
PUBLIC HEALTH IN ATLANTIC CANADA:

A DISCUSSION PAPER

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The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Public Health Agency of Canada.

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EXECUTIVE SUMMARY

This discussion paper was created for the Public Health Agency of Canada, Atlantic Region (PHAC Atlantic) in February and March 2005. The objectives of the paper are to assist the PHAC Atlantic to better understand the regional public health environment and to identify opportunities to build effective public health partnerships that can enhance the capacity of all levels of government, academia, and community to work together.

As a primary activity, an inventory of stakeholders in public health in the region was identified. Building upon this base, a selection of publically available documents was collected in a descriptive bibliography. A tool that used both focus areas and enabling functions in public health as lenses for activity was developed by the steering committee, and 125 groups were identified for interview. Interviews were conducted with 92 individuals spanning government, academic, and non-profit groups in all four provinces, including Francophone and Acadian groups and multi-sector and pan-Atlantic groups.

Respondents were asked to describe how public health is organized in their region and to comment specifically on the public health role of their organization, department, or group. This provided the basis for a broad snapshot of public health activity in the region. As public health is in a period of great flux across Canada, the picture provided here is a basic one and should be built upon with further activity.

Stakeholders were asked to identify barriers and challenges to effective public health practice in the region. The main challenges and barriers identified were a lack of funding and resources for public health; challenges in working both across jurisdictions and within sectors; the disconnect between practice, research, and policy; an overall public focus on health care services; and fragmentation within the public health system.

Success stories were collected from all respondents. Several of these success stories are highlighted in the body of this paper.

Stakeholders were also asked about priority areas for public health enhancement in the region, and they identified both enabling functions and topic areas for public health. Priority work needed to enhance the function of public health in the region falls under the categories of health surveillance; research, evaluation, and knowledge translation; policy, legislation, regulation, and planning; health human resource planning, development, and training; and community capacity building. Topic areas include work on specific risk factors as well as a call to focus on certain population groups.

The respondents were asked to identify areas in which the PHAC Atlantic can improve coordination and collaboration and support the development of public health in the region. The nine overarching recommendations for the PHAC Atlantic are as follows:

- Champion public health.
- Define and promote the role of the PHAC.
- Facilitate a strategic plan for pan-Atlantic public health.
- Build capacity for all areas of public health in the Atlantic region.
- Build on the assets, existing models, and areas of strength in Atlantic Canada.
- Support sustainable and targeted funding for public health.
- Create opportunities for networking and partnership.
- Maintain a structure of long-term relationships.
- Be a knowledge broker for public health in Atlantic Canada.

While there are acknowledged gaps in this discussion paper, it does provide a starting point for further discussion and action. The PHAC Atlantic is encouraged to build upon the work of this paper and engage in further activity with stakeholders in the region in order to enhance the entire scope of public health practice.

INTRODUCTION

“Health care is vital to all of us some of the time, but public health is vital to all of us all of the time.”
– C. Everett Koop, Former Surgeon General, U.S.A.

The purpose of this discussion paper is to assist the Public Health Agency of Canada, Atlantic Region (PHAC Atlantic) and other stakeholders to better understand the regional public health environment. The work was carried out in February and March 2005 and is seen as an important step towards strengthening public health partnerships in the region.

THE PUBLIC HEALTH AGENCY OF CANADA

In order to strengthen its ability to protect the health and safety of Canadians, the Government of Canada delivered on its commitment to establish a new Public Health Agency of Canada (PHAC) in September 2004. The mission of the PHAC is to promote and protect the health of Canadians through leadership, partnership, innovation, and action in public health. With pillars in Winnipeg and Ottawa and regional offices across the country, the PHAC is well placed to collaborate with Canada’s provinces and territories on matters of public health.

The creation of the PHAC came as the result of wide consultation with the provinces, territories, non-government stakeholders, and Canadians in general. A national public health agency was also recommended in Dr. David Naylor’s report, *Learning from SARS: Renewal of Public Health in Canada*, as well as in other Canadian and international reports.

The PHAC’s focus areas

The PHAC identifies promotion, prevention, and protection as the three main activities for public health practice. These three areas focus on communicable disease, non-communicable disease and injury, and healthy human development.

Communicable disease encompasses diseases that are transmitted through various forms of contact. It includes zoonotic diseases such as the West Nile virus and avian influenza. It also includes sexually transmitted diseases such as syphilis, HIV/AIDS, and hepatitis C and respiratory diseases such as SARS. Chicken pox, measles, and mumps are common childhood communicable diseases. Some communicable diseases have effective vaccines that limit the spread of the disease, and others do not. There are currently 52 communicable diseases reported nationally.

Non-communicable disease and injury can be broken down into several areas. Non-communicable disease includes a broad range of diseases – many sharing common risk factors – such as arthritis, cancer, stroke, diabetes, cardiovascular disease, and respiratory disease. Injury encompasses a wide range of activities related to motor vehicles, recreational vehicles (such as ATVs), bicycles, and pedestrian safety. It also includes home-setting and age-specific safety issues such as falls prevention in seniors. Suicide (self-injury), fetal alcohol spectrum disorder, occupational health and safety, and shaken baby syndrome are other diverse areas related to injury control and prevention.

Healthy human development focusses on the life-course context of the health of citizens and includes a focus on addressing the upstream causes of many of the diseases listed above. Often, the “determinants of health,” defined by Health Canada,¹ are used as a lens for action. They include

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture

Healthy human development includes actions in all of the above areas, with a special focus on health promotion, health policy development, and protection. Supporting healthy human development acknowledges the complexities and interactions of all of the social, economic, and emotional factors that influence our health.

The PHAC’s enabling functions

The PHAC also identifies five enabling functions related to building the capacity to carry out work in the areas listed above. These five enabling functions are

- public health surveillance
- research, evaluation, and knowledge translation
- policy, legislation, regulation, and planning
- health human resource planning, development, and training
- community capacity building

Public health surveillance is defined as the “systematic collection, analysis, interpretation, and dissemination of health data on an ongoing basis, to gain knowledge of the pattern of disease occurrence and potential in a community, in order to control and

prevent disease in the community.”² Having access to community-level data and information to perform a regular community health assessment is a critical step in moving forward to enhance population health.

Research in public health helps answer community questions, facilitate the understanding of population health issues, and inform and support policy development. The evaluation of public health activities provides an opportunity to explore the relationship between interventions and defined health outcomes. Knowledge translation focusses on the opportunity to share information in a way that can be easily understood and used for influencing practice by the parties involved. From researchers to public health practitioners, and from community members to government decision-makers, knowledge translation ensures that information flows in a meaningful way.

The role of public policy, legislation, regulation, and planning is a crucial part of public health. Policies that set standards for seat-belt or helmet use have obvious public health implications through reducing injury. Child-benefit clawbacks and poorly planned public transportation routes may also have real and direct implications for community health. A municipal commitment to green spaces may mean more accessible recreation activities for families, while regulations related to pollution emissions protect the air we breathe.

The health human resource planning, development, and training enabling function recognizes the need to have a well-trained, supported, and resourced body of individuals with diverse training and cross-training to work in all aspects of public health. This may include service delivery by public health nurses, dental hygienists, and nutritionists; research capacity in all areas of public health; diagnostic capacity; and knowledge of how to work effectively with diverse communities.

Community capacity building for public health refers to the opportunity to build upon the inherent knowledge and questions of a community with regard to the health of citizens and the population. Resources, information (including data and statistics, best practices, and research outcomes), and funding at the community level can support the work of community-based organizations and informal groups in making positive, effective, culturally sensitive, and context-specific changes to enhance their own health.

National Collaborating Centres for Public Health

Announced at the same time as the creation of the PHAC, National Collaborating Centres for Public Health are also being developed.

“As a primary goal, the centres will build on existing strengths and create and foster linkages among researchers, the public health community, and other stakeholders to ensure the efficiency and effectiveness of Canada’s public health system. The National

Collaborating Centres will facilitate the sharing of knowledge and help put it into practice at all levels of the public health system across Canada.”³

British Columbia will host the National Collaborating Centres for Environmental Health and Aboriginal Health. The National Collaborating Centre for Public Policy and Risk Assessment will be based in Quebec, and Ontario will be home to the National Collaborating Centre for Infrastructure, Info-Structure and New Tools Development. The National Collaborating Centre for Infectious Diseases will be based in the Prairies, and the Atlantic region will be home to the National Collaborating Centre for Determinants of Health.

The PHAC Atlantic

While the roles of the regional offices as part of the new PHAC are not yet well-defined, it is clear that these will be built upon the strong foundations of the work done in the past by the Population and Public Health Branch, Health Canada. Throughout the transition, existing partnerships will continue to be strengthened, new partnerships and opportunities forged, and consultation with stakeholders expanded.

The PHAC Atlantic expects to continue to support collaboration and other initiatives that promote understanding, acceptance, and implementation of a population health approach, with a focus on vulnerable communities (including Francophone and Acadian communities), healthy public policy development, and promoting social and economic inclusion. The PHAC Atlantic identifies three key areas of work: community capacity building, knowledge development, and inter-sectoral collaboration.

The PHAC Atlantic strives to help volunteer, non-profit, and non-government organizations increase their capacity to act on the determinants of health through various funding programs. Funding programs include Aboriginal Head Start; the AIDS Community Action Program; the Canada Prenatal Nutrition Program; the Community Action Program for Children; the Diabetes Prevention and Promotion Contribution Program; the Hepatitis C Disease Prevention, Community-based Support and Research Program; and the Population Health Fund. Each of these programs, in turn, sponsors local or province-wide community projects.

Knowledge development is another broad area of activity for the PHAC Atlantic. The publication of research findings and discussion papers helps community partners and other stakeholders increase their understanding of key health issues and how best to address them.

The PHAC Atlantic is committed to promoting inter-sectoral collaboration to address the determinants of health. Such collaboration occurs on many levels and requires a commitment to creating and supporting ongoing inter-sectoral working groups. Key partners include various levels of government, universities, research centres, and community organizations as well as linguistic and cultural communities throughout the region.

PUBLIC HEALTH IN ATLANTIC CANADA

Public health in Atlantic Canada shares many of the same challenges as in other parts of the country. However, long-term economic problems in the region, high rates of poverty, a rapidly aging population, a smaller population base, and high rates of chronic-disease risk factors may add further challenges to public health practice.

There are several main public health stakeholder groups in Atlantic Canada, including the provincial governments, the federal government, non-profit organizations, and academic institutions and researchers. Of course, none of these groups work in isolation. Public health is a complex mix of the work of all of the above groups, and there is a lot of overlap in mandate and some duplication of services in a few areas.

