these data suggest the need for OHPRS to communicate better the full range of services and supports that are available through its participating organizations. Such communication would have to be planned and implemented in such a manner so as to carefully consider the capacity of the system to respond to a larger and potentially more diverse client group. Health promoters working full-time, in mid-sized to large organizations, with more years of experience and/or working in a Public Health Unit, tended to use more of the OHPRS organizations. This suggests the need for targeted promotion of the OHPRS network to smaller organizations, especially beyond PHU's.

(7) *Multiple contacts with the system:* A large majority of respondents had accessed the services and supports of more than one OHPRS organization in the past two years and about one-third had accessed six or more of the organizations. This is consistent with the findings from the results of the 2002 health promotion capacity survey (Rush & Urbanoski, 2003). Such multiple contact with several of the organizations represents an opportunity to the OHPRS organizations to share information about other services and supports that may be available. Many of the OHPRS organizations have developed collaborative partnerships on specific projects (e.g., an annual symposium jointly hosted by FOCUS and ODAP realizes increased networking opportunities for constituents and financial efficiencies). The potential for additional collaborations will be one of the primary tasks during system-level strategic planning processes to which our survey data will undoubtedly make a substantive contribution. A good example for consideration that would be consistent with our survey data would be issues and topics related to multicultural diversity.

(8) *Multi-cultural-related challenges:* About 60% of respondents stated that they had experienced barriers to accessing health promotion materials with respect to the cultural groups they worked with. Although this was particularly true in Toronto (80%) the concern was clearly a provincial rather than region-specific issue. Comments on the cultural/language issue reflected a lack of translated or cultural-specific materials; limited knowledge of the required language; and the lack of culture-specific needs assessment information. Such concerns were related to work with a wide range of cultural groups including Canada's aboriginal people. The needs are high for services and supports for health promoters in Ontario's multicultural landscape and the challenges to effectively meeting these needs will be best met with a coordinated response across the OHPRS and many other partners.

(9) *French-language health promotion:* The lack of resource materials and training opportunities in French, as well as access to French-speaking health promoters, are particularly challenging across the province. Those working more than 50% of the time with the Francophone community stood out in terms of the many challenges faced in their work and their needs for training, education and networking opportunities. These needs

have been further highlighted in a special report on French-language health promotion in Ontario (Rush, 2005).

(10) *Services and supports external to OHPRS:* Although the OHPRS organizations are frequently used by Ontario's health promoters, they are not "the only game in town" as almost 60% of the total sample had accessed services and supports outside the OHPRS in the past two years. Of the over 1000 responses to the item asking what organizations had been accessed, it was noteworthy that many of the responses reflected access to a local or regional source of support, in particular the Public Health Units/Departments. This suggests that some of the OHPRS organizations might strategically target selected focal points at the local or regional level as "critical intermediaries" as part of a strategy to improve their reach into Ontario's communities. This finding also requires a feasibility analysis of alternate training and capacity building strategies, such as 'train the trainer' events and resources. Lastly, OHPRS organizations might also consider a systematic mapping of their own respective inter-organizational networks in order to identify shared partnerships and collaborations that may further increase the reach of the network as whole. This would build upon the evaluative work of some of the OHPRS organizations as well as the OHPRS network survey conducted in 2002 that looked at the nature and level of inter-connectivity between the OHPRS organizations (Rush & Urbanoski, 2003).

(11) *Challenges regarding conferences and events:* A wide range of health promotion related conferences/events were considered appropriate for participation and many of these options were accessed within the past two years. Barriers to conference/event attendance were, however, encountered by about 75% of respondents. In addition to issues related to securing financial support and time/travel other important barriers included lack of managerial/board support, various types of organizational policies, insufficient notice or information about the event and a dearth of conferences/events in a specific topic area. Some of these challenges will be more easily addressed by the OHPRS organizations than others, for example, supporting the distribution of notices about conferences and events through their centralized web site. Organizational challenges could be included as a component of services and supports aimed at increasing

organizational as opposed to individual health promotion capacities, for example, leadership and fostering a learning culture.

(12) *Information technology:* Over the past decade, computers and the Internet have become a critical part of work life in Canada and we see this clearly reflected in our data from Ontario's health promoters. Although not universal as yet, almost all have some access to computers for their work and about 80% had very good access to high speed Internet service. The majority of respondents clearly preferred receiving information by downloading documents from the Internet or via emails versus receiving paper versions via postal mailout. That said, 40% to 50% of respondents cited less than ideal access to appropriate software as well as training and support on the use of the computer and the Internet. Such needs were also identified in the qualitative data on training and education needs, suggesting that this as an important topic area for inclusion in training and education opportunities led by one or more OHPRS organizations.

