Health Promotion as Practiced by Public Health Inspectors: The BC Experience

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ABSTRACT

Objective: To explore the experiences of British Columbia’s (BC’s) Public Health Inspectors in practicing health promotion.

Methods: We administered a mixed qualitative-quantitative survey to 15 BC Public Health Inspectors (in BC, titled Environmental Health Officers – EHOs), selected to represent different levels of authority, areas of work and geographic regions. We queried whether and how they practice health promotion; strategies utilized, how health promotion relates to their enforcement mandates, perceived effectiveness of health promotion, and barriers and enabling factors affecting its adoption.

Results: Fourteen respondents (93%) practiced health promotion. Common practices included building healthy public policy, developing personal skills, and creating environments that support health. Health promotion was most often applied as “part of enforcement”; EHOs first advocated to educate and create environments that support regulatory standards and best practices, utilizing enforcement measures should the former prove ineffective. Enforcement was recognized as an important tool. Most respondents did not feel that their enforcement mandate limited their use of health promotion; however barriers exist where the EHO is perceived unfavourably as an “enforcer”. The majority felt that an increased use of health promotion would make their protection work more effective. Strategies to facilitate its application include practical training in implementation, clear expectations and accountability at all levels of planning, resources, and relationships with stakeholders.

Conclusion: EHOs engage in a broad and varied health promotion practice. Practical training with a focus on health promotion implementation in the BC context, and clear and consistent direction regarding expectations and accountability, would facilitate greater involvement.

Key words: Health promotion; environmental health; public health; allied health personnel; public health administration

La traduction du résumé se trouve à la fin de l’article.

Health promotion is the process of enabling people to increase control over and to improve their health. Health promotion involves actions directed at strengthening the skills and capabilities of individuals, as well as changing social, environmental and economic conditions to alleviate their negative impacts on public and individual health. There are a range of activities under the umbrella of health promotion, including policy initiatives, environmental strategies, community development, as well as the more traditional lifestyle and public education initiatives. The Ottawa Charter for Health Promotion (1986) identifies five key strategies for health promotion: building healthy public policy; creating supportive environments; strengthening community actions; developing personal skills; and reorienting health services.

Health protection describes the activities, many of them based on traditional mandates, of public health units/departments, especially in food hygiene, water purification, environmental sanitation, involvement with permits for facilities, and other activities in which the emphasis is on actions that can be taken to reduce or contain the risk of adverse consequences for health attributable to environmental hazards, unsafe or impure food, water, dangers in care facilities, etc. In the province of British Columbia (BC), Environmental Health Officers (EHOs), formerly called Public Health Inspectors, are mandated to protect health by enforcing provincial regulations. They surveil and monitor activities and premises that may affect the public’s health, administer provincial legislation, and intervene to minimize health and safety hazards.

It is recognized that health promotion and health protection have followed two paths, yet EHOs are often invested in promoting health. Further, the importance of health promotion in the work of health protection is reflected in the strategic plan for the Health Protection Branch of the BC Ministry of Healthy Living and Sport, in which health promotion is identified as an important strategy specifically in promoting resilient communities. Theoretically, the use of health promotion upstream might create conditions in which breaches of health protection are unlikely to occur, and therefore decrease the need for enforcement downstream. Further, a progressive approach to enforcement (e.g., a continuum, beginning with education and compliance promotion, progressing to warnings, and then to penalties) when lapses of hygienic practice do occur, limits the impacts, economic and social, on operators, and encourages them to consult prospectively rather than to effect corrections in response to penalties.

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Conflict of Interest: None to declare.
Developing personal skills

- Teaching FOODSAFE [a comprehensive BC food hygiene training program designed for the food service industry].
- Teaching MarketSafe [a food safety training program for farmers and producers who make, bake or grow products to sell at farmers’ or other temporary markets].
- Delivering presentations for water system operators.
- Establishing information booths at malls with the theme “holiday food safety” (offering information on how to cook turkey properly, providing thermometers).
- Providing handwashing education in schools re: H1N1 prevention.
- Providing handwashing education in restaurants.
- Delivering disease prevention messages through media interviews.
- Delivering education in diverse community settings (e.g., schools, seniors fairs).