It is difficult to summarize public health practice across 24 diverse regional health authorities in the four provinces. Dozens of universities and colleges and hundreds of non-profit organizations also contribute directly to public health practice in the region, while the work of many other groups, government departments, and national groups influences the health of populations throughout Atlantic Canada. Urban and rural areas of all four provinces experience different challenges and have very different resources available to meet their needs. The complexity of the picture of public health in the region should not be understated.

THE ROLE OF THE PROVINCIAL GOVERNMENTS

The provincial governments have the overall responsibility for the coordination and delivery of public health services, and there are differences in how public health is structured and funded from coast to coast and within Atlantic Canada. Some provincial public health programming is structured to support certain population groups (e.g., young children, schools, families, and communities), while other programming focusses on activities across populations (e.g., injury prevention, mental health, tobacco use, addictions, active living, chronic disease, and health promotion). Most regional health authorities support a matrix configuration with a focus on both population groups and topic-specific activities.

Some key provincial public health positions in the region are chief medical officers of health, regional or district medical officers of health, public-health-services district or regional managers, public-health-services staff (e.g., nutritionists, nurses, dental hygienists, and school health educators), epidemiologists, public health inspectors, provincial policy and planning staff, research staff, and provincial program staff.

All four Atlantic provinces have restructured* in the last five years (Nova Scotia in 2001, New Brunswick in 2002, Prince Edward Island in 2003, and Newfoundland and Labrador in 2004-2005).⁴

*Since this paper was prepared, New Brunswick and Nova Scotia have each experienced further structural change.

THE ROLE OF THE FEDERAL GOVERNMENT

In addition to the work of the PHAC, the federal government plays other public health roles in the region. While the provincial governments provide direct services to most of the population, the federal government provides health services delivery to First Nations, inmates of federal correctional institutions, and the Canadian Military Forces. The Canadian Food Inspection Agency and Health Canada through the First Nations and Inuit Health Branch, the Healthy Environments and Consumer Safety Branch and the Health Products and Food Branch also play additional unique and complementary roles in supporting public health in the region.

THE ROLE OF NON-PROFIT ORGANIZATIONS

Non-profit organizations and volunteer groups play many diverse roles in contributing to community health. Some groups engage in policy and advocacy work to impact the health of communities and raise issues for public awareness. Some groups work with stakeholders to do research with community members and share information at the community level. Other groups provide training and skills development to individuals and organizations. Still others offer direct public health services, such as needle-exchange programs. Some do all of the above.

Most non-profit organizations rely heavily on various funding programs and donations. These organizations also rely on volunteers to support their work. There are many challenges in volunteer recruitment, training, and support, and the volunteer base is changing as increased workplace demands and an aging population are altering the roles that volunteers can play in their communities and neighbourhoods.

THE ROLE OF ACADEMIC INSTITUTIONS AND RESEARCHERS

Academic institutions and researchers are also important public health stakeholders in the region. Atlantic Canada is home to a wide range of community colleges, universities, and other post-secondary institutions. Academic institutions of all levels train and prepare health practitioners for diverse careers within public health. Academic

institutions also offer research expertise and skills and experience in key public health function areas.

Researchers at all universities in Atlantic Canada are engaged in examining public health questions of relevance to Atlantic communities. Detailed information about individual research projects and areas of expertise are available from university departments.

Advanced training programs in public health fields are strongly supported at many institutions in the region.

The role of health research foundations in the four provinces is also important to note. While some have the financial capacity to directly fund public health research by students and researchers, all seek to build research capacity to leverage national funding and enhance opportunities for researchers in the Atlantic provinces. The National Alliance of Provincial Health Research Organizations, created in 2003, links many provincial health research groups across the country.

SOME DEFINITIONS

WHAT IS PUBLIC HEALTH?

The Merriam-Webster dictionary defines public health as “the art and science dealing with the protection and improvement of community health by organized community effort and including preventive medicine and sanitary and social science.”⁵ This definition from 1617 reflects the focus on community and prevention, promotion and protection, that is the widely held understanding of a great number of people working in this area in Atlantic Canada. The Naylor report, *Learning from SARS*, defines public health as “systems that are population-focused, and include functions such as population health assessment, health and disease surveillance, disease and injury prevention (including outbreak or epidemic containment), health protection, and health promotion.”⁶ This definition was reflected in the scope of activity that was discussed by stakeholders in Atlantic Canada. However, there is some degree of confusion about the activities that public health encompasses, as it is being redefined in light of emerging best practices, new research, and community learning from across the country and around the world.

For this paper, a broad definition of public health was used – one that encompasses a wide range of activities and acknowledges the interconnected work of a broad range of groups, organizations, government departments, and individuals across the region. This includes clinical work (such as vaccinations) and policy work (such as legislation for smoke-free workplaces and public areas). It also encompasses a broad range of activities – from work with school-aged children concerning healthy eating to anti-poverty and social-justice work.

WHAT IS A POPULATION HEALTH APPROACH?

The PHAC’s website defines a population health approach succinctly: “Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health... The population health approach recognizes that health is a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one’s goals, to acquire skills and education, and to grow. This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health.”⁷

DISCUSSION-PAPER FRAMEWORK

DESIRED OUTCOMES

The background information below sets the stage for the desired outcomes of this discussion paper. They include

- assisting the PHAC Atlantic and its partners in the Atlantic region to better understand the regional public health environment
- beginning to nourish effective public health partnerships that can enhance the capacity of all levels of government, academia, and community to work together

BACKGROUND ACTIVITIES

Several activities were undertaken in the course of preparing this discussion paper. First, a broad inventory of stakeholders in public health in the four Atlantic provinces was identified through a wide search of available materials and through discussions with individuals and groups across Atlantic Canada.

Second, a selective descriptive bibliography on topics relevant to public health in Atlantic Canada was compiled. This bibliography is intended to offer a short selection of free, easily accessible (published online) resources on public health issues, with a strong focus on regional topics and themes.

These two documents are not intended to be all-encompassing – given the wide range of organizations at work in Atlantic Canada – but rather to offer resources to help people begin to understand the complexities and issues of public health in Atlantic Canada. These documents could, in the future, form the basis of a regional organizational database or an online library for supporting public health in the Atlantic region.

Third, interviews were conducted by phone and in person with identified stakeholders across the Atlantic region. Given resource constraints and tight timelines, it was not possible to speak with all organizations and stakeholders working in public health, as would have been ideal. Rather, an efficient list, including a wide range of groups working at all levels of public health, was drawn from the initial inventory of stakeholders developed in the first part of this project.

METHODS

The inventory of stakeholders, prepared as the first part of this project, formed the sampling frame for this work. A function-based matrix was developed as a tool to identify organizations and stakeholders in public health. This matrix was a lens to ensure

a broad inclusion of groups working across the PHAC's focus areas (communicable disease, non-communicable disease and injury, and healthy human development) and in its enabling functions (public health surveillance; research, evaluation, and knowledge translation; policy, legislation, regulation, and planning; health human resource planning, development, and training; and community capacity building). It also served to broaden the spectrum of key informants, resulted in a wide array of interviews, and permitted the gathering of information across sectors, provinces, and public health functions.

In order to ensure the meaningful inclusion of Francophone and Acadian voices in the scan, groups working primarily in French with French-speaking populations were identified separately. Collaborative coalition groups that span provincial borders and are pan-Atlantic were also included as a separate category of recruitment in the matrix, as they often represent a large number of stakeholder groups and their inclusion is an efficient way of "taking the pulse."

Efforts were made to ensure the inclusion of rural voices, small organizations, and groups working with specific subpopulations with diverse health vulnerabilities. The knowledge and expertise within the steering and advisory committees and other community partners was drawn upon to identify several groups per province for each function/focus-area intersection and to target them for interviews. Wherever possible, multiple organizations from different sectors (government, non-government, and academic) were identified in each matrix area to ensure greater diversity.

Key informants in each organization were selected with the help of steering committee members or in consultation with the specified organization or umbrella group. Contact information and other publically available information was collected prior to the interview.

DATA COLLECTION

In order to address the two key desired outcomes of this discussion paper, two broad questions were posed:

- In what priority areas, key initiatives, partnerships, and collaborations are public health stakeholders in the Atlantic provinces currently engaged?
- What role can the PHAC Atlantic play in working in collaboration and partnership with local stakeholders on current opportunities, gaps, priorities, and directions for the sector?

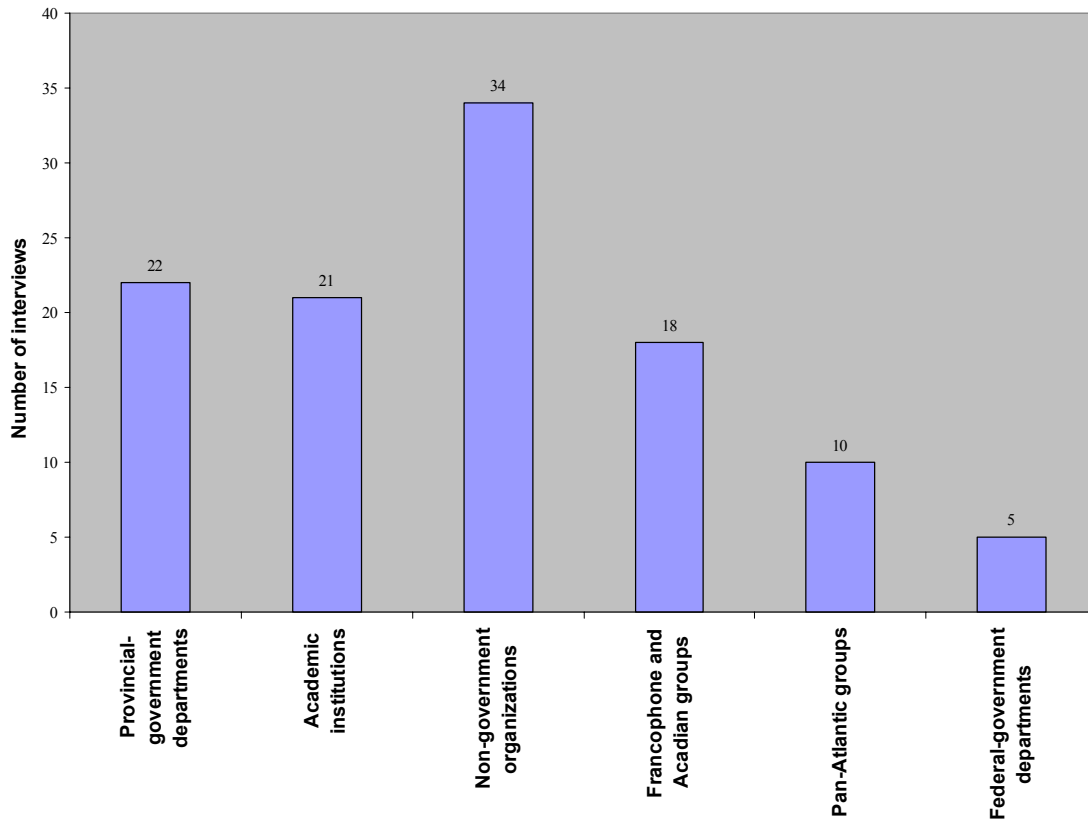
An interview guide consisting of a set of open-ended questions, based on the two primary questions above, was developed and piloted with the steering committee members on this project. Semi-structured interviews were conducted with individuals in each organization, either by phone or in person, by the project worker.