(13) *Training and education format*: With respect to health promoters' past training and education experiences, a wide range of options had been utilized in the past. In terms of meeting the respondents' needs the highest ratings were given to the more intensive options such as coaching and mentoring, expert consultation, training workshops and conferences or other events. Local and regional training events were clearly preferred over provincial events and, when asked about challenges with respect to attendance at conferences or events in general, issues related to cost and time to travel away from family, work and other commitments were frequently mentioned. This suggests the need to retain a local and regional focus to training as much as possible within the resource constraints. Electronic and other technology- based options were frequently used and are undoubtedly important options for the future. Several people commented specifically on the need to improve the reach of the traditional conference/training approach, for example, through web casting or subsequent preparation and dissemination of materials electronically.

(14) *Training and education topic areas:* A wide range of other training and education needs were identified which spanned the full range of health promotion topic areas (e.g.,

smoking, maternal and infant health, alcohol and other drugs, nutrition, physical activity, tobacco control) and capacity areas (e.g., community networking and partnerships, project planning and management, funding strategies, program and policy evaluation, health communication, mutual aid/self-help, and incorporating best/better practice). As noted earlier, this speaks to the individualized and community specific nature of training and education needs and the continued requirement for a diverse complement of training and support resources. At this stage in our analysis of both the quantitative and qualitative data it is not possible, however, to prioritize within the many topic areas and capacity domains for training and education. Further analyses will be required to tease out the expressed needs of special sub-groups within the survey data that will be of high interest to specific OHPRS organizations. Future more in depth analysis of the survey data will also explore areas where OHPRS members may be able to strategically and effectively collaborate with each other to address particular training needs of health promoters.

5.0 References

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Appendix A

OHPRS organizations

Organizations of the Ontario Health Promotion Resource System

Alcohol Policy Network (APN)
http://www.apolnet.org/ Phone: 416-367-3313 / 1-800-267-6817

APN facilitates the development of policies that prevent problems associated with alcohol use and promote the health, safety and well-being of individuals and communities across Ontario. APN monitors developments in alcohol policy and prevention research, disseminates timely information and best advice, promotes knowledge and skill development and facilitates networking and collaboration. People who often use APN's services include: professionals in public health, substance abuse, injury prevention and policy development, or anyone interested in alcohol policy.

Association to Reduce Alcohol Promotion in Ontario (ARAPO)
http://www.apolnet.org/arapo.html Phone: 416-367-3313 / 1-800-267-6817

ARAPO is a group of concerned individuals who share the common goal of promoting public health and safety through reducing the impact of alcohol advertising, promotion and sponsorship through education, policy and community action, and other health promotion strategies. People who often use ARAPO's services include: public health units, schools, impaired driving awareness groups and summer camps.

Best Start – Ontario's Maternal, Newborn and Early Child Development Resource Centre
http://www.beststart.org/ Phone: 416-408-2249 / 1-800-397-9567

Best Start supports community health professionals across Ontario working on health promotion initiatives to enhance the health of new and expectant parents (including both parents), newborns and young children. People who often use Best Start's services include: Community Health Centres, public health professionals and organizations serving children.

Consumer Health Information Service (CHIS)
http://www.tpl.toronto.on.ca/uni_chi_index.jsp Phone: 416-393-7056

CHIS helps people gain greater control over their own health through access to a range of credible, timely health information. CHIS also supports the provision of health information to public libraries. People who often use CHIS' services include: members of the public, librarians and health care providers.

Council on Drug Abuse (CODA)
http://drugabuse.ca Phone: 416-763-1491

The Council on Drug Abuse (CODA) works to prevent and reduce substance abuse through education, with a primary focus on youth and those associated with youth. Programs and priorities set by CODA are constantly being updated, researched and developed. People who often use CODA's services include: schools (all ages), youth groups, parent groups, community groups, professional groups (e.g. teachers) and workplace teams.

Focus Resource Centre (FRC)
http://www.frcentre.net/ Phone: 613-531-3895 / 1-888-433-3181

FRC supports FOCUS Community Programs, which are all funded by the Government of Ontario to develop and carry out alcohol and drug abuse prevention programming in their communities. including harm reduction and chronic disease prevention. Under the sponsorship of the Centre for Addiction and Mental Health, FRC builds on the resources and expertise of partner agencies to provide seamless service delivery to the 22 FOCUS sites. People who use FRC's services include: Ontario's 22 FOCUS communities and other community groups and partners that work with FOCUS communities.