Creating supportive environments

- Conducting routine inspections of restaurants.
- Working with farmers’ markets to ensure that food is safe.
- Showing interest in bringing healthy and safe local foods into restaurants, and encouraging healthier food choices on menus.

Strengthening community action

- Along with the Medical Health Officer (MHO), visiting local municipalities to liaise with communities and identifying a designate in the community to work with the health authority; holding sessions where issues were raised and questions were answered (re: the Public Health Act).
- Facilitating multidisciplinary stakeholder meetings to develop emergency response plans in preparation for mass gatherings.

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Reorienting health services

- Encouraging a focus on preventing West Nile virus, not just focusing on recognition and treatment (a ‘traveling road show’ about West Nile Virus).

There is literature that discusses the work of nurses in environmental health practice who have expertise in health promotion. However, no literature has been found that specifically explores the knowledge, attitudes and behaviours of EHOs with respect to health promotion. In BC, it is uncertain whether, or how, EHOs practice health promotion, how health promotion relates to their enforcement mandate, and what factors support or hinder their involvement with health promotion. In order to assist in documenting the work of EHOs in the area of health promotion, and to support the ongoing development of this field, the study team at the BC Centre for Disease Control (BCCDC) – Environmental Health Services Division (EHSD) sought to explore the experiences of EHOs in practicing health promotion and create a roadmap for the ongoing integration of health promotion into health protection mandates.

**METHODS**

**Sample and data collection**

A convenience sample of EHOs was selected to represent different geographic locations (i.e., the five BC Health Authorities), levels of experience and authority (e.g., senior and junior EHOs, managers and consultants), and areas of work (e.g., food protection, drinking water, air quality, land use, safety or other local health-related issues). The Regional Directors of Health Protection of each Health Authority identified three EHOs who agreed to be interviewed. A nine-item, mixed qualitative and quantitative survey was developed to explore EHOs’ perceived involvement in health promotion, strategies utilized, the relationship between health promotion and their enforcement mandates, effectiveness of health promotion, and barriers and enabling factors affecting implementation. The survey was first reviewed by EHOs outside of the sample and the Regional Directors of Health Protection. Participants received the survey in advance, then were contacted to discuss the purpose and methods, intended uses of the data, and provisions for confidentiality. All participants provided verbal consent, and one-to-one interviews were conducted by one interviewer in person or by telephone in August and September 2010. Data were transcribed by hand or notes were taken using a computer.

**Analysis**

Qualitative data contained in field notes were analyzed through the following process: familiarization with the raw data and identification of ideas and recurrent themes; selection of themes; review of the data and arrangement by theme; and data interpretation. Identifying information (e.g., names, geographic area of practice) was removed. Direct quotations are included throughout the text. Quantitative data were analyzed using Microsoft Excel (version 12.2.5, 2007) to produce proportions with percentages. The draft results document was circulated to participants and feedback was requested to ensure that the data were accurate and reflected important themes.

**RESULTS**

Three EHOs from each of BC’s five Health Authorities participated. The sample included one manager from each Health Authority, consultants, and EHOs with a range of years in practice from 2 to 20+. Respondents worked in various areas, including drinking water, food safety, land use, etc. Fourteen of the fifteen respondents (93%) indicated that they did practice health promotion. A few commented that “EHOs have been doing health promotion all along, in a subtle way” before it was called health promotion. One respondent explained that her work involved helping individuals/businesses “come up with solutions on their own.” The most commonly utilized strategies for health promotion were building healthy public policy (13/14, 93%) and developing personal skills (13/14, 93%). Twelve (86%) were involved with creating supportive environments for health, and a few respondents stated that this is what EHOs do during their routine inspections (e.g., food premises). Strengthening community action and reorienting health services were practiced by 9/14 (64%) and 6/14 (43%), respectively. A wide variety of examples were provided, illustrating the diverse health promotion activities of EHOs...
public speaking: "we know why you should do it, the health reasons behind it, but you have to be comfortable getting up in front of a group and saying it." A few respondents felt that the curriculum of current training programs addresses health promotion to a greater degree than occurred in the past.