The project worker sent out an initial introductory e-mail to all identified key informants and followed up with a phone call to arrange for an interview time. Detailed notes were taken by the project worker during the interview, and key quotes were confirmed and recorded. Approximately 15 percent of the interviews were conducted with organizations or departments that work primarily in French, reflecting the linguistic makeup of the Atlantic provinces. Additional, previously unidentified groups or organizations and additional documents relevant to public health, discovered during the interview process, were added to the list of stakeholders and the descriptive bibliography as appropriate.

PARTICIPATION

Twenty-two individuals from government departments across the four provinces, working in areas related to public health (e.g., health, community and social services, finance, and transportation), participated in the interviews for the compilation of this discussion paper. Twenty-one individuals from departments from seven universities were also interviewed. Thirty-four non-government organizations spanning a spectrum of work from HIV/AIDS to early childhood development and education, from anti-poverty work to non-communicable-disease-specific groups, participated in the interviews. Eighteen groups that work primarily in French with Francophone and Acadian populations provided input. Individuals from 10 pan-Atlantic academic, non-profit, and government groups were also interviewed for this paper. Five individuals from federal-government departments also contributed. One hundred and twenty-five groups were contacted in total, with 10 individuals declining participation, and tight timelines and busy schedules not permitting the scheduling of interviews in 23 cases. In total, 92 interviews were conducted during a three-week period in March 2005.

ENVIRONMENTAL-SCAN INTERVIEWS



LIMITATIONS

It is worth reiterating that this paper was prepared within a short time period, which shaped the process of the interviews and data collection. Because of limitations on time and availability, it was not possible to include a representative from New Brunswick on the steering committee. This would have enhanced collaboration and information gathering in that province. Contact with committed and supportive individuals in New Brunswick helped greatly in completing the interviews and information gathering, but representation from all four provinces is recommended if a project of this nature is conducted again. Francophone or Acadian representation would have provided more information on work that is being conducted in both official languages in the Atlantic provinces. More interviews with government employees working in all areas related to public health, especially those working in the regional health authorities, would also have been preferable, although the short timelines did not allow for greater contact.

The initial proposal included travel to all four provinces to conduct interviews in person, but the subsequent time frame and weather made this difficult. (E.g., A planned trip to Newfoundland was cancelled due to poor weather in Nova Scotia.) Travel to all four provinces, to permit more interviews in person and the opportunity to interview a greater number of stakeholders from all areas and regions, would have optimized the information gathering in this scan. The majority of interviews in Halifax were face-to-face, and all other interviews were conducted by phone.

The information and recommendations in this discussion paper are based on the interviews with stakeholders. Statistical analysis of data relevant to assessing resources for public health was not part of the scope of this paper. A thorough analysis of public health activity and services in the Atlantic region was not possible within the limitations of the project activity. A more in-depth review, in partnership with a greater number of stakeholders (especially those in the regional health authorities), would provide a more complete picture.

The information contained in this paper is intended to provide a very broad context, to serve as a preliminary step for understanding public health activity in Atlantic Canada, and to support moving forward in rejuvenating public health practice in the region. Suggestions from stakeholders on how to move forward and build upon the public health assets contained in the Atlantic region, and on how to further support collaboration and coordination across sectors, form an important part of the analysis and discussion.

WHAT DID PEOPLE HAVE TO SAY?

A wealth of information came out of the interviews with stakeholders. The great majority of people contacted were keen to participate in the interviews – despite the short timelines and additional demands this made on their daily workload.

The analysis of the data has been divided into several sections. Challenges and barriers in public health practice form the first section. This is followed by a list of priority public health issues – both structural and topical – that were identified in the course of the project. General overarching themes from all of the interviews are summarized in the third part of the analysis. Recommendations from stakeholders as to how the PHAC Atlantic can facilitate and support public health in the Atlantic provinces make up the final section. Quotations recorded from the interviews are included throughout this paper.

Stakeholders were asked about success stories in their work in public health. These stories are inspirational and exciting and highlight the wealth of capacity, dedication, and innovation that are the great assets of Atlantic Canadian communities. Stakeholders spoke to the need for the re-energizing of public health in Canada – and in Atlantic Canada specifically – by building upon these successes through collaboration and partnerships. The highlighting of these success stories throughout this paper illustrates the many opportunities available for collaboration and an asset-based approach to public health rejuvenation. Only a few of the great many success stories that illustrate innovation at all levels of public health practice could be included here. Each success story highlighted in this paper represents hundreds more in communities all across Atlantic Canada.

CHALLENGES AND BARRIERS IN PUBLIC HEALTH PRACTICE

Stakeholders freely and frankly discussed the challenges and barriers in public health practice in Atlantic Canada. As with many aspects of public health, these challenges and barriers are all interrelated and are often connected to insufficient funding and resource limitations.

Lack of funding and resources

Identified first and foremost by almost everyone interviewed were the issues of funding and resources, itemized as follows:

Public health services

Chronic underfunding of public health services has stretched staff capacity to the limit in almost all areas. Improving public health services delivery and community health means providing new funding, resources, and positions at all levels to support the development

of infrastructure, sustainable programming, and outreach as well as effective and meaningful work in improving the health status of the population.

New funding, targeted specifically for public health function enhancement at provincial and regional levels, will help to develop regional capacity for public health practice.

“Support at the national and provincial levels is important, but all of this is meaningless unless investments are made in local public health infrastructure.”
– Stakeholder, NS

Non-profit organizations

How activities are currently funded in the non-profit sector is a barrier to public health practice. Competitive funding practices fuel turf wars and tension with other players in the sector and make collaboration and partnership difficult to achieve and maintain on anything other than a project-by-project basis. Pilot and project funding helps innovative and creative ideas get started, but finding the funds to continue the work – despite positive and measurable outcomes – is extremely difficult. The short funding cycles don’t reflect that building trust among diverse groups and individuals takes time and is essential to continued success.

Non-profits especially are forced to “chase” dollars, and this can result in “mission drift” away from their original purpose and target groups. Non-profit groups also mentioned the time and resource burdens that applying for funding places on their organizations. Each proposal requires a different and complex application and a different reporting structure. For small non-profits, the capacity to do all of this work is a huge resource challenge. While reiterating the importance of accountability, non-profit organizations find the burden of funding applications onerous.

“We’re not out to enrich ourselves; we’re just out to enrich the community.”
– Stakeholder, NB

Working across jurisdictions

Building understanding

Stakeholders repeatedly discussed the challenges of working across jurisdictions. Stakeholders expressed that different day-to-day “cultures” for those working in academia, government, and non-profit organizations is a challenge to overcome and often fuels further tensions. It is important to enhance the opportunities for meaningful interaction between jurisdictions to build greater understanding of the commonalities and

differences between academic researchers, government employees, and non-profit groups.

Success Story: Cross-Sectoral Community Partnerships

Vibrant Communities Initiative, Saint John, NB

In 2001, groups partnered in Saint John to become part of the Vibrant Communities movement and joined with 14 other communities across Canada. Initially convened by the Business Community Anti-Poverty Initiative, this movement is supported by a leadership committee composed of the Urban Core Support Network, Human Development Council, Enterprise Saint John, City of Saint John, Human Resources and Skills Development Canada, Family and Community Services NB, and Saint John Non-Profit Housing Inc. The group is taking an asset-based approach to developing a comprehensive community plan for poverty reduction.

See www.vibrantcommunities.ca for more information.

Negotiating different priorities

Stakeholders also commented on the challenges in negotiating the different values and priorities in place in federal and provincial funding. The multiple and overlapping agendas provide diverse opportunities but can serve also to turn the focus to proprietary interests rather than to what can be done in a strategic, well-planned, and integrated way for the health of communities. Conflicts between federal, provincial, and regional strategies and structures form a barrier to an integrated public health system, and support is needed to negotiate the different priorities at federal, regional, and local levels. Various examples were given by stakeholders. Healthy-living initiatives may or may not include mental-health issues, depending upon which groups are engaged in defining the strategies. A harm-reduction approach to drug use may be supported by federal funders, while abstinence or treatment may be the only options supported by the local community or province. School boards can decide on the resources that are used to support healthy sexuality for teens, leading to great discrepancies throughout the provinces.

Many funding applications call for partnership without expressly recognizing the huge amount of work, resources, time, and energy that must go into building sustainable and meaningful partnerships. Developing new partnerships across diverse sectors is seen as especially challenging. A small amount of funding to support staff in building cross-jurisdictional partnerships – especially at the practitioner and neighbourhood levels, where resources are especially limited – is seen as a means of facilitating this work.

Success Story: Finding Common Ground

Atlantic Summer Institute on Healthy and Safe Communities

Building on the success of the first Atlantic Summer Institute, in 2004, the theme for the 2005 institute will be “Finding Common Ground: Creating a Healthier and Safer Atlantic Canada.” This cross-sectoral conference will bring together participants from diverse sectors to build skills, share tools and models, network, and build a common understanding for healthier and safer communities.

The 2005 Atlantic Summer Institute on Healthy and Safe Communities is co-sponsored by the Atlantic Health Promotion Research Centre and the Atlantic Centre of Excellence for Women’s Health and is being supported under the Government of Canada’s National Crime Prevention Strategy and the PHAC Atlantic. Hosts for this year’s institute are the UPEI Centre for Life Long Learning and the PEI Health Research Institute.

See www.upei.ca/SI for more information.

Working within sectors

As complex as working between jurisdictions is, funding structures, geography, and historical precedence makes working within sectors equally challenging. The university system of funding and recognition of excellence often fuels competition between universities and individual researchers, although there are excellent models of recent interdisciplinary and multiple-university collaboration.

At the provincial-government level, good work is being done across Atlantic Canada in building capacity to work across ministries and departments. However, budget responsibilities, funding structures, and barriers to pooling funding for meaningful cross-sectoral work impede further progress within government work.