Heart Health Resource Centre (HHRC)
http://www.hhrc.net/ Phone: 416-367-3313 / 1-800-267-6817

The HHRC provides support to the 37 community partnerships of the Ontario Heath Health Program – Taking Action for Healthy Living in Ontario, who plan, deliver and/or evaluate comprehensive community-based hearth health strategies. The HHRC fosters networking and communication between peers through the Ontario Hearth Health

Network as well as its newsletter and e-mail discussion lists. People who often use HHRC's service include: Heart Health coordinators, members of the Heart Health Community Partnerships, public health personnel and NGO's.

National Clearinghouse on Tobacco and Health (NCTH)
http://www.ncth.ca/NCTHweb.nsf Phone: 613-567-3050 / 1-800-267-5234

NCTH offers a comprehensive inventory of critical information for health intermediaries and other professionals in the field of tobacco control. People who often use NCTH's services include: health intermediaries, policy makers, researchers and health advocates.

Nutrition Resource Centre (NRC)
http://www.nutritionrc.ca/ Phone: 416-367-3313 / 1-800-267-6817

The NRC works to strengthen the capacity of community nutrition practitioners of Ontario. The NRC has a mandate to increase the level of coordinated provincial support of nutrition promotion programming, resource development and dissemination and support services for nutrition practitioners across Ontario. People who often use NRC's services include: dietitians and nutritionists working in public health, Community Health Centres and other settings (hospitals, NGO's, etc.), health promoters working in chronic disease prevention and Heart Health programs.

Ontario Drug Awareness Partnership (ODAP)
http://www.odap.org/ Phone: 705-745-5864 / 1-866-202-2146

ODAP raises awareness of the effects of alcohol and other drugs by encouraging and supporting drug awareness initiatives throughout Ontario. ODAP sets the theme for the annual Drug Awareness Week Campaign. Drug Awareness Committees are the primary users of ODAP's services.

Ontario Health Communities Coalition (OHCC)
http://www.healthycommunities.on.ca Phone: 416-408-4841 / 1-800-766-3418

OHCC works with the diverse communities of Ontario to strengthen their social, environmental and economic well-being. Educational materials, newsletters, a website, a monthly e-bulletin and annual conferences are co-ordinated through the Central Office in Toronto. Regionally-based Community Animators provide information, training, consultation and linkages to support local efforts to create healthier communities. People who often use OHCC's services include: non-profit community groups and organizations (NGO's), community coalitions, environmental groups and the general public.

Ontario Prevention Clearinghouse (OPC)
http://www.opc.on.ca Phone: 416-408-2249 / 1-800-263-2846

The Ontario Prevention Clearinghouse (OPC) helps individuals, groups and communities use health promotion strategies to achieve health and well-being. People who often use OPC's service include: staff and volunteers of public health units, Community Health Centres, voluntary health organizations, community coalitions and workgroups, people working in the areas of human and social services, recreation and education and anyone working to implement health promotion strategies in Ontario.

Ontario Self-Help Network (OSHNET)
http://www.selfhelp.on.ca/ Phone: 416-487-4355 / 1-888-283-8806

Appendix B

Organizations Supporting Recruitment of the Non-User Sample

Alcohol and Drug Recovery Association of Ontario

Active Living Alliance for Canadians Living with a Disability

ALCOA (Active Living Coalition for Older Adults)

Association of Early Childhood Educators Ontario

Association of Local Public Health Agencies

Association of Ontario Health Centres

Breakfast for Learning

Canadian AIDS Treatment Information Exchange CATIE

Canadian Association of Rehabilitation Professionals – Ontario

Canadian Cancer Society, Ontario Division

Canadian Diabetes Association

Canadian Intramural Recreation Association – Ontario

Centre for Activity and Aging

Coalition for Active Living -

Dairy Farmers of Ontario

Dietitians of Canada (Ontario)

