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Celebrating 40 Years of the Ottawa Charter: Setting Community Priorities

Andrea Bodkin, Public Health Ontario

Dr. Alex Summers, Middlesex-London Health Unit

Joëlle Martel, Public Health Sudbury & Districts

Darcie Renaud, Windsor-Essex County Health Unit and Windsor-Essex Ontario Health Team

Marc Frey, Windsor-Essex County Health Unit

November 10, 2026

Land Acknowledgement



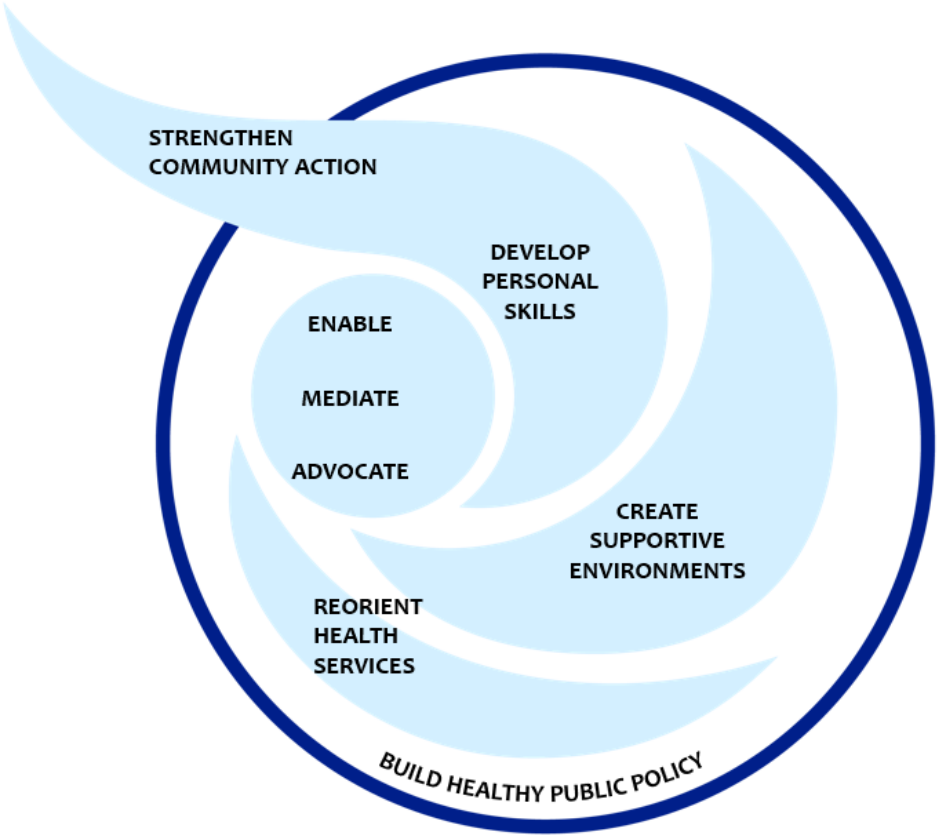
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Disclosure

The speakers have no disclosures to declare.

40th Anniversary of the Ottawa Charter for Health Promotion



1. Health Promotion in Practice
2. Moving Health Promotion Upstream
3. **Setting Community Priorities**
4. Reflecting on the Past, Shaping the Future

World Health Organization (WHO); Health and Welfare Canada; Canadian Public Health Association. Ottawa charter for health promotion: an international conference on health promotion. Geneva: WHO; 1986

Learning Objectives

By the end of this session, participants will be able to:

- Identify sources of data and information which can inform health promotion priority setting for public health professionals.
- Describe the importance of engaging with partners and priority populations when setting priorities
- Compare the priority setting approaches used by three health units

Today's Speakers



Dr. Alex Summers
Medical Officer of Health
Middlesex-London Health Unit



Joëlle Martel
Program Specialist
Public Health Sudbury & Districts



Darcie Renaud
Data and Performance Lead
Windsor-Essex County Health Unit and Windsor-Essex Ontario Health Team



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Setting Priorities for Comprehensive Health Promotion in Middlesex-London