Non-profit organizations often collaborate on many levels, but competitive funding structures within this sector form a serious barrier to inter-sectoral work. The quick turnaround time required on many funding opportunities further limits opportunities to consult with partners and build innovative and collaborative work within the community. It is also challenging for stakeholders to know the scope of work being conducted within the region. The sharing of best practices, the evaluation of projects, and other opportunities for learning and refining practice is conducted on a mostly ad hoc basis with a few notable strong and effective umbrella groups in all of the provinces.

Success Story: Educational Innovation

Atlantic Regional Training Centre

This centre is a collaborative venture of Dalhousie University, Memorial University of Newfoundland, the University of New Brunswick, and the University of Prince Edward Island and is supported by the Canadian Institute for Health Research and the Canadian Health Service Research Foundation.

The Atlantic Regional Training Centre (ARTC) demonstrates an innovative model of partnership in delivering health education and training across four provinces. It builds on collaboration between the four above-mentioned universities and the expertise of individual professors to deliver courses to master's-level students studying in the area of applied health services research throughout the region. The ARTC also offers student residencies, linkages to health decision-makers, and other mentoring opportunities for students.

See www.artc-hsr.ca for more information.

Disconnect between practice, research, and policy

Respondents discussed the disconnect between practice, research, and policy. Bureaucracy, politics, and limited knowledge transfer impede evidence-based policy- and decision-making and the development of community-defined research questions. Stakeholders highlighted the challenges of finding practical and effective ways of implementing good evidence-based practices.

While there are great pockets of expertise in many diverse topic areas, there remain gaps in capacity for public health research. Building this capacity requires new resources and the restructuring of systems. As funding priorities often help to dictate research questions and topics, reallocating funding to support more public health research would increase opportunities for investigators in this field.

Stakeholders suggest that there is an overall lack of capacity in clearly articulating questions for public health research, building science-based approaches for public health practice, and communicating research to policy-makers and practitioners.

Success Story: Atlantic Network for Prevention Research

This network is a collaboration between the Atlantic Health Promotion Research Centre, Dalhousie University; SafetyNet, Memorial University of Newfoundland; the PEI Health Research Institute, University of Prince Edward Island; and the Canadian Research Institute for Social Policy, University of New Brunswick.

The Atlantic Network for Prevention Research is a six-year initiative that will focus on developing research infrastructure in Atlantic Canada to advance population health science and public health systems in the areas of illness and injury prevention and on developing a program of research, knowledge translation, and training in environmental diagnostics in three environments: workplaces, schools, and communities. A public health research unit forms one of the core areas of the network's Communities Research Unit.

See www.ahprc.dal.ca/CRD.pdf for more information.

Focus on health care services

The low profile of public health – both in the mainstream media and with citizens – makes it difficult for policy-makers to focus on the social determinants of health and advocate for public health issues. Hospitals, wait-lists, and the health care system dominate most news media about health.

Stakeholders noted that there needs to be a greater connection and more active partnership between public health and acute care services. Bridges need to be built within the health care system, and practitioners and citizens need to be encouraged to make the links between upstream prevention and downstream illness management. Competition for funding within restricted health care budgets means that public health must compete for funding priorities with hospitals and acute services. Effective professional associations within the acute care sector effectively lobby for funding with decision-makers and, perhaps more importantly, with the public to bring acute care issues to the top of the agenda, overshadowing public health.

“It gets increasingly more difficult to comprehend why people say, ‘Yes, we believe in prevention’ but all the dollars go into acute care.” – Stakeholder, NB

Fragmentation

While there are many effective partnerships in the region, public health work is being done by lots of different groups in a disconnected and unintegrated way. There are a multitude of jurisdictions across the region. What is being delivered by whom is difficult to determine for those working within the system and almost completely opaque to those trying to navigate the system from the outside.

“How can we get it right if we’re not working together?” – Stakeholder, NB

Stakeholders expressed concern that public health services delivery by the regional health authorities limits the overall accountability for public health practice at the provincial level. The reporting and accountability relationships are at times not clearly defined within the current structures, and public-health-defined tasks and roles are not understood as such by community members. Regionalization – while theoretically allowing for a more responsive, flexible, and context-specific system – has also resulted in multiple accountabilities for public health within all of the provinces. Stakeholders are concerned that the focus on well-being and public health practice is secondary to the health-care-management responsibilities of the district health authorities. The provincial governments maintain some public health functions, such as policy work, which are perceived by some as being disconnected from public health work in the regions. Other stakeholders raised the concern that regionalized public health services delivery may also limit the provincial capacity to deal with emergency public health situations, as mobilizing a large number of resources quickly and effectively across the region may be extremely challenging because it is impeded by numerous structural barriers.

Stakeholders also stressed the need for better connection between economic, community, and social and health development.

“There is not a true system but more a jumble of poorly connected components.”
– Stakeholder, NS

PRIORITY PUBLIC HEALTH ISSUES

Stakeholders were asked about what they see as key priority areas for public health in their own province and across the region. The priority areas that they identified have been organized according to the enabling functions and topic areas defined by the PHAC.

Enabling functions

Public health surveillance

A system: Public health surveillance was identified by many key stakeholders as a weakness in the current public health system. In some places, the breakdown of infrastructure to support public health surveillance has meant that work is being done on paper, which is slower, more prone to errors, and less efficient. A practical, viable, and integrated national system of surveillance was mentioned by many stakeholders as an important priority. There is also a matching need for specialists (e.g., epidemiologists and health planners) to interpret the data for use in planning and practice. Good examples of public-health-surveillance activity are found in the region, but they need to be further developed, enhanced, and linked in an appropriate and useful way.

Success Story: Building Canadian Capacity in Epidemiology

Canadian Field Epidemiology Program, PHAC

The Canadian Field Epidemiology Program places a number of field epidemiologists for practical-skills development at the PHAC and other federal-government-department divisions, provincial ministries of health, local health departments, or public health agencies across Canada for the duration of their two years of training. Placements contribute to the field epidemiologists' training and development in public health practice, and benefits are realized from the work of the field epidemiologists during their placement.

The Canadian Field Epidemiology Program is celebrating its 30th anniversary in 2005. The Atlantic provinces have hosted 18 field epidemiologists since the program began in 1975.

See www.cfep.ca for more information.

Diagnostic capacity: Stakeholders also identified the need to better link human and animal health surveillance. Enhanced linkages would build the capacity to track communicable diseases that have their origins in animals and would increase the understanding of the interconnectedness of human health and animal health. There is also just one biosafety Level 3 Laboratory* in the region, which structurally limits the overall capacity for diagnosis.

*This facility deals with agents that can cause serious disease. It is specially designed to minimize the release of hazardous materials into the environment and to provide enhanced worker protection.

Success Story: Linking Human and Animal Health: Communicable-Disease Surveillance

Atlantic Veterinary College, University of Prince Edward Island

The Atlantic Veterinary College (AVC) at the University of Prince Edward Island is a regional institution funded by the four Atlantic provinces. The AVC serves the training, research, educational, and professional services needs for veterinary medicine in Atlantic Canada and beyond and has a strong reputation in animal disease diagnostics. Examples include the AVC Diagnostic Services Unit, which provides the four Atlantic provinces with centralized animal pathology, microbiology, toxicology, and drug monitoring services as well as a comprehensive proficiency-testing quality-assurance program to over 200 veterinary laboratories worldwide; and the Atlantic Node for the Canadian Cooperative Wildlife Health Centre, which performs routine surveillance for diseases (many of which are human health concerns, such as the West Nile virus) in wildlife populations.

See www.upei.ca/~avc/ for more information.

Information technology: While many stakeholders noted the importance of information technology as a tool to support surveillance work specifically and public health work more generally, they also cautioned that it must be well thought out and supported carefully. In some areas of the region, broad Internet access is not available, thus limiting the usefulness of online resources and training. Information technology capacity and infrastructure, and the ability to maintain the two, were strongly identified needs – especially for more rural regions. These needs must also be met with an awareness of the costs of maintaining the information technology capacity within an organization.

Data: Easy access to a broad range of reliable and accurate health data was mentioned repeatedly as a necessity for good population health practice. Much innovative work has been done by groups across the Atlantic provinces, but there remain functions to be accomplished. There are many gaps in the data available, and the cost of getting data from Statistics Canada is prohibitive for many groups. Different organizations collect statistics that may be of interest and use to other stakeholders, but there is limited sharing of data. There is also great diversity in data collection between the provinces, thus building a regional picture is even more challenging.

“We need to develop our surveillance capacity to ensure that we are making informed and timely decisions.”
– Stakeholder, NS

Stakeholders stressed that surveillance must cut across the topic areas of public health and include communicable disease, non-communicable disease and injury, and healthy human development indicators (social, economic, and environmental) based on the broad determinants of health.

Success Story: Setting the Standard for Community Data Use

Community Accounts, Department of Finance, Government of Newfoundland and Labrador

The award-winning Community Accounts website puts accurate and essential data into the hands of community members in an engaging and user-friendly fashion. This free website provides citizens with a single comprehensive source of community, regional, and provincial data that would otherwise not be available.

Users can generate tables and graphics on key social and economic indicators organized by geography and data topic within 10 distinct accounts: Household Spending, Income, Social, Health, Labour Market, Production, Demographics, Education, Resource/Wealth, and Environment. An additional account, Well-Being, allows users to compile indicators from each of the above domains to develop a better understanding of the factors that determine the status and progress of their communities and regions. Community Accounts has also provided training in its use to over 4,000 individuals.

In 2005, Community Accounts will begin working in partnership with the Crime Prevention Initiative to develop indicators and accessible data related to community safety. (Community Counts in Nova Scotia, a similar initiative, has recently been launched.)

See www.communityaccounts.ca (Newfoundland and Labrador) and www.gov.ns.ca/finance/communitycounts (Nova Scotia) for more information.

Information: The need for an integrated information system in public health, which would provide health-related information to all stakeholders, was highlighted. Challenges in accessing journals or texts relevant to practice in rural areas was also emphasized. Stakeholders working at the community level spoke about the need for relevant baseline data and facts to mobilize the community for action.

Research, evaluation, and knowledge translation

Population-health-indicator development: Respondents expressed the need to develop and measure appropriate population health indicators. Indicators measuring rates of poverty, community participation, access to public health services, and literacy – to cite

a few examples – need to be combined into a useful and relevant tool for public health measurement and reporting. The limitations of clinical-health-care-services-indicator measurement, such as wait times, were acknowledged, and there was widespread agreement that more complex measures of population health indicators are needed and must be measured effectively.

Also emphasized was the need to be able to plan for the future. This requires integrated information that can be fed into research questions. The results of the research can further feed planning and action on the front lines.

Building research capacity for public health across disciplines and optimizing opportunities for knowledge and skills transfer were also identified as key areas of focus.