Most respondents felt that their relationships with local governments, and individuals and firms over which they had regulatory authority, enabled them to use health promotion (14/15, 93% and 12/15, 80%, respectively). Examples were given of strong relationships with local governments, and involvement with community groups. However, for some EHOs, this varied. Some described difficulties in attempting to engage in community outreach due to some members of the community perceiving that EHOs would enforce policies that were unfavourable to them.

The majority of respondents (12/15, 80%) felt that the increased use of health promotion would increase the effectiveness of their work. Further, one respondent in a management position suggested that it was important to broadly increase the health promotion profile of health protection activities. Among those who did not feel that health promotion would increase the effectiveness of their work, one commented "as much as you try to use health promotion, you still always have this legislative expectation and legal obligation that you have to enforce, and I don’t necessarily think that health promotion in the line that we are working in would help. You do try, but in the end people always say that you enforce the law: it is there, enforce it."

Respondents suggested a variety of strategies to facilitate their involvement with health promotion. Many identified that more training was needed. It was suggested that training should be ongoing, and be available to all EHOs (managers, field staff, specialists, etc.). Comments were made that health promotion is very theoretical, and that guidance on practical implementation is lacking; as one EHO requested, “tell us what we can actually do.” Components of training should include: the theoretical basis for health promotion; examples of how health promotion has been implemented elsewhere (provincially, nationally and internationally) and impact; how health promotion can be operationalized in BC; and how health promotion strategies can complement enforcement activities. Suggested structures and venues for delivery included hands-on ‘implementation-focused’ workshops; annual education days in which speakers are brought in (“mini-conferences”); and the use of regular staff meetings to deliver information.

Another common suggestion is that health promotion needs to be included in the goals and plans of health protection policies and programs, at all levels. One respondent suggested “the Ministry needs to specify a mandate for [health promotion], an expectation that the Health Authorities will do it, and accountability...this will then be integrated into the Health Authority’s ‘strategic plans’ and then into ‘program plans’.” Another respondent proposed that “we need a system and acknowledgement for measuring health promotion activities...it would need to be built into our current workplans...there is no way to measure [health promotion] right now.” Further, that the “accountability frameworks and expectations need to be as uniform as possible across BC’s Health Authorities.”

A number of respondents commented that a lack of resources (e.g., time, personnel, money) is a barrier to engaging in health promotion. One respondent said “[we need] more time; we are stretched so thin, at times it becomes very trying to do your job the way it needs to be done, including education. When you have
limited time and are asked to do more with less, it becomes difficult, almost impossible.” Another respondent suggested that there needs to be a greater allocation of financial resources for health promotion, beyond what is necessary to meet the core health protection programs.

Other suggestions included ongoing relationship building with individuals, businesses and communities. One respondent commented that there is a long history of enforcement with individuals and firms, and there is a need to “build relationships to move towards health promotion.” It was also suggested that partnerships with communications staff within the Health Authorities should be developed further, in order to facilitate the production of health promotion information and tools. Finally, the importance of having EHO input into the type of health promotion they should be doing was highlighted. In other words, if EHO staff could do things that interest them, this would facilitate buy-in.

**DISCUSSION**

This study has provided initial insights into the perspectives and behaviours around health promotion for a convenience sample of Health Protection Officers in BC.