PHO Rounds
November 10, 2026

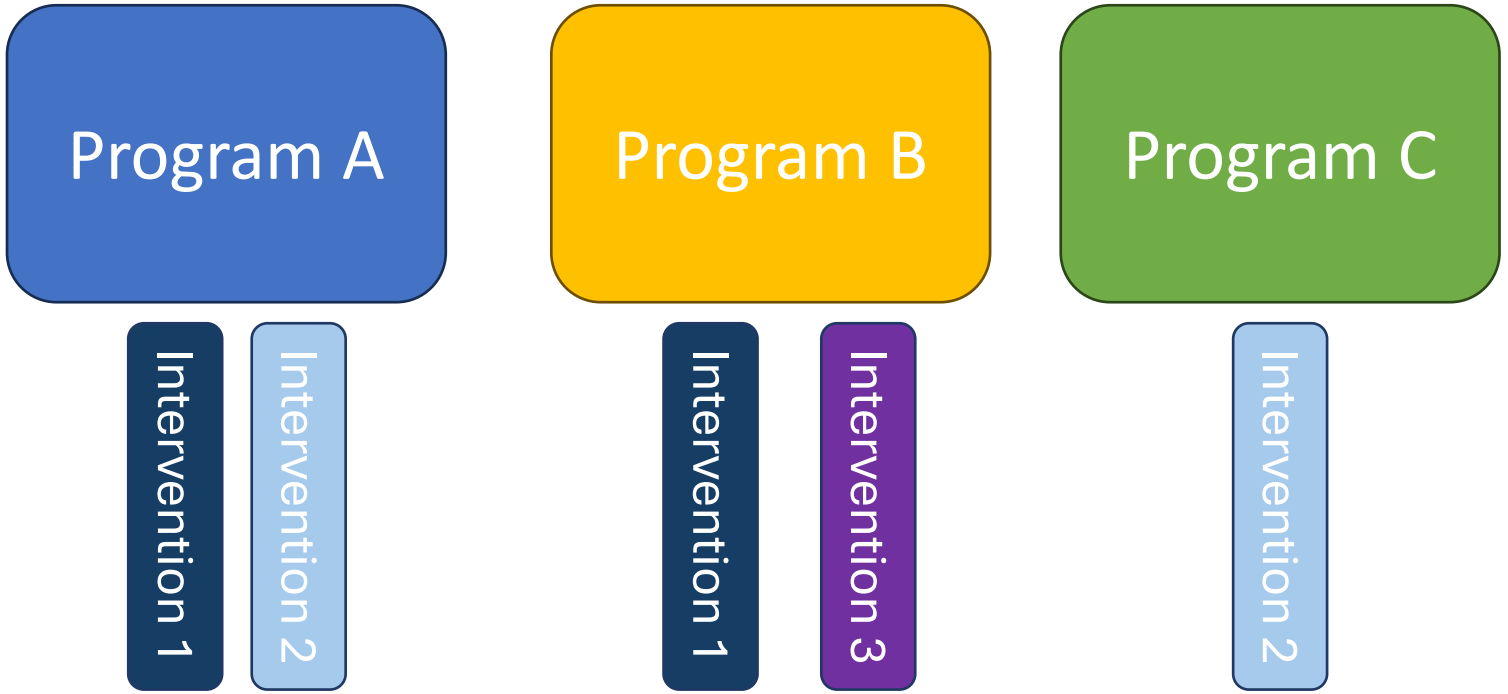
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Setting the stage for prioritization

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Programs and Interventions

- MLHU has a defined list of **public health programs**.
  - These are often focused on disease outcomes or determinants of health and are interrelated.
- MLHU has a discrete list of **public health interventions** that describe the work of a local public health agency.
- Work of the MLHU is driven by employing these various interventions within strategically targeted prioritized programs.


Program A
Program B
Program C
Intervention 1
Intervention 2
Intervention 1
Intervention 3
Intervention 2

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Health promotion-oriented interventions

- Health promotion-oriented interventions include:
  - Social Marketing,
  - Healthy Public Policy Development,
  - Community and Partner Mobilization, and
  - Education and Skill Building.

- These broadly align with the approaches identified in the Comprehensive Health Promotion Standard, including:
  - Informing Local Healthy Public Policy,
  - Creating Supportive Environments,
  - Strengthening Community Action, and
  - Supporting Individuals and Families.

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Use of Education and Skill Building is limited

- In alignment with the Health Impact Pyramid framework, MLHU generally prioritizes the **population-level health promotion-oriented interventions**
  - Social Marketing
  - Healthy Public Policy Development
  - Community and Partner Mobilization

- Education and Skill Building is only utilized if it is well-defined and focused.
  - Reflects the challenge of scaling this intervention within constrained resources to have a population-level impact.

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Annual Prioritization and Budgeting Process

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Annual Prioritization and Budgeting