District Health Councils - provincial

Durham, Haliburton, Kawartha, Pine Ridge DHC

Economic Developers Council of Ontario

Father Involvement Initiative Ontario Network Initiative

Girl Guides of Canada – Ontario Division

Go for Green - Ontario

Hamilton-Wentworth DHC

Health Promotion Ontario

Heart and Stroke Foundation of Ontario

Inter-Church Health Ministries Parish Nurse Association

Jean Tweed Centre and Women's Addiction Network

Men's Health Network

Occupational Health: Ontario Occupational Health Nurses Association

Ontario Aids Network

Ontario Association of Community Care Access Centres

Ontario Association of Sport and Exercise Sciences

Ontario Coalition of Senior Citizens Organizations

Ontario Federation of Community Mental Health and Addiction Programs

Ontario Federation of Indian Friendship Centres

Ontario Fitness Council

Ontario Healthy Schools Coalition

Ontario Hospital Association / Hospital Health Promotion Network

Ontario Multifaith Council for Spiritual and Religious Care

Ontario Non-profit Housing Association

Ontario Women's Health Network

Ontario Public Health Association and Members

Social Determinants Listserv

Parks and Recreation Ontario (PRO)

RCMP

Safe Communities Coalition

Social Planning Network of Ontario

South West Ontario Community Development Network

Tamarek - An Institute for Community Engagement

The Federation of Urban Neighbourhoods (Ontario) Inc.

Toronto Men's Health Network

Appendix C

Detailed Coded Open-ended Data
To Core Survey Component

Table Core3a. Other sources of information and support[24]

	n	%
Other community agencies/source (generic)	24	15.3
Courses/university	22	14.0
Consumers/client group	21	13.4
A type of resource mentioned	19	12.1
Colleagues/professional networks	17	10.8
Public health	12	7.6
Specific OHPRS resource centre named	7	4.5
Expert consultation	6	3.8
Government/government department	5	3.2
Internet-based resources	4	2.5
Other specific organization named	4	2.5
Conferences	2	1.3
Training workshops	2	1.3
Doesn't fit above categories	12	7.6
Total	**157**	**100.0**

[24] Only 8 French language respondents included something in the other category, a number too small for separate tabular analyses

Table Core3b. Other types of info and support materials[25]

	n	%
Research/survey data/own evaluation or needs assessment data	34	13.7
Other materials/products (i.e. not centre specific or as described as a toolkit/resource)	30	12.1
An OHPRS–specific source but didn't mention the product itself	14	5.6
Other resource kits/materials/toolkits	10	4.0
Audio/video resource material	9	3.6
Research articles/books	7	2.8
Best-better practice documents	5	2.0
Material from media-releases, clippings	4	1.6
Personal accounts/stories	3	1.2
Newsletter	2	0.8
Specific Resource Centre materials/toolkits	1	0.4
Other – doesn't fit above categories	2	0.8
A source of information (e.g. Internet, expert, talking to colleagues, conference, workshop)	127	51.2
Total	**248**	**100.0**

[25]Only 12 French language respondents included something in the other category, a number too small for separate tabular analyses

Table Core4b. Access issues for those citing difficult and very difficult access to information

	n	%
Topic specific – e.g. not enough on specific topic of interest, incl. lack of best practice info on that topic	62	22.1
Generally – poor access to information, resource people; need to find/go through	32	11.4
Finding out what is out there – more specific concerns about lack of time or resources	31	11.0
Finding out what is out there – general concerns with don't know where to look, who has what, too much info	26	9.3
Cost – finding free materials, shipping, general costs	22	7.8
Access issue is language or culture-related	21	7.5
Francophone specific concerns such as access to materials, translation, experts	18	6.4
General concern about lack of evidence-based practice recommendations	14	5.0
Access issue is jurisdiction specific - not enough local information	14	5.0
Lack of response from; person too busy; material out of stock; not willing to share	10	3.6
Cost – for training and/or conferences	9	3.2
Access issue is Ontario/Canadian specific – not enough Canadian data	9	3.2
Isolated; not enough people locally working in my area, transportation	5	1.8
Finding out what is out there – specific comment re: need for more centralized source of information/contact info	5	1.8
Internet access issues	3	1.1
Privacy act registrations	1	0.4
Poor intergovernmental coordination; need consistent policies	1	0.4
Other – doesn't fit above categories	8	2.8
Total	**281**	**100.0**