Policy, legislation, regulation, and planning

Continuing to develop the capacity to understand and negotiate policy development was deemed important by the stakeholders. They agreed that policy plays a major role in getting research into practice and that this link needs to be strengthened. Advocacy, behind-the-scenes work, and collaboration build strong links for changing policies and legislation. Building stakeholder capacity for policy development – as has been done under the Population and Public Health Branch of Health Canada, Atlantic Region – is seen as a successful and empowering strategy.

“The voice of many is stronger than the voice of one.”

– Stakeholder, NB

Health human resource planning, development, and training

Respondents support greater health human resource training across the spectrum of activity. There was a focus on exploring creative and innovative models of education, training, and development to address the diversity of work within the sector. They also mentioned that the education system needs to be well connected to practice within the community in order to be able to respond to changing public health needs. For example, the growing rate of diabetes and an aging population demographic needs to be addressed in public health infrastructure planning, including human resources, along the spectrum of diabetes prevention and care.

Success Story: Working Regionally for Health Human Resource Planning

Atlantic Health Human Resources Association, Atlantic Council of Premiers

The Atlantic Health Human Resources Association was set up to respond to a need for information related to health human resource planning identified by the four provinces. The project builds upon recent health human resource inventories in each of the provinces and maps the demographics of health professionals in 30 professions. It will also calculate population health needs by looking at demographics, disease incidence, and health services usage, among other factors. It is designed to increase the efficiency of health human resource planning by determining the right number and mix of health professionals when and where they are needed. It will also allow the provinces to rehearse the impacts of policy decisions, such as a greater focus on primary care, on the health of the population and on the health workforce's requirements. Deputy ministers of education and health in all four provinces form the steering committee for this project.

Respondents emphasized that setting a framework and standards for comprehensive public health education at a national level is critical to supporting ongoing public health education and development in the Atlantic region.

"A highly qualified workforce is the key ingredient of any public health program."

– Stakeholder, PEI

Attracting and retaining staff: Attracting and retaining well-trained public health staff in the region is a challenge, especially in rural areas. Practitioners of public health need to be able to see a career path and be part of ongoing learning and collaboration so they can stay current on best practices and evidence and maintain and develop their practice.

Specialization: Stakeholders noted that the relatively small populations within the Atlantic provinces mean there are a limited number of specialists working in public health. This can mean that building a professional group for research in very specific areas can be difficult on a provincial basis. They also noted that there are few cross-training opportunities in public health. Increasing secondment opportunities or funding cross-sectoral internships would provide for greater learning. Including public health more prominently within the medical schools, creating opportunities for residencies in public health, and offering joint degrees such as an MD and an M.Sc. in Community Health may encourage more physicians to work in public health. Specialized training in public health nursing, dental hygiene, and nutrition would encourage more practice in non-clinical areas.

“New public health education programs are required. Additional federal and provincial resources would help make this happen.” – Stakeholder, PEI

Professional development: Stakeholders agreed that value must be placed on supporting and enhancing ongoing professional development and specialized training for staff. This would allow for a more effective implementation of public health practices in the region. Online resources, such as the PHAC’s Skills Enhancement for Health Surveillance document, were recognized as useful tools for building capacity.

Training at all levels: Other respondents noted that it is important to train staff well at all levels of public health. Health administrators need support in how to deal with infrastructure changes and staffing issues in public health. Researchers need training in knowledge transfer in order to be able to communicate their findings in a useful way to decision-makers. There also needs to be a focus on practical public health vocational training in all areas. Staff working at the community level may need support in grant writing and proposal development in order to continue to run valuable community level programs.

Success Story: Facilitated Online Continuing Education

Skills Enhancement for Health Surveillance Program, Centre for Surveillance Coordination, PHAC

The Skills Enhancement for Health Surveillance Program supports continuing education for public health professionals. This pan-Canadian e-learning program is free, widely available, and self-pacing; has limited technology infrastructure requirements; and retains a distinguished list of facilitators to mentor online-learning students. Current course modules are Basic Epidemiological Concepts, Measurement of Health Status, and Descriptive Epidemiologic Methods. The structure of the course also facilitates networking and interaction across disciplines and regions.

The program will be expanded in 2005, with enhanced access for non-profit organizations and new modules on chronic-disease epidemiology and outbreak investigation and management. As of March 2005, 134 people from across Atlantic Canada have participated in the program, and five facilitators are located in the Atlantic provinces.

See www.phac-aspc.gc.ca/csc-ccs/sehs-acss/index_e.html for more information.

Health services training in French: Francophone and Acadian groups spoke about the need to train people in public health services in French in Atlantic Canada. People trained in the region are more likely to stay and work here. There is a great need for French-language public health services to support healthy Francophone and Acadian communities throughout the Atlantic provinces. Stakeholders in Newfoundland and Labrador, Prince Edward Island, and Nova Scotia also identified the need to maintain an inventory of French-speaking health professionals, including public health staff, in each province.

Diverse sources of training: Health human resource training and education is conducted by many groups other than universities. Governments, community colleges, other post-secondary institutions, and non-profit organizations are also instrumental in developing and delivering public health training. Respondents highlighted the need to engage in training partnerships across professions related to the field of public health.

Success Story: Community Expertise Shared

AIDS Committee of Newfoundland and Labrador

In addition to a wide range of community services in HIV prevention and providing support to people living with HIV/AIDS, the AIDS Committee of Newfoundland and Labrador offers expert training to public health staff, social workers, and other public health practitioners in HIV/AIDS prevention, health promotion and disease management. Staff do HIV prevention, education, and awareness work in the school system and with community groups across the province. The committee offers support to businesses to provide training and develop workplace policies. It also works closely with public health services to offer confidential HIV/AIDS testing at a community-based health clinic.

See www.acnl.net for more information.

Community capacity building

Stakeholders identified the need to articulate clearly which activities encompass community capacity building; it is much more than programs of services delivery in communities. Capacity building can be defined as “the mobilization of individual and organizational assets from the community and combining those assets with others to achieve community building goals.”⁸ Stakeholders identified the need to more clearly tie community capacity building activity to public health goals. University research grants support some community capacity building throughout the region. Funding directed to community groups and citizens also builds the capacity for research, training, policy development, data collection, and knowledge transfer at the community level. Also

important is working with and supporting community groups to help them to understand the health information available and to use it in their practice.

Building capacity building into public health practice: Cutbacks have meant that the mandate and scope of public health services have become more restricted. Community capacity building needs to be prioritized within the mandate of public health services and supported with staff, time, and resources.

“We need to do more than scratch the veneer of community capacity building. If we really want to make a difference and work differently, we must consider how to fund it properly.”
– Stakeholder, PEI

There is also a concern that community capacity building is sometimes used as a euphemism for downloading activity to communities in which volunteers and non-profit organizations will be forced to use their limited resources to support the health of citizens in the absence of other support structures.

“In our experience, it is necessary to have a staff person whose job it is to make linkages and actively nurture partnerships and collaboration between local residents, community groups, agencies, service providers, and different levels of government. This takes time and is far less likely to happen without appropriate and sufficient staff support.”
– Stakeholder, NS

Logistics: To really engage citizens, one needs to facilitate their participation by offering child care, food, and meeting times outside of the work day. Accessing free meeting space for groups can be an additional challenge.

Sustaining the work in communities: Keeping community stakeholders engaged is an ongoing and lengthy process. The commitment to community capacity building needs to be long-term and sustained, with opportunities for further engagement, participation, and learning. Efforts should be made to build and nurture leadership in communities.

Success Story: Building Neighbourhood-Level Public Health Capacity

Spryfield Multiservice Roundtable, Nova Scotia

Once a month, a group of more than 30 people from diverse organizations providing services in the Spryfield area come together at the Captain William Spry Community Centre to share news, build connections and partnerships, and identify community challenges and solutions. The district MLA; practitioners from the district health authority; and representatives from the Halifax Regional Municipality, schools, churches, and a wide range of large and small non-profit organizations focussing on issues as diverse as urban farming, employability skills, families, children, youths, mental health, and addictions regularly attend the Roundtable. Originally responding to a need to collectively address mental-health issues in the community, the Roundtable now functions as a cross-sectoral “neighbourhood connector” and knowledge centre that supports the health of the community.

Topic areas

More specific topic areas were also identified as priority public health issues by stakeholders in the Atlantic provinces. The topic areas are wide-ranging and diverse and encompass demographic groups, risk factors, and the determinants of health. The long list of topic areas identified illustrates the strengths and the challenges of work in public health. The need to focus on specific activity areas, or groups, within the broader context of public health work highlights the need for integration and an overarching framework.

The topic areas are grouped below as follows: priority population groups that stakeholders identified as most urgently requiring public health action, and other areas that fall within the scope of the PHAC’s focus areas (communicable disease, non-communicable disease and injury, and healthy human development).

Stakeholders noted that these topic areas are not discrete categories; many issues converge for subpopulations within our communities. The relationships between poverty and food insecurity, chronic disease and homelessness, addictions and mental health, and social support and child care are complex and intertwined. An effective response to these identified topic areas needs to take the complexities of the social context and community into account.

There were no great provincial or sectoral differences in topic areas identified through the interviews. A more detailed and in-depth priority-identification exercise with stakeholder groups may reveal more about the topic areas for specific subgroups or provinces.

Priority population groups

An aging population: An aging population means that public health resources in the community need to shift to address changing issues in the population. Forecasting health issues and resource needs associated with an aging population needs to be considered in all areas of the public health system. The changing demographics also have social support and community structure implications for many communities. In tight-knit and resource-poor areas, the reliance on neighbours for all kinds of assistance (e.g., transportation, respite, elder care, and emotional support) may no longer be possible because the neighbours are also aging.

The challenges of an aging population were noted especially during interviews with people from Newfoundland and Labrador, which has the most rapidly aging population in Canada and is dealing with the challenges of huge out-migration from rural areas. Other rural communities – especially those with large Francophone or Acadian populations – across the Atlantic provinces also identified the challenges of an aging population as a key public health issue that needs to be addressed in resource planning and priority setting.

First Nations and Inuit: The delivery of public health services by the federal government to First Nations groups needs to be clarified and better integrated with public health services under the provincial mandate. There is some overlap in practice, yet resources, best practices, and partnerships are not necessarily being shared across jurisdictions. The poor health status of First Nations peoples, compared to that of the general population of Canada, is of great concern.