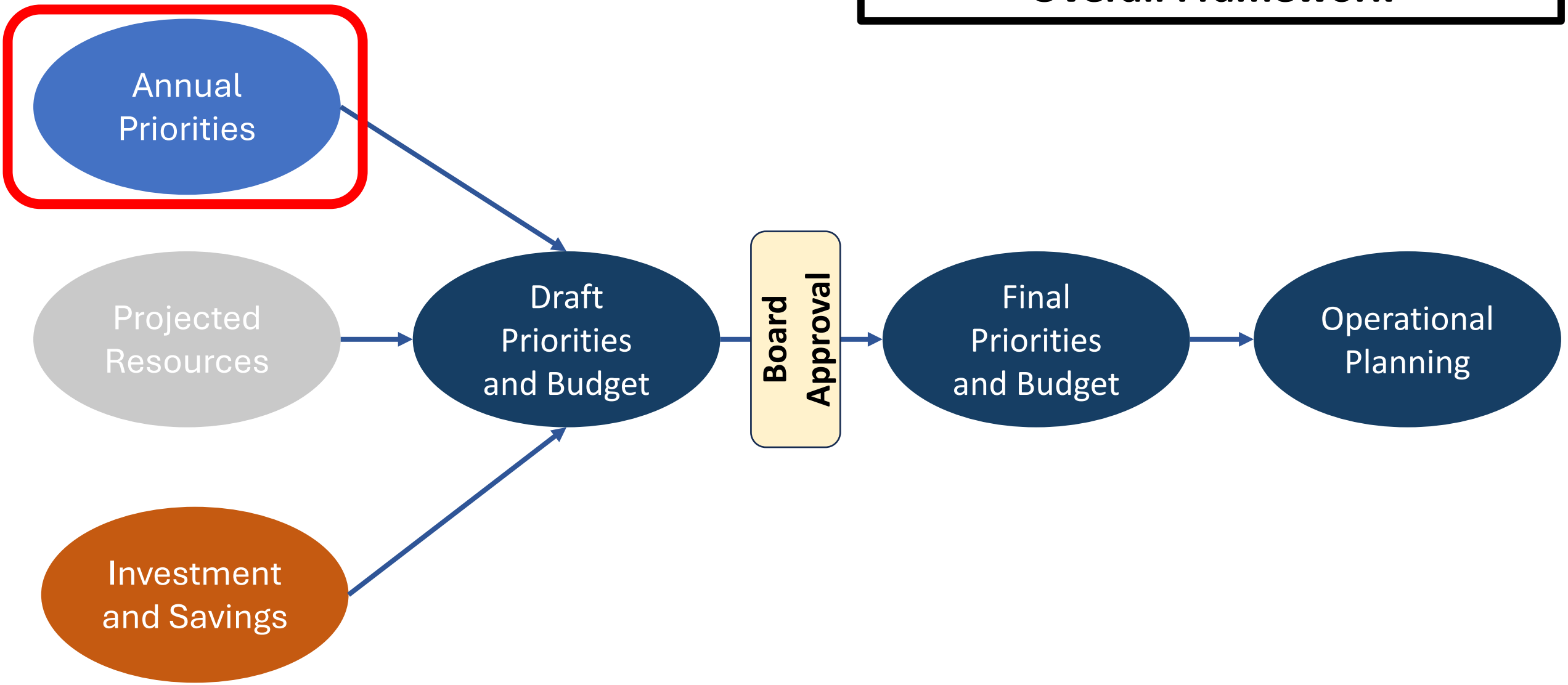
- Annually, MLHU reviews, scales, and focuses the work within different public health programs.
- Accomplished by expanding or contracting the number of public health interventions implemented.
- Based on the National Collaborating Centre for Methods and Tool's model for evidence-informed decision-making.