Table Core4c. Additional needs regarding access to resource materials and expertise

	n	%
Issue is topic specific – e.g. not enough on specific topic of interest, incl. best practice info	114	20.5
Generally – poor access to information, resource people; need to find/go through	72	12.9
Finding out what is out there – specific comment re: need for more centralized source of information/contact info	50	9.0
Finding out what is out there – more specific concerns about lack of time or resources	37	6.7
Finding out what is out there – general concerns with don't know where to look, don't know who has what, too much info, don't know web search terms	35	6.3
Cost – finding free materials, shipping, general costs	29	5.2
More general lack of evidence-based practice recommendations	27	4.9
Access issue is Ontario/Canadian specific – not enough Canadian data	26	4.7
Cost – for training and/or conferences	25	4.5
Francophone specific concerns such as access to materials, translation, experts	22	4.0
Evaluation tools needed/evaluation needed	13	3.2
Access issue is language or culture-related	17	3.1
Poor intergovernmental coordination; need consistent policies	14	2.5
Isolated; not enough people locally working in my area, transportation	15	2.1
Access issue is jurisdiction specific - not enough local information	9	1.6
Lack of response; person too busy; material out of stock; not willing to share	8	1.4
Internet access issues	8	1.4
Other – doesn't fit above categories	35	6.3
Total	**556**	**100.0**

None/nothing mentioned 83

Table Core5. Additional gaps faced planning and implementing their health promotion programs

	n	%
Low support for health promotion/making the business case	37	17.1
Access to relevant resource material and expertise	36	16.7
Lack of internal organization support for their work, topic area, or health promotion	23	10.6
Funding issues	18	8.3
Lack of coordination/duplication of effort	18	8.3
Time	18	8.3
Access to appropriate evaluation models	12	5.6
Finding trained people to help	11	5.1
Access to culturally or language appropriate materials and expertise	7	3.2
Difficult in rural areas, travel time, transportation	7	3.2
Francophone issues	7	3.2
Access to appropriate needs assessment information	2	0.9
Other	20	9.3
Total	**216**	**100.0**

None identified 35

Table Core7. Explanation as to why they had not accessed any of the OHPRS organizations

	n	%
Didn't know what is available and/or what they do	22	55.5
Many other places; no need to go here	9	22.5
My topic area doesn't fit	8	20.0
Work outside of Ontario	1	2.5
Total	**40**	**100.0**

Table Core9. Up to three other non-OHPRS organization used for health promotion services and supports

	n	%
Public Health Unit	103	9.5
Other - Organization - Canadian - Local	74	6.8
None Other - Association - Canadian - National	52	4.8
Other U.S.-based Resource (non-CDC)	52	4.8
Other provincial organizations or citation	47	4.3
Heart & Stroke Foundation	46	4.2
Other - Organization - Canadian – Jurisdiction Unknown	45	4.1
Other - Organization - Canadian – National level	42	3.9
Centre for Addiction and Mental Health	41	3.8
Universities (including those in the united States)	40	3.7
Other - Network/Coalition - Canadian – Provincial level	37	3.4
Other - Network/Coalition - Canadian – National level	36	3.3
Health Canada	35	3.2
Other - Association - Canadian – Ontario level	32	2.9
Cancer Care Society	28	2.6
Other - Network/Coalition - Canadian - Local level	28	2.6
Canadian Mental Health Association	25	2.3
Centre for Disease Control	23	2.1
Diabetes Association	21	1.9
Internet / search / website listed / listservs	19	1.7
WHO/PAHO/other international organization	19	1.7
Other - Organization - Canadian – Ontario level	16	1.5
Ontario Public Health Association	15	1.4
Dieticians of Canada	14	1.3
Mood Disorders Association - Ontario Schizophrenia Society	12	1.1
Registered Nurses Association of Ontario	12	1.1
Canadian Centre on Substance Abuse	11	1.0
Other - Network/Coalition - Canadian - Not specified	11	1.0
Lung Association	10	0.9
Community Health Centres	9	0.8
PHRED	8	0.7
National Clearinghouse or Family Violence	7	0.6
Other - Association - Canadian - not specified	7	0.6
Centre for Health Promotion	6	0.6
Ontario MOHLC	6	0.6
Other - Government Department - Canadian - Local	6	0.6
SMART Risk	6	0.6
CDPAC	5	0.5
Cancer Care Ontario	4	0.4
OHPE (Bulletin)	4	0.4
Other - Government Department - Canadian - Fed-Non HC	4	0.4
Risk watch	4	0.4
CIHR or one of the Institutes	3	0.3
Canadian Public Health Association	3	0.3
Other - Association - Canadian - Local	3	0.3
Other - Government Department - Canadian - Provincial	3	0.3
Other - Government Department - Canadian - Not specified	2	0.2
AOH Centres	1	0.1
Health Information Partnerships	1	0.1
Media	1	0.1
Other – e.g. not clearly identifiable acronym	48	4.4
Total	**1087**	**100.0**