Francophone and Acadian populations: Recognizing qualitative and cultural differences in receiving health services (including public health services) in one's first language is a key aspect of supporting Francophone and Acadian populations. History and culture must be taken into account in order to appropriately support Francophone and Acadian population health in the region. Many Francophone and Acadian communities are also located in rural areas, thus compounding the challenges of public health support. Educational materials, school and community presentations, and building staff capacity to work in French can support Francophone and Acadian communities in public health practice. Francophone and Acadian groups also noted the need for health data and health status information to help them plan strategically for their population. Francophone and Acadian groups in Nova Scotia, Newfoundland and Labrador, and Prince Edward Island identified challenges in accessing any public health services whatsoever in French. In New Brunswick, comments from French-speaking groups were related more to deepening the scope of French-language services available, building local health human resources and training in French, and ensuring better access to public health services for rural communities.

Success Story: Healthy Acadian Communities in New Brunswick

Le Mouvement acadien des Communautés en santé du Nouveau-Brunswick (MACS-NB)

MACS-NB supports the Healthy Communities movement in villages and towns in the Acadian areas of New Brunswick. It also offers support and coordination services that enable villages and towns in the area to adopt a holistic approach to the health of their community. A large, and growing, number of communities are participating in Healthy Communities activities, information sharing, and knowledge exchange and are building the capacity of citizens in the region to work collectively for enhanced community health.

See www.macsnb.ca for more information.

Newcomers to Canada/immigrants: Across Atlantic Canada there is a renewed focus on increasing immigration to the region, and this has several implications for public health. As the population diversifies, there is a more pressing need for cultural and linguistic interpretation in public health practice and services delivery. Newcomers to Canada who have specialization and expertise in public health fields should be integrated quickly and effectively into meaningful employment.

Rural areas: Rural areas are experiencing many of the same social problems as urban centres, but their needs are often harder to identify and resources are less easily accessible in these communities. Rural communities are further challenged by shrinking resource and economic bases and by a more rapidly aging population than in urban areas.

Youths: Some youths are disengaged and don't feel welcome in areas of their own community. A lack of affordable recreational and social activities, transportation issues, and limited part-time employment opportunities hinder youths' capacity to be active participants in society. There is great concern about youths who are already at risk, living in poverty and with ill health. Fostering resiliency in youths was identified as a key community activity. On the other hand, many youths are actively involved, interested, and participating in youth-run and youth-led activities, but youth inclusion, participation, mentoring, and cross-generational learning is important for all aspects of our society.

Communicable disease

Communicable-disease prevention: An expansion of the development of infectious-disease-management-and-prevention capacity is greatly needed in the Atlantic region. To effectively combat the spread of infectious diseases, better linkages are needed

between research on human and animal health. The development of mechanisms for enhanced communication between these two fields should be a priority in this region.

Emergency planning: A set of procedures and resources for region-wide public health emergency planning that integrates all parts of the system is desperately needed to ensure an appropriate and coherent response. Identifying the roles of individuals, groups, and governments is critical to ensure that the region can respond quickly in the face of a public health emergency. Having a strong, clear, and well-communicated emergency plan allows for a focus on long-term planning in other areas of public health.

“Don’t wait for the next plague.”

– Stakeholder, NFLD

Sexually transmitted diseases (STDs): Rates of STDs across the Atlantic region are climbing. The physical, economic, and social costs of STDs on the long-term health of the population are of concern to stakeholders. The increasing rates of STDs also signal a greater prevalence of unsafe sexual practices, which could lead to increased HIV infection in the population.

Non-communicable disease and injury (and related risk factors)

Chronic disease: Chronic disease was overwhelmingly the most common response when stakeholders were asked about topic areas in public health. Rates of chronic disease in the Atlantic provinces are, on average, higher than in other regions of Canada. Common lifestyle-related risk factors, such as tobacco use and overweight and obesity, are also high. Prevention issues and a focus on the upstream causes of chronic disease and its risk factors were mentioned frequently by respondents.

“The social and economic consequences of chronic disease are much more substantial than those of communicable disease.”

– Stakeholder, NB

Fetal alcohol spectrum disorder: Fetal alcohol spectrum disorder (FASD) is preventable and was identified as a growing problem in Atlantic Canada. Individuals are affected across their lifespan, and there are serious resulting impacts for entire communities across the region. There is limited community knowledge and understanding of FASD across the region, but groups are working effectively to increase public awareness and support.

Injury prevention: Injury-prevention work has made great strides in recent years in Atlantic Canada. There are active partnerships in all four provinces that work on a range of injury-prevention programs and initiatives. Some stakeholders feel that injury

prevention needs to be positioned more intentionally within the scope of public health activity.

Obesity and overweight: Alarming increases in the rates of obesity and overweight in Atlantic Canadians, and the role that this plays in chronic disease, are priority issues for many stakeholders. Concerns were raised about both the root causes of the epidemic and the impact that it will have on chronic-disease rates in the future. The high rates of obesity and overweight in children are a cause for special concern. Stakeholders feel that there is a strong need to deal with the resource implications of this epidemic immediately.

Physical inactivity: Rates of regular physical activity are low in Atlantic Canada. Access to a variety of affordable recreational activities is becoming more limited for many residents of the Atlantic provinces. A sedentary lifestyle is considered a risk factor for many chronic diseases.

Tobacco use: There are many successful umbrella groups working across the spectrum of anti-tobacco activity in Atlantic Canada. They have been instrumental in the passage of Smoke-free Public Places Acts in municipalities and provinces in the region. Provinces have seen the use of tobacco decline in some demographic groups, but tobacco use continues to be a public health priority for the region.

Healthy human development

Child care: Child-care availability and quality were identified as public health issues. A lack of affordable quality child care impacts early childhood development as well as development throughout the lifespan. It also negatively influences the ability of parents – especially women – to contribute to their community socially and economically.

Early childhood development: A focus on early childhood development was also mentioned by many stakeholders. The early years influence health throughout the lifespan. While there are many successful models of work being done in schools in the region, stakeholders feel that the entire span of childhood – from prenatal development to age 18 – needs to be a concentrated focus area for public health.

Environment: Respondents frequently mentioned the environment and environmental health as important areas of focus for public health. Energy use, air pollution, clean water, and garbage disposal all influence the health of communities. (E.g., Health Canada's contribution to the remediation of the Muggah Creek Watershed at the Sydney Tar Ponds supports the public health importance of a health-enhancing environment.) However, environmental-health-and-protection functions are not well integrated with public health in some provinces and regions.

Food insecurity: Food insecurity refers to hunger issues in developed countries. Food insecurity is defined as “the inability to acquire or consume an adequate diet quality or

sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.”⁹ Excellent participatory-action research has been conducted in Nova Scotia that provides a better picture of food insecurity in the region, but the issue continues to be a necessary focus area, and food bank use throughout the Atlantic provinces continues to rise.

Housing and homelessness: Issues of inadequate, unsafe, insecure, or inaccessible housing are enormous challenges for a great number of citizens in the Atlantic provinces. Rents and housing prices continue to rise, making safe and affordable housing out of the reach of many Atlantic Canadians.

Injection-drug use: The Atlantic region, as other parts of Canada, has seen an increase in injection-drug use. Methadone clinics, needle-exchange programs, and other harm-reduction programs are important in reducing the risk of infectious diseases transmitted through injection-drug use. Drug education and community-based programs with youths and children, to address the upstream causes of drug use, have an important place in lowering the incidence of drug use.

Literacy: Atlantic Canada has low rates of literacy compared to other regions in Canada. This can impact its health status in many complex ways. Most directly, it may impact the ability of citizens to participate actively in their own health through limiting their understanding of health related issues. More broadly, it limits participation in the daily activities of our society and may lead to social isolation, low self-esteem, poor school performance, and poor employment prospects.

Mental health: Stakeholders shared concerns about the growing prevalence of mental-health issues and the need to ensure a focus on mental health within public health activity. More information and resources are needed by those working in public health to deal with increasingly complex mental-health issues. The importance of mental-health promotion was also highlighted by respondents.

Poverty: Stakeholders referred to a wealth of research connecting socio-economic status and health outcomes. Anti-poverty initiatives recognize the multi-level relationship between living in poverty and health status. Access to health services, healthy food, educational and employment opportunities, and participation in society are all impaired by living in poverty. Generational cycles of poverty are a huge concern for communities in Atlantic Canada.

Social support networks: Stakeholders also noted the erosion of traditional social support networks in neighbourhoods across Atlantic Canada. Changing societal demands and structures increasingly limit the opportunities to build strong connections with neighbours and to build a local societal infrastructure that supports trust, respect, and interdependence – key elements of a healthy community.

Transportation: Transportation is a barrier to participation for many citizens in Atlantic Canada, especially in rural communities. Inadequate public transportation routes, limited transportation for differently abled citizens, and rising fees for services make physical distance from resources and support a challenge for many citizens in the region. Respondents in Newfoundland and Labrador noted that the large size of the province and the physical separation of Labrador from the administrative centres on the island make transportation costly and time-consuming.

GENERAL OVERARCHING THEMES

Respondents clearly articulated specific challenges, barriers, opportunities, and priorities for public health action in Atlantic Canada. They also spoke more generally about the public health practice overall. From 92 interviews and discussions – across four provinces and in two languages – five overarching themes were identified:

- A focus on both “traditional” and “new” public health
- Priorities within public health
- A profile of public health
- Building on strengths and assets
- Working across sectors

A focus on both “traditional” and “new” public health

Public health itself was clearly identified as a priority for action in the Atlantic region. The overwhelming focus on the clinical aspects of the health care system has kept public health low on the priority list.

“We hope that the [Public Health] Agency will put public health back into the health system.”
– Stakeholder, PEI

Two interrelated focus areas within public health were identified:

- “Traditional” public health work needs support, development, and renewed capacity building. Increased resources, core staff, and funding are needed to develop “on the ground” capacity and infrastructure for public health practice in areas such as outbreak control, surveillance, and health protection. Human and financial resources need to be invested at the front lines of public health services delivery to ensure sufficient capacity to deal with public health challenges. Infrastructure such as linked databases and integrated and user-friendly surveillance technology is essential to support this work.
- There was also consensus that a more collective emphasis is needed on “new” public health – more specifically, a focus on upstream causes framed by the social determinants of health. There was a general expression that public health needs to be

more actively integrated into the spectrum of activities related to health promotion, disease prevention, and health protection. A population health approach that focusses on the overall health of populations and supports work reducing health inequities is integral to this work. The necessity of infrastructure to support work related to the determinants of health was also highlighted. This infrastructure could include meaningful cross-sectoral partnerships with mandates and funding to support effective change, a comprehensive review of best practices, and the development of new tools to identify effective ways to work proactively on the root causes of population health. A focus on lowering the prevalence of risk factors (both determinants, such as poverty, and related risk behaviours, such as tobacco use) through healthy public policy, community support, and integrated and effective structures was identified as a key goal for “new” public health.