The majority of EHOs in our sample do practice health promotion, and utilize a wide variety of strategies to both effect change in the environment and provide individuals and communities with information and support skill development. Box 1 outlines tools that facilitate EHOs’ use of health promotion. It is interesting to note that building healthy public policy is widely practiced, illustrating involvement with policy and advocacy to promote healthy lifestyle conditions and remove impediments to individuals and communities making healthy choices.

Attempts are often made to use health promotion strategies first to support necessary behaviour change, with enforcement applied when these efforts are not successful. However, the relationship between health promotion and enforcement was often situation-specific. Ongoing relationships with government, individuals and firms enable health promotion, but given the wide range of situations that EHOs encounter, their ability to apply health promotion varies. Most EHOs felt that the increased use of health promotion would increase the effectiveness of their work, with calls for practical training, clear expectations and accountabilities, the inclusion of health promotion in program planning, greater resource allocation, and the further development of partnerships.

The importance of consistency of expectations across the provincial health authorities with respect to health promotion, and guidance on when and how to apply it is a concern worth noting. The development of an evaluation process is also an important challenge. Further, the question of how health promotion experts within the health authorities can support health protection staff is a key question for consideration.

Our study was limited by the fact that participants were selected by the Regional Directors of Health Protection, which may introduce bias (e.g., if those selected were more likely to be involved with, or have an interest in, health promotion). The study authors hold leadership and learner roles within the BC CDC-EHSD; as such, they are aware of the roles and areas of work of EHOs, but are not EHOs themselves. Although our study involved a small, convenience sample, this is appropriate for this novel exploratory study. The important issues raised should be examined with a larger sample.

**REFERENCES**


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**RÉSUMÉ**

**Objectif :** Étudier l’expérience des inspecteurs en santé publique de la Colombie-Britannique (C.-B.) qui pratiquent la promotion de la santé.

**Méthode :** Nous avons soumis un questionnaire qualitatif–quantitatif mixte à 15 inspecteurs de santé publique de la C.-B. (nommés agents de santé environnementale [ASE] en C.-B.) choisis de façon à représenter différents niveaux d’autorité, différents secteurs de travail et différentes régions géographiques. Nous leur avons demandé s’ils pratiquaient la promotion de la santé et comment, quelles étaient les stratégies employées, comment la promotion de la santé s’intégrait dans leur mandat d’exécution, quelle était l’efficacité perçue de la promotion de la...
santé, et quels étaient les barrières et les facteurs habilitants liés à son application.

**Résultats :** Quatorze répondants (93 %) pratiquaient la promotion de la santé. Les pratiques courantes comprenaient l’élaboration d’une politique publique saine, le développement des compétences personnelles et la création de milieux favorables à la santé. La promotion de la santé était le plus souvent exercée de façon coercitive. Les ASE tentaient tout d’abord de sensibiliser et de créer des milieux propices à l’application des normes réglementaires et des bonnes pratiques, puis utilisaient des mesures coercitives si cette approche s’avérait inefficace. L’autorité était considérée comme un outil clé. La plupart des répondants avaient l’impression que leur mandat d’exécution n’entravait pas leur utilisation de la promotion de la santé, mais qu’il existait des barrières dues au fait que l’agent de santé environnementale était perçu négativement comme un « exécuteur ». Une majorité de répondants pensaient qu’une utilisation plus fréquente de la promotion de la santé rendrait leur travail de protection plus efficace. Les stratégies pour en faciliter l’application comprennent une formation pratique sur la mise en œuvre, des attentes claires et une responsabilisation à tous les niveaux de la planification, des ressources, ainsi que des relations avec les parties intéressées.

**Conclusion :** Les activités de promotion de la santé des ASE sont vastes et variées. Une formation pratique ciblée sur l’adaptation de la promotion de la santé au contexte de la C.-B., ainsi que des directives claires et cohérentes relativement aux attentes et aux responsabilités, contribueraient à une meilleure implication.

**Mots clés :** promotion de la santé; santé environnementale; santé publique; personnel paramédical; gestion de la santé publique

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