Identified 10
OHPRS organization or one of their programs named 122

Table Core10. Other self- help strategies employed by respondents

	n	%
Support groups/ chat group	13	27.1
Using (involving) peer volunteers (or paid) in program delivery	5	10.4
Named a program or community resource (presumably as an example)	6	12.5
Individual or group work/skills training	5	10.4
Used OshNet	3	6.3
Participatory planning and evaluation	2	4.2
Clients/consumers provided feedback	2	4.2
Research/research about self-help	2	4.2
All aspects of the program	2	4.2
Provided learning opportunity for staff/others about self-help	1	2.1
Community –based program planning	1	2.1
Other ways not codeable above	6	12.5
Total	**48**	**100.0**

Table Core14b. Advanced training and education needs

Should take more advanced course or degree; certification or credentialing process for health promotion	12	7.1
Need resources to bring people together	11	6.5
Maternal health (incl. child health, developmental)	11	6.5
General statement about evaluation	11	6.5
Computer literacy; use of the Internet	10	5.9
Multicultural diversity/issues (community or client)	7	4.1
Community development services; coordinate/get people on the same page; conflict resolution; building relationships; coalition building	7	4.1
Need to know what is available/how to access, including OHPRS	6	3.6
Best Practice applications – translating research to practice	6	3.6
Health communication, marketing, media work	5	3.0
Planning - general statement	4	2.4
Nutritional issue/food security	4	2.4
Mental health (include stress management, self-image, anger, forensics)	4	2.4
Alcohol or other drugs	4	2.4
Building clinical skills; integrating health promotion into clinical/hospital settings or other health care settings	3	1.8
Project implementation (general comment)	3	1.8
Policy work/policy options/policy writing skills	3	1.8
Health (social) determinants – population health approach	3	1.8
Funding for access to various things needed for work	2	1.2
Workplace health/issues, including staff wellness	2	1.2
Tobacco control/cessation	2	1.2
Strategies/working in rural/remote area	2	1.2
School-based health promotion including university	2	1.2
Proposal writing/development/developing goals and objectives, logic models taking advantage of funding calls	2	1.2
Physical environment	2	1.2
Outcome evaluation/indicators	2	1.2
Involving the community/community participation	2	1.2
Internship/focused short-term work experience/mentoring	2	1.2
how to coach and mentor others	2	1.2
General health promotion/nothing too specific	1	0.6
Youth/high risk teens	1	0.6
Using plain language; presentation methods, including PowerPoint; knowledge translation	1	0.6
Self-help/peer support	1	0.6
Physical activity	1	0.6
Participatory action evaluation/research	1	0.6
Needs assessment, finding and using supportive statistical information; epidemiology and health promotion	1	0.6
Injury prevention	1	0.6
How to work with consultants	1	0.6
HIV; STDs	1	0.6
General training or teaching methods	1	0.6
General statement re sustainability	1	0.6
Chronic disease prevention	1	0.6
Advocating; working with advocacy group	1	0.6
Other/ doesn't fit any of above categories	12	6.5
Total	**169**	**100.0**