Priorities within public health

From the interviews, concerns also emerged about priorities within public health. Some stakeholders mentioned that while the SARS outbreak and the ensuing crisis management seems to have stimulated a review of public health more broadly, they are concerned that public health is only identified by the general public as infectious-disease control, thereby neglecting preventive measures and health promotion. These include healthy human development and non-communicable disease and injury prevention. The need for integration and strengthening of the entire public health system, rather than just a focus on crisis management (as is articulately argued in Naylor’s report), was reconfirmed through stakeholder interviews.

“Public health is the weakest part of our universal health care system.”
– Stakeholder, NFLD

A profile of public health

Many stakeholders mentioned the low profile of public health within the scope of health care and health services delivery. There is a feeling that public health is often “lost” within the scope of health services delivery. Public health represents a very small proportion of the budget and a relatively small number of personnel. With public health services delivery now generally falling under regional-health-authority responsibility, there is broad concern that acute care services delivery will further overshadow public health work.

Stakeholders said that the PHAC has the opportunity to be the champion of public health in Canada. Advocacy work with all Canadians for public health would go a long way in improving the allocation of resources to public health, through greater citizen

understanding of the role of public health in the spectrum of health care services and the creation of healthier communities.

Building on strengths and assets

Conversations with stakeholders also highlighted that there are enormous strengths in public health in the Atlantic region. There are award-winning innovations, creative and collaborative working groups, sustained and supportive partnerships, unique solutions to challenges, and nationally and internationally recognized specialization and expertise in a wide variety of areas. Stakeholders were clear that the best way to rejuvenate public health in Atlantic Canada is to recognize these strengths and to build upon the region's assets.

“We can't always be leaders, but we can be part of the solution.”

– Stakeholder, PEI

Many stakeholders noted that the PHAC Atlantic is uniquely positioned to support an overview of public health strengths and assets in the region. Through working with government, academic, and non-profit stakeholders in the four provinces, the PHAC Atlantic can identify opportunities for greater connection and linkages to enhance the work already being done.

Success Story: Linked Health Service Database

Population Health Research Unit, Department of Community Health & Epidemiology, Dalhousie University

Nova Scotia is fortunate to be the site of one of the few linkable health services databases in the world. It is held at Dalhousie University's Population Health Research Unit (PHRU) and covers health services use in the public and private sectors across the whole province, including in-patient, outpatient, and community contacts with both specialist services and primary care. The Province of Nova Scotia supplies the PHRU with complete Medicare, Pharmacare, and hospital files suitable for research purposes. The PHRU also has access to Workers' Compensation records, clinical databases, and large-scale population surveys. Anonymity is ensured through encryption of health-card numbers. The PHRU has particular expertise in chronic-disease surveillance through the creation of data repositories covering areas such as head injury, cardiovascular disease, and mental health.

See www.phru.dal.ca for more information.

Working across sectors

Common throughout all of the conversations with stakeholders was the recognition that working collaboratively and inter-sectorally across the Atlantic region is key to public health practice. Pan-Atlantic solutions require bringing together stakeholders around a variety of themes and functions. This gives groups a chance to share their strengths and challenges, learn about the strengths and challenges of others, and share practices and innovations. The opportunity to cross-pollinate with the ideas of others is invaluable. It is important to include relevant stakeholders, especially in areas where public health intersects with the work of others (e.g., transportation, health services, and the education system).

As well as needing good intentions, working across sectors requires resources. Cross-sectoral collaboration needs to be recognized as an important part of the public health mandate, and resource support is needed to ensure participation at cross-sectoral tables. Funding cutbacks and staffing cuts affecting public health practitioners mean that the remaining staff have limited opportunities to expand upon this kind of work. Cutbacks have meant that the mandate and scope of public health services have by necessity become more restricted, and often just those activities identified as essential core services are possible with the limited resources available.

“If you get enough people together, there is always a way.” – Stakeholder,
NB

RECOMMENDATIONS FROM STAKEHOLDERS TO THE PHAC ATLANTIC

Based on the interviews completed during the short time period of the project activity, the following recommendations were suggested as to the role that the PHAC can play in supporting public health in the Atlantic provinces. These recommendations are broad in scope and in some cases may not clearly match the federal government’s role in public health activity. As the scope of the PHAC’s work evolves over time, further discussions with stakeholders across Canada will help elucidate the role of the PHAC.

The key recommendations for action fall under nine major themes:

- Champion public health.
- Define and promote the role of the PHAC.
- Facilitate a strategic plan for pan-Atlantic public health.
- Build capacity for all areas of public health in the Atlantic region.
- Build on the assets, existing models, and areas of strength in Atlantic Canada.
- Support sustainable and targeted funding for public health.
- Create opportunities for networking and partnership.

- Maintain a structure of long-term relationships.
- Be a knowledge broker for public health in Atlantic Canada.

These recommendations are explored in more detail on the following pages.

Champion public health.

Stakeholders were almost unanimous in identifying a role for the PHAC as a champion of public health. The PHAC Atlantic has an opportunity to advocate for disease prevention and health promotion, with a focus on upstream causes and the social determinants of health. The PHAC Atlantic is encouraged to be a leader in the region and to be a strong, independent voice for public health. A key role identified for the PHAC Atlantic is to be inclusive and proactive and to engage the visionaries in diverse areas of the region in a from-the-ground-up process that builds a vision for the entire Atlantic region.

“We need to develop an integrated, independent, and effective public health voice, free from politics, in order to be true advocates for the population.”

– Stakeholder, NS

Define and promote the role of the PHAC.

A great many stakeholders said that the PHAC Atlantic needs to more aggressively define itself, promote its possible role in public health, and reach out to the community. There is a need to clearly articulate the scope and mandate of the PHAC in the Atlantic provinces and to communicate effectively and regularly with stakeholders.

There is confusion as to the difference between the mandates of the PHAC and Health Canada, both nationally and regionally. Respondents had questions about how public health work that crosses the boundaries of the two agencies would be managed effectively. The examples given were anti-tobacco and anti-alcohol work, which still lie within the scope of Health Canada. Stakeholders are worried that the division of public health activity will fuel greater disconnection.

Questions were raised: What is new and different about the PHAC? How is this change going to alter things? How can we fit into that? What will the relationship be between the national and regional offices of the PHAC? Without having answers to these questions, some respondents were unable to offer recommendations as to how the PHAC Atlantic can support their work in public health.

Respondents praised the excellent work of the Population and Public Health Branch of Health Canada in supporting population health work in Atlantic communities. They encourage the PHAC to continue this work.

Facilitate a strategic plan for pan-Atlantic public health.

Stakeholders suggested that an effective role for the PHAC Atlantic would be to facilitate the development of a strategic public health plan for the region. This long-term work would bring stakeholders from the four provinces together, build collective commitment and responsibility, and help shift resources to public health. Hosting regular regional planning forums on public health would enable the PHAC Atlantic to further identify priorities, possibilities, and gaps in the current public health systems.

A strategic plan would include working together for research and helping groups identify priority public health areas for research. The PHAC Atlantic can build capacity for joint research projects across Atlantic Canada and work with partners to identify and access sources of national funding. Building research capacity would also mean supporting mentorship and training opportunities to facilitate attracting and retaining new researchers.

Planning should also include a focus on dealing with public health emergencies and facilitate the development of an action plan that is feasible, widely communicated and understood, and resourced effectively.

Stakeholders also stressed the importance of a national framework and set of standards for comprehensive public health education. The work developed nationally must be brought in a meaningful way to the region by the PHAC Atlantic.

“The Public Health Agency has a role in ensuring equity and making sure the smaller provinces don’t fall behind in public health issues.” – Stakeholder, NS

Build capacity for all areas of public health in the Atlantic region.

There also exists a need for further capacity building in all areas of public health, above and beyond the current systems in place. New, innovative, and creative opportunities for public health training in both official languages are needed to support public health work at all levels. The PHAC Atlantic can support capacity building through connecting Atlantic Canadians to national opportunities and encouraging innovation to address the special needs of the region.

The PHAC Atlantic can also contribute to capacity building through supporting the development of tools for wide use. Practical and thought-provoking work, such as the Social Inclusion Lens, contributes greatly to community development in public health. Many stakeholders cited the *Tides of Change* report on social inequity and chronic disease – prepared by Karen Hayward and Ronald Colman for the Population and Public Health Branch, Atlantic Regional Office, of Health Canada in 2003 – as an excellent example of a relevant, user-friendly, and applicable document. Respondents also suggested that the PHAC Atlantic can help groups to develop strategies to use the tools and research in their own work.

Supporting community-university research programs, especially those that are based in participatory-action research, builds multiple levels of capacity. There is also a need for the PHAC Atlantic to work effectively with the district health authorities and public health services delivery throughout the region. Building public health infrastructure and capacity for services delivery throughout the region was a priority stressed by many stakeholders.

Many respondents thought the PHAC Atlantic should support citizens' capacity to better understand the role of public health within the entire health care system. Stakeholders suggested that the PHAC Atlantic should provide tools for groups to build that capacity in plain, easy-to-understand language.

Build on the assets, existing models, and areas of strength in Atlantic Canada.

Stakeholders stressed that great assets, models, and opportunities for growth and change in public health practice already exist in Atlantic Canada and that the PHAC Atlantic should seek to build on these relationships and infrastructures as it works to increase public health capacity in the region. Identifying areas of regional excellence, strength, and expertise in specific areas, and connecting them across the region in meaningful ways, would be a powerful step in enhancing public health.

Stakeholders also encouraged the PHAC Atlantic to take the time to understand the “lay of the land” and how things work in the region. This discussion paper was identified by stakeholders as a positive first step, but they encourage the PHAC Atlantic to deepen its understanding and knowledge of all areas of public health in the region. Stakeholders acknowledged that this takes time. Building lasting and meaningful relationships and engaging in long-term planning will build trust and communication throughout the region. Building a from-the-ground-up process and engaging stakeholders in a meaningful way is critical. This process will allow stakeholders to help the PHAC Atlantic to define its role in the Atlantic provinces.

The PHAC Atlantic is encouraged to take shared leadership of capacity building with other regional stakeholders. The federal government is not always considered well-connected at the community level, and it is important to engage regional stakeholders who are and who can then draw in others.

Government stakeholders highlighted the need for broad and in-depth consultation with all areas of the provincial governments and district and regional health authorities in order to more completely answer the primary questions raised in this discussion paper.

Stakeholders also encouraged the PHAC Atlantic to build upon its own successes and assets, as priorities for public health are being defined nationally and regionally. Working with and supporting community groups, evaluating outcomes, developing tools, and supporting health promotion and policy work in the region are areas of present strength within the PHAC Atlantic that were specifically recognized by stakeholders.

Support sustainable and targeted funding for public health.