Focused on health-promotion oriented interventions

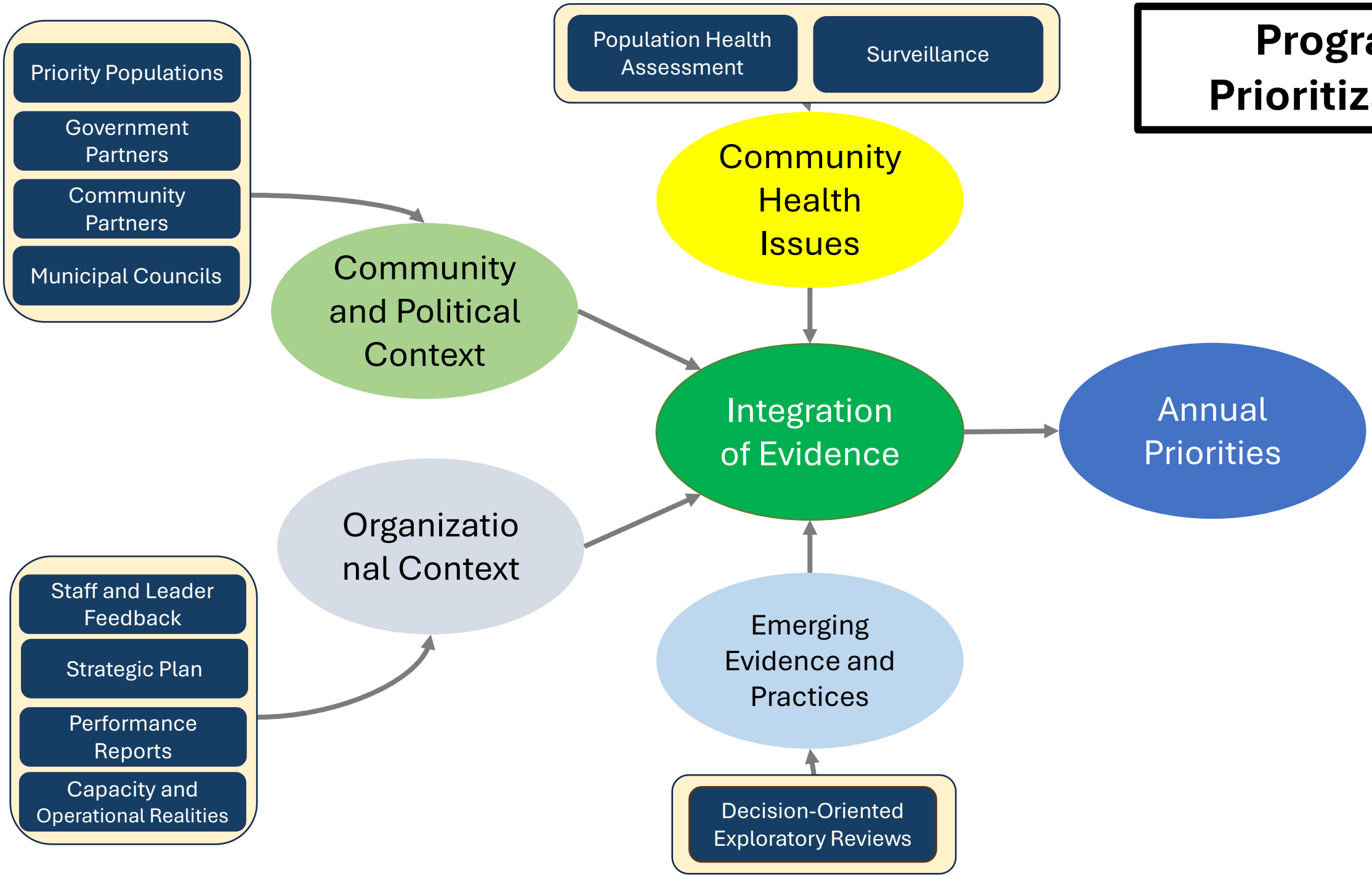
- All programs and interventions are considered, but generally it is the health promotion-oriented interventions that could be utilized for the widest number of programs and therefore, are the primary focus on any prioritization exercise.
  - For example, Inspections are generally utilized in the food safety and recreational water programs, and this doesn't change significantly year over year.
  - In contrast, Health Public Policy Development could be deployed within the oral health program in one year, and the immunization program the next.
- Although distinct, the population-level health-promotion oriented interventions are co-dependent and are generally prioritized and operationalized in concert.

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Prioritization and Budgeting - Overall Framework