Nothing stated specifically or just said “nothing needed’ 16

Table Core15b. Topics of interest for training and education

Community development services; coordinate/get people on the same page; conflict resolution; building relationships; coalition building	51	8.9
Best Practice applications – translating research to practice	35	6.1
Advocating; working with advocacy group	26	4.5
Multicultural diversity/issues (community or client)	23	4.0
Proposal writing/development/developing goals and objectives, logic models taking advantage of funding calls	23	4.0
Mental health (include stress management, self-image, anger, forensics)	22	3.8
Policy work/policy options/policy writing skills	22	3.8
Maternal health (incl. child health, development)	20	3.5
Managing projects (resources, budgeting, work plan monitoring, time management)	18	3.1
Health communication, marketing, media	17	3.0
Involving the community/community participation	17	3.0
Building clinical skills; integrating health promotion into clinical/hospital settings or other health care settings	16	2.8
Needs assessment, finding and using supportive statistical information; epidemiology and health promotion	16	2.8
Computer literacy; use of the Internet	12	2.1
General statement about evaluation	11	1.9
Health (social) determinants – population health approach	11	1.9
Using plain language; presentation methods, including PowerPoint; knowledge translation	11	1.9
Nutritional/food security	10	1.7
Tobacco control/cessation	10	1.7
Workplace health/issues (include staff wellness	10	1.7
General health promotion/nothing too sp	9	1.6
Marketing health promotion; building the business case for health promotion	9	1.6
Youth/high risk teens	9	1.6
Self-help/peer support	8	1.4
Government relations; communicating with government; keeping abreast	7	1.2
Need resources to bring people together	7	1.2
Planning - general statement	7	1.2
Alcohol or other drugs	6	1.0
General training or teaching methods	6	1.0
Physical activity	6	1.0
School-based HP (include university)	6	1.0
Strategies/working in rural/remote area	6	1.0
Facilitating groups	5	0.9
General statement re sustainability	5	0.9
Chronic disease prevention	4	0.7
High-risk families /neighbourhoods	4	0.7
Need to know what is available/how to a	4	0.7
Poverty/income/housing/employment	4	0.7
Program implementation/tracking/quality	4	0.7
Sex; gender positivity	4	0.7
Violence	4	0.7
Dealing with literacy issues (community	3	0.5
Developing on-line materials and courses	3	0.5
Fundraising	3	0.5
How to coach and mentor others	3	0.5
Organization change strategies	3	0.5
Outcome evaluation/indicators	3	0.5
Physical environment	3	0.5
Volunteer recruitment/finding helpers	3	0.5
Funding for access to various things needed for work	2	0.3
Heart health	2	0.3
Injury prevention	2	0.3
Participatory action evaluation/research	2	0.3
Project implementation (general comment	2	0.3
Using different theories (e.g. diffusion of innovation)	2	0.3
Engaging/working with men	1	0.2
HIV; STDs	1	0.2
Internship/focused short-term work experience/mentoring	1	0.2
Qualitative evaluation	1	0.2
Should take more advanced course or degree; certification or credentialing process for health promotion	1	0.2
Train the trainer	1	0.2
Other/ doesn't fit any of above categories	28	4.9
Total	**575**	**100.0**

Nothing stated specifically or just said “nothing needed” 36

Table Core15b. Topics of interest for training and education[26]

Topic Areas/Populations		
Alcohol or other drugs	6	1.0
Chronic disease prevention	4	0.7
Physical environment	3	0.5
Heart health	2	0.3
Injury prevention	2	0.3
Maternal health (including. child health, development)	20	3.5
Mental health (include stress management, self-image, anger, forensics)	22	3.8
Nutritional/food security	10	1.7
School-based health promotion (including university)	6	1.0
Tobacco control/cessation	10	1.7
Self-help/peer support	8	1.4
Violence	4	0.7
Physical activity	6	1.0
Poverty/income/housing/employment	4	0.7
Self-help/peer support	8	1.4
Sex; gender positivity	4	0.7
Workplace health/issues (include staff wellness)	10	1.7
HIV; STDs	1	0.2
Youth/high risk teens	9	1.6
Strategies/working in rural/remote area	6	1.0
High-risk families /neighbourhoods	4	0.7
Engaging/working with men	1	0.2
General health promotion/nothing too specific	9	1.6
Health (social) determinants – population health approach	11	1.9
Subtotal	**170**	**29.6**
Training and Education in Health Promotion (capacity areas)		
(a) ***Needs Assessment and Planning***		
Best Practice applications – translating research to practice	35	6.1
Needs assessment, finding and using supportive statistical information; epidemiology and health promotion	16	2.8
Using different theories (e.g. diffusion of innovation)	2	0.3
Proposal writing/development/developing goals and objectives, logic models taking advantage of funding calls	23	4.0
Planning - general statement	7	1.2
Subtotal	**83**	**14.4**
(b) Implementation		
Fundraising	3	0.5
Organization change strategies	3	0.5
Involving the community/community participation	17	3.0
Project implementation (general comment)	2	0.3
Policy work/policy options/policy writing skills	22	3.8
Community development services; coordinate/get people on the same page; conflict resolution; building relationships; coalition building	51	8.9
Building clinical skills; integrating health promotion into clinical/hospital settings or other health care settings	16	2.8
Advocating; working with advocacy group	26	4.5