Supporting public health includes providing funding, infrastructure, and resources in a strategic and targeted way. Systemic change is needed for public health to function effectively, and this requires investing in public health in all areas. New structures need to be developed and existing ones need maintenance and development in order to provide effective public health services to the region.

Sustainability was also an issue raised by many groups. Funding for specific projects that have excellent proven outcomes in the community is often a challenge to maintain, even in a limited form, after the funding term is over. The PHAC Atlantic is asked to consider core funding along with project-based funding. This would support population groups in maintaining sustainability and long-term continuity. Relationships with marginalized groups, such as injection-drug users in rural areas, can take a long time to build and nurture.

Supporting collaboration – not competition – in funding arrangements with universities, non-profit organizations, and governments will increase sustainability and build a stronger infrastructure for public health. The PHAC Atlantic is asked to recognize that partnership- and collaboration-building processes take time and resources and to build support for these processes into its funding packages.

Stakeholders widely applauded the Population Health Fund for its focus on policy development at the community level. This has had the effects of encouraging community groups to move beyond lifestyle and behavioural issues, broadening the discussion of public health issues, and encouraging groups to put energy into upstream causes and healthy public policy change. While some stakeholders expressed their appreciation for the role of the Population Health Fund in bringing money to the community level for public health, there were also suggestions on how to make it more effective for communities. The grant proposals are often seen as onerous and overly time-consuming. While agencies agree with the importance of being accountable, the process of applying for grants needs support and capacity development. Health Canada recently announced one-day training sessions to support groups interested in applying for anti-tobacco initiative funding at sites throughout Atlantic Canada. This was acknowledged as a good

step, but stakeholders reiterated that streamlining or simplifying the grant process is also important.

Stakeholders also called for effective mechanisms that ensure that new federal funding can be directed to the local level in order to support the resolution of public health challenges. There is certainly not an expectation that the PHAC Atlantic will fund everything, but it was suggested that the federal government can provide leadership for pooling funds and supporting public health practice at the regional level.

Create opportunities for networking and partnership.

Stakeholders stressed that the PHAC Atlantic should act as a catalyst to bring people together on a regular basis and help groups to build partnerships and collaborations and share knowledge in meaningful ways. Often, groups are very focussed on their own work and don't have the opportunity or time to reach out, network, and gather useful information or contacts. Small non-profits and rurally based staff are especially restricted by resources and funding in engaging with other stakeholders in areas of common interest.

Having the opportunity to build personal relationships with individuals within organizations, including the PHAC Atlantic, was also mentioned as a key step in trust building and further partnership development.

“Partnerships allow us to do public health.”

– Stakeholder, PEI

Respondents also encouraged the PHAC Atlantic to build cross-sectoral groups to work on strategic plans with shared outcomes and topics of common interest, such as risk-factor surveillance for chronic disease, and to create opportunities for networking within sectors, such as bringing together representatives from academic institutions that are active in public health education in the region.

The PHAC Atlantic is also encouraged to play a role in building bridges between Anglophone and Francophone groups working in public-health-related fields in the region. At the current time, there are limited connections between the two groups and information is not being shared effectively across linguistic barriers. There are great opportunities to build relationships and partnerships between Anglophone and Francophone researchers, policy- and decision-makers, and non-profit groups.

The PHAC Atlantic can serve the function of a connector and convenor and can offer support to pan-Atlantic umbrella groups that are already serving that function. Respondents recommended that the PHAC should offer grants to support the work of groups that already exist purely to network and link groups and help them achieve their mission. In recognizing that networking and information sharing is a first step in

building sustainable partnerships and collaboration, the PHAC Atlantic has the opportunity to build trust and long-lasting relationships.

The PHAC Atlantic should also be broad enough to support work that crosses municipal, provincial, and federal jurisdictions. Connecting across other federal departments that influence public health is also an important role for the PHAC Atlantic. It has a role in reaching out and integrating groups and professions that may be considered by some to be on the “margins” of public health activity, such as acute care and dentistry. The PHAC should look beyond traditional partners and build better linkages with related stakeholders. Municipalities, religious institutions, schools, police and fire services, libraries, and businesses were all mentioned during the interviews as important stakeholders to include in discussions. The PHAC Atlantic should also build better links with those working in transportation, education, agriculture, aquaculture, and the environment.

“Don’t just talk to the converted.”

– Stakeholder, NS

Stakeholder groups suggested that the PHAC Atlantic should consider holding regular think tanks with diverse groups of players in order to support the development of innovative, flexible, and appropriate solutions to regional public health challenges. Great opportunities exist in the possibilities that would come from pooling resources, but practical and logistical support is required in order for this to happen.

Respondents also mentioned that the PHAC Atlantic has a role in connecting Atlantic Canadian public health to the rest of the country and to international activity. For Atlantic Canada, specifically, connections to the entire Atlantic seaboard of the United States, especially in the areas of environmental and communicable disease, are important.

“Public health issues are borderless.”

– Stakeholder, NS

Maintain a structure of long-term relationships.

The PHAC Atlantic is encouraged to build and maintain a structure of long-term relationships. Suggestions included building a cross-sectoral advisory committee in each province and a regional umbrella group with membership from each province and sector. Providing funding to support these groups in holding regular discussions would ensure that the presence of the PHAC Atlantic is truly regional. Building up a more active PHAC presence in New Brunswick, Prince Edward Island, and Newfoundland and Labrador will facilitate regional knowledge sharing and learning. The PHAC Atlantic should build long-standing and structured relationships with relevant government

departments (federal, provincial, and regional) and include academic institutions and non-profit groups in long-term-planning activities.

Working together with regional stakeholders on a regular basis will help the PHAC Atlantic to define priorities and plan strategically for an integrated region. This relationship structure would also support emergency preparedness and maintain the region's ability to react and communicate positively in emergency situations. Collaborative work carried out regularly in a long-term, structured manner will also help connect Atlantic Canada to national work in public health.

“Partnerships don’t just come together. They take work!” – Stakeholder PEI

Be a knowledge broker for public health in Atlantic Canada.

Another effective and practical role suggested for the PHAC Atlantic is that of a knowledge broker for public health in the region. Suggestions from stakeholders included

- maintaining a website that serves as an online repository for reports, research, and other useful documents that relate to public health in the region
- playing a clearing-house function and disseminating information about local, national, and international workshops, conferences, events, research projects, best practices, etc., related to the three focus areas and five enabling functions of public health
- creating a regional listserv that serves a complementary function to the clearing-house one and more proactively provides an outreach of information

CONCLUSIONS

Stakeholders consulted during this scan indicated that public health capacity in Atlantic Canada has declined through many years of underfunding, resource cutbacks, a lack of strategic and intentional planning, and overshadowing by the health care system. Surveillance, health resource planning and training, public health research, and community capacity building all need strengthening and enhancement in order to better meet the public health challenges of the 21st century.

Common themes emerged around priority areas in public health in the Atlantic region, and barriers and challenges were identified. While the diverse structures, histories, and experiences of the provinces are recognized, there was province-wide consistency with regard to priority areas for building public health focus, capacity, and infrastructure. Respondents also highlighted the existing strengths and assets in the Atlantic region. Clearly articulated recommendations for the PHAC Atlantic have been made and can be built upon in further discussions with stakeholders.

There are more opportunities to build a strong, independent, apolitical, integrated, and coherent public health system in Atlantic Canada than there have been in many years. There is increased attention being placed on public health practice across Canada. Recent announcements of the creation of the PHAC, the appointment of Dr. David Butler-Jones as chief public health officer, and new federal resources targeted for public health enhancement in the provinces allow for this optimism.

A coherent system across the region – that has comparable structures and the ability to further build capacity through training, networking, and knowledge transfer – is possible. The PHAC Atlantic can be a key player, catalyst, and champion for public health in the region if it builds on existing strengths and assets, supports infrastructure and development, works across jurisdictions and sectors, and works in partnership with key stakeholders at all levels of public health practice.

This discussion paper is a small and preliminary step in moving public health rejuvenation in Atlantic Canada forward. The PHAC Atlantic should continue to connect with local stakeholders – ensuring their inclusion and that their voices are heard at a national level – and actively influence regional activity.

NEXT STEPS

While it is recognized that not all of the recommendations contained within this document can be implemented, the PHAC Atlantic is encouraged to build on the very preliminary findings and recommendations of this discussion paper through further activities. The following next steps are suggested:

- Build upon the recommendations in this document and use it as an opportunity to further build relationships and a common understanding about public health in Atlantic Canada.
- Hold more in-depth meetings and consultations with stakeholders in the Atlantic region in order to build relationships and facilitate greater knowledge exchange.
- Find methods to communicate regularly and efficiently with the regional public health community and engage key players actively in the transition process. E-newsletters are an easy and resource-efficient way to share information with a large number of stakeholders.
- Use this document as a tool to start other conversations and to include additional stakeholders.
- Disseminate this document widely, and encourage others to do the same.
- Take a primary role in working with agencies and communities in the region to help develop national public health goals. In this role, the PHAC Atlantic can help facilitate the building of relationships and partnerships in the region and can help ensure that the national goals also reflect regional priorities.
- Take this document and others like it to the national and regional PHAC offices to provide stakeholders across Canada with a greater understanding of public health in the Atlantic region.
- Set realistic timelines for future input and participation. Stakeholders stressed that they are very keen to participate and support the important work of the PHAC but that the quick turnaround time required often limits meaningful participation.
- Recognize the gaps and limitations of this document, and support creative opportunities to include new stakeholders in a meaningful way.
- Use a multiplicity of means to solicit information, support, and recommendations from the local public health community. Meetings, communiqués, and outreach by PHAC officials will build relationships and understanding. Methods that make use of information technology – such as websites, online surveys and listservs – are useful ways to share and gather information but should not replace personal contact.

ENDNOTES

1. Public Health Agency of Canada, Population Health website, www.phac-aspc.gc.ca/ph-sp/phdd/determinants/#determinants
2. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Reproductive Health, Glossary of Epidemiology Terms website, www.cdc.gov/reproductivehealth/epiglossary/glossary.htm
3. Public Health Agency of Canada, Population Health website, www.phac-aspc.gc.ca/ph-sp/phdd/approach/index.html
4. Canadian Centre for Analysis of Regionalization and Health website, www.regionalization.org
5. Merriam-Webster Online website, www.m-w.com/
6. Public Health Agency of Canada online document, www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf
7. Public Health Agency of Canada, Population Health website, www.phac-aspc.gc.ca/ph-sp/phdd/approach/index.html
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9. Lynn McIntyre, "Food Security: More Than a Determinant of Health," *Policy Options*, March 2003. www.irpp.org/po/archive/mar03/mcintyre.pdf