Program Prioritization

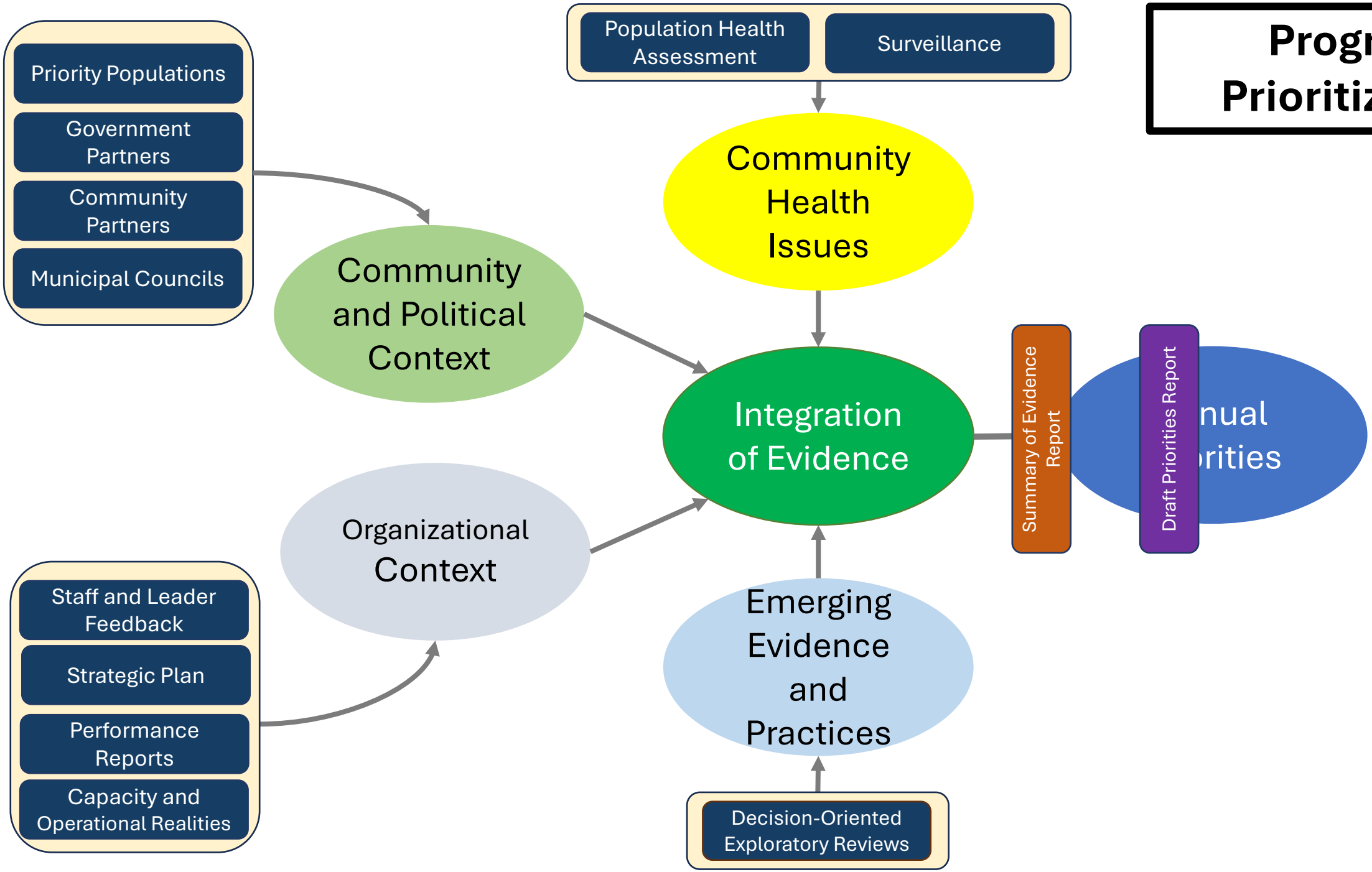


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Classifying prioritization status of programs

- Programs are classified as Active, Opportunistic, or Inactive.
- **Active programs**
  - Allocated one or more interventions that will be planned and prioritized.
- **Opportunistic programs**
  - Do not have assigned interventions, and work is not planned for these programs. However, depending on operational capacity throughout the year, there may be emerging or sporadic issues that lead us to do work in these programs.
- **Inactive programs**
  - Do not have assigned interventions, and work will not be completed in these programs in the next year.

Program Prioritization



Active Programs	Program Status	Case, Contact and Outbreak Management	Clinical Service Delivery	Health Resource Inventory Management	Inspections	Investigations	Surveillance	Vector Control	Education and Skill Building	Healthy Public Policy Development	Community and Partner Mobilization	Social Marketing
Active Transportation and Built Environment	Active											
Alcohol	Active										2	
Anti-Racism and Anti-Oppression	Active											
Cannabis	Active											
Child Visual Health and Vision Screening	Active											
Community Based Immunization Outreach	Active											
COVID-19 Vaccine	Active											
Digital Health	Active											
Drinking Water	Active						2					
Early Childhood Development	Active		2						2			
Food Safety	Active				2	2						
Food Systems and Nutrition	Active										2	
Health Hazards	Active				3	2						
Healthy Environments and Climate Change	Active											
Healthy Pregnancies	Active		2						2			
Healthy Sexuality	Active											
Healthy Smiles Ontario	Active											
Health System Reorientation	Active											
Housing and Homelessness	Active											
Immunization Monitoring and Surveillance	Active											
Immunizations for Children in Schools and Licensed Child Care Settings*	Active											
Infant Nutrition	Active		2						2			
Infectious Disease Control	Active				3	3						
Intimate Partner Violence Prevention	Active											
Needle Syringe	Active											
Non-Mandatory Oral Health	Active											
Ontario Seniors Dental Care	Active											
Opioids	Active										2	
Oral Health Assessment and Surveillance	Active											
Rabies and Zoonotic Disease	Active											
Recreational Water Program	Active											
Sexually Transmitted and Blood-Borne Disease	Active		3									
Tobacco and Vapour Products	Active										2	
Vaccine Administration	Active		2									
Vaccine Management	Active											

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Timelines

- Prioritization and Budgeting is initiated in Q1, with draft priorities determined by the end of Q2.
- Board approval of annual priorities and budget generally occurs in October.
- Operational planning is then initiated in Q4, and implementation starts in Q1.

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Prioritized Programs for CHP in 2027

Active Transportation and Built Environment	Alcohol
Anti-Racism and Anti-Oppression	Immunizations
Digital Health for Children and Youth	Opioids
Food Systems and Nutrition	STBBIs
Healthy Environments and Climate Change	Tobacco and Vapour Products
Gender-Based Violence	Child and Youth Health

During Operational Planning, further refinement occurs.

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Thank you!

Setting Community Priorities at Public Health Sudbury & Districts

Joelle Martel, Program Specialist

Comprehensive Health Promotion

November 10, 2026

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Health promotion at Public Health Sudbury & Districts

This presentation will review the process used to:

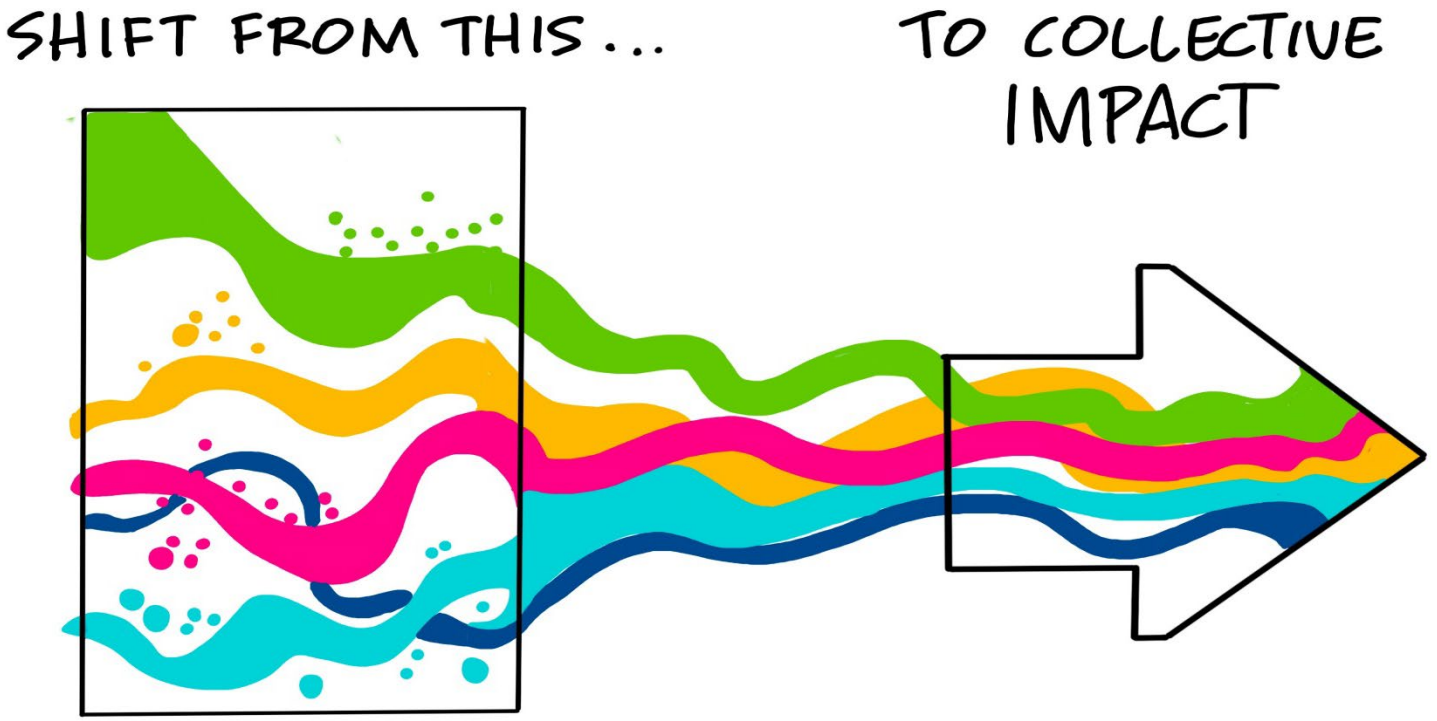
- Map out PHSD's new comprehensive health promotion model
- Identify health promotion priorities

Overall goal

Develop a comprehensive health promotion model that addresses **upstream** health promotion and other key priority areas, that fosters cross-collaboration, that enhances **impact and outcome** measurements, and that supports capacity building.

The intention is to concentrate efforts on defined priorities, **ensuring depth** and impact, rather than continuing a broad, diffuse approach of previous years. We will achieve this by **being innovative, flexible and integrating our learnings** using a CQI approach.

Collective Impact



Frameworks Collection by finegood@sfu.ca | Illustrated by sam@drawingchange.com | © CC BY-NC-ND

- COMMON AGENDA
- SHARED MEASUREMENTS
- MUTUALLY REINFORCING ACTIVITIES
- CONTINUOUS COMMUNICATION
- BACKBONE SUPPORT

A model for evidence-informed decision making



Source: NCCMT: A model for evidence-informed decision making in public health

Evidence to inform our priorities

Type of evidence	Local examples
Research	• Systematic reviews • Peer-reviewed research • Evidence briefs
Community health issues, local context	• Canadian Community Health Survey (CCHS) • Ontario Student Drug Use and Health Survey (OSDHS) • PHO snapshots
Community and political preferences and action	• Community consultations and engagement sessions • Feedback from community partners and coalitions • Anecdotal information
Public health resources	• Human resources • Budget considerations

Evidence to inform our priorities



Evidence repository



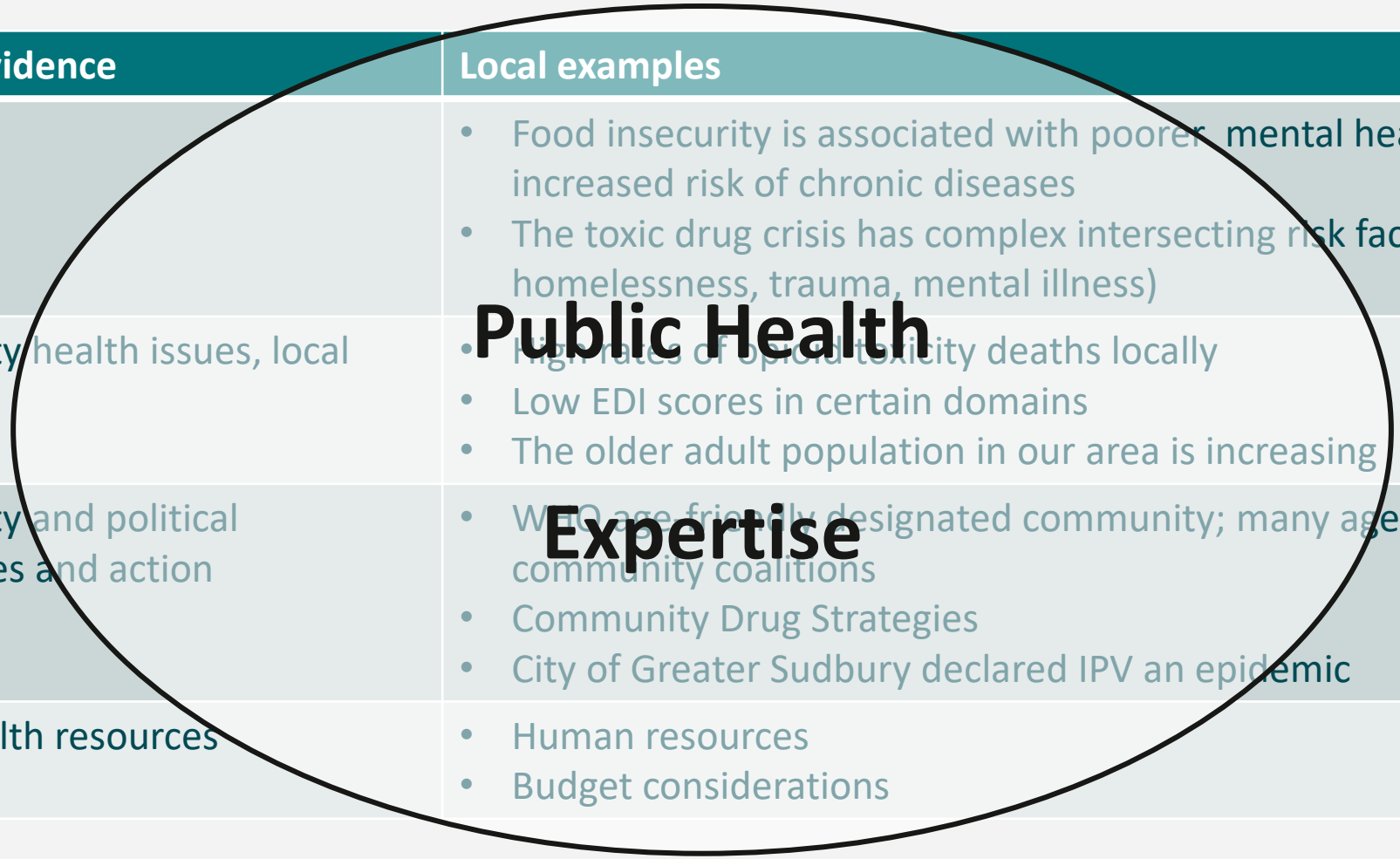
Evidence summary

Examples of prompts:

- Burden of illness (mortality, morbidity, impact of illness)
- Risk and protective factors
- Barriers to accessing services
- Needs and interests of community members
- Programs and services being delivered by others
- Support/opposition at local, provincial, federal levels
- Changes to public health mandates or legislation
- Gaps in evidence

Evidence to inform our priorities

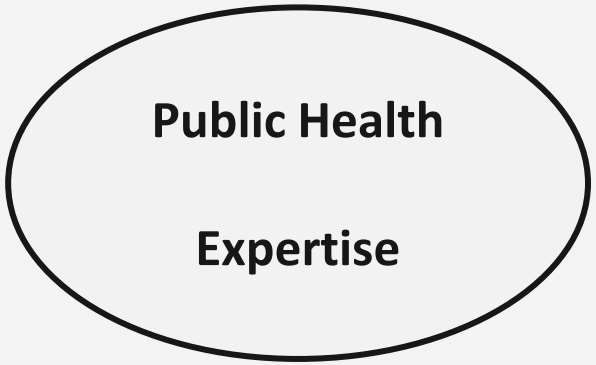
Type of evidence	Local examples
Research	• Food insecurity is associated with poorer mental health and increased risk of chronic diseases • The toxic drug crisis has complex intersecting risk factors (poverty, homelessness, trauma, mental illness)
Community health issues, local context	• High rates of opioid toxicity deaths locally • Low EDI scores in certain domains • The older adult population in our area is increasing
Community and political preferences and action	• WHO age-friendly designated community; many age-friendly community coalitions • Community Drug Strategies • City of Greater Sudbury declared IPV an epidemic
Public health resources	• Human resources • Budget considerations

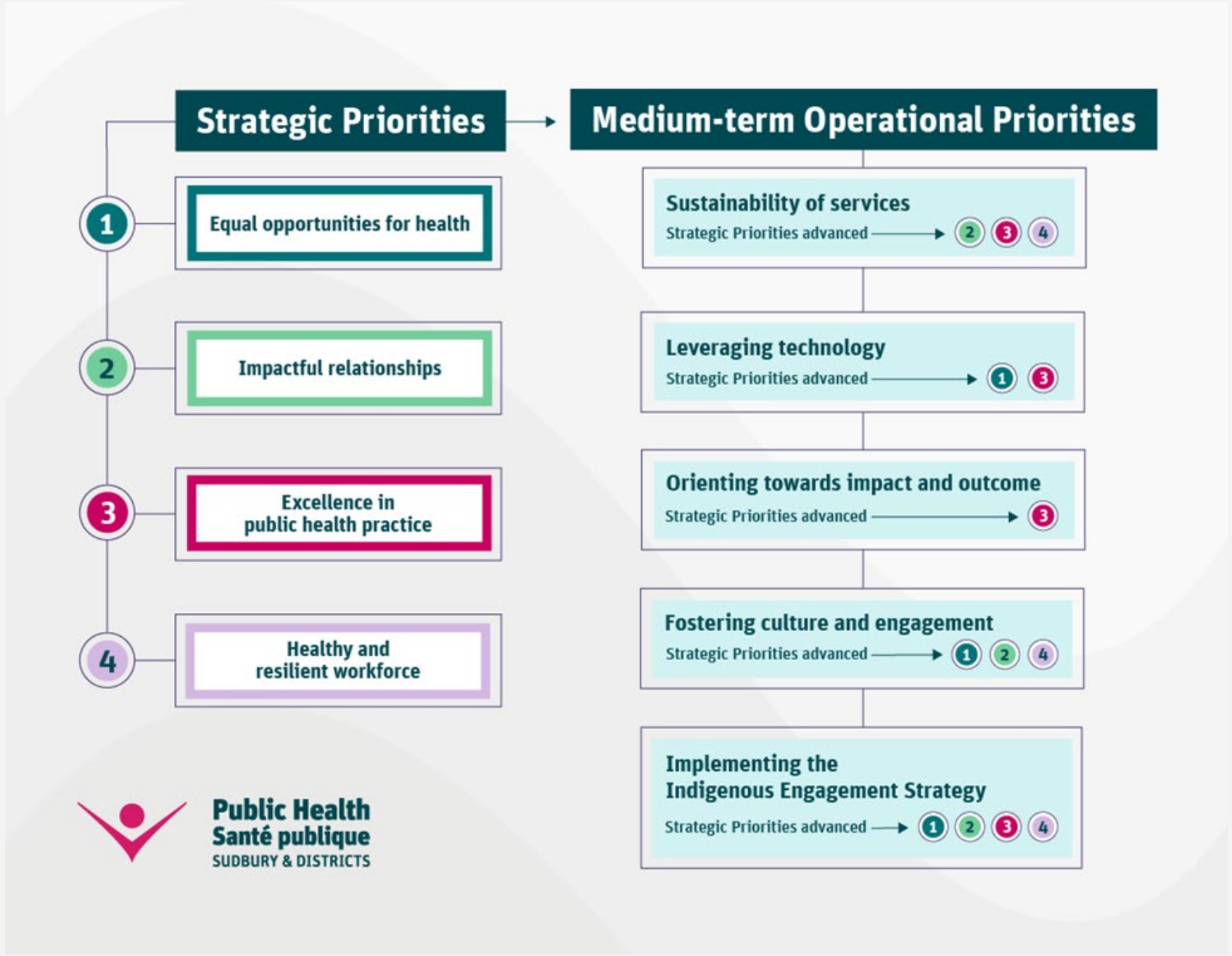


Evidence to inform our priorities