[26] Same coding scheme as question 14 but here grouped into categories

Volunteer recruitment/finding helpers	3	0.5
Marketing health promotion; building the business case for health promotion	9	1.6
Managing projects (resources, budgeting, work plan monitoring, time management)	18	3.1
Health communication, marketing, media	17	3.0
Facilitating groups	5	0.9
Subtotal	**192**	**33.4**
(c) Program Evaluation		
General statement about evaluation	11	1.9
Program implementation/tracking/quality improvement	4	0.7
Outcome evaluation/indicators	3	0.5
Participatory action evaluation/research	2	0.3
Qualitative evaluation	1	0.2
Subtotal	**21**	**3.7**
(d) Sustainability		
General statement re sustainability	5	0.9
Subtotal	**5**	**0.9**
Individual Cross-cutting Capacity Issues/areas		
Computer literacy; use of the Internet	12	2.1
Multicultural diversity /issues (community or clients)	23	4.0
Dealing with literacy issues (community	3	0.5
Government relations; communicating with government; keeping abreast	7	1.2
Subtotal	**45**	**7.8**
Training in how to train/ teach others		
Developing on-line materials and courses	3	0.5
Funding for access to…(various things n	2	0.3
General training or teaching methods	6	1.0
How to coach and mentor others	3	0.5
Train the trainer	1	0.2
Using plain language; presentation methods, including PowerPoint; knowledge translation	11	1.9
Subtotal	**26**	**4.5**
General training and education needs and issues		
Need to know what is available/how to access	4	0.7
Need resources to bring people together	7	1.2
Respondent acknowledges they should take more advanced course or degree; certification or credentialing process for health promotion	1	0.2
Internship/focused short-term work experience/mentoring	1	0.2
Subtotal	**13**	**2.3**
Other/ doesn't fit any of above categories	15	2.6
Other topic/no topic/general	13	2.3
TOTAL mentions	**575**	**100**

Nothing stated specifically or just said “nothing needed” 36

Core 17b. Challenges experienced making choices for conferences/events

	n	%
Organization policies (no coverage, only one can go; lack of manager support)	26	25.2
Too far to travel/poor location (Toronto, South) – sometimes connected with family/cost	25	24.3
Not enough notice and/or info about conferences or associations	15	15.6
Other responsibilities (family, work); bad timing / no time/too much time away	15	14.6
Lack of conferences/events in topic area / content not appropriate	8	7.8
General concern re: cost – doing it in the budget	5	4.9
Event was full, they fill up quickly	3	3.0
Personal health reasons (e.g. allergy; disability)	2	1.9
Conferences should collaborate/redundant	2	2.0
Benefits to organization not clear	1	1.0
Other – don't fit above, not codeable	1	1.0
Total	**103**	**100.0**

Not really a barrier or challenge identified / comment or blank 4

Table Core18. Other comments regarding conferences

	n	%
Funding issues; $ cost; travel costs	85	25.0
Location / too far to travel; sometimes connected to family and also cost of travel	56	16.5
Comments offered but no conference or conference topics offered; need notification of conferences	42	12.4
General – no specific conference/event listed – (e.g. conferences in topic area)	41	12.1
Need to broaden reach (e.g. web casting; send out disk or copy of materials after; teleconference	29	8.5
Other responsibilities/work/family issues; bad timing; no time; too much time away	16	4.7
Organizational policies (only one can go; no coverage; front line staff can't go; lack of manager support; no reimbursement if on days off)	15	4.4
Suggestions for format – (e.g. don't like long 1.5hr. workshops; like more mix of formal presentations and informal issue/round tables	11	3.2
OHPRS – related events mentioned (THCU, HHRC workshop)	10	2.9
Conferences are good opportunity for networking	10	2.9
Canadian event (National, Provincial, Regional)	9	2.6
Need more themes and topics relevant to Francophone	3	0.9
Local event (if identifiable)	3	0.9
Other event but not codeable in above categories	10	0.6
Non-Canadian event (U.S., Other country, World)	2	0.6
Other	8	2.4
Total	**340**	**100.0**

No comments offered 23

Table Core29c. Other type of organization

	n	%
Local health or social service (e.g. addictions, mental health, family counselling)	45	43.3
Other local non-profit agency/program	18	17.3
Private/workplace/industry	9	8.6
Health Unit	9	8.6
Pre-school, Early Years Centre	8	7.7
Local coalition; neighbourhood program	8	7.7
DHC	2	1.9
Parish/church	1	1.0
Other	4	3.9
Total	**104**	**100.0**

Comments but organization not really stated 9

Core29e: Title of position

	n	%
Public health nurse	143	20.2
Manager/executive director/supervisor/chairperson	130	18.4
Program or project coordinator/hp coordinator/other coordinator	87	12.3
Health promoter	84	11.9
Other profession (e.g. dietician, nutritionist, midwife)	63	8.9
Community worker (outreach, support); case manager; animator	39	5.5
Teacher/instructor/educator/lecturer	34	4.8
Program/policy Consultant	31	4.4
Other nursing	30	4.2
Analyst/evaluator/researcher	19	2.7
Project officer	14	2.0
Principal/superintendent	7	1.0
Planner	7	1.0
Professor	5	0.7
Other	14	2.0
Total	**703**	**100.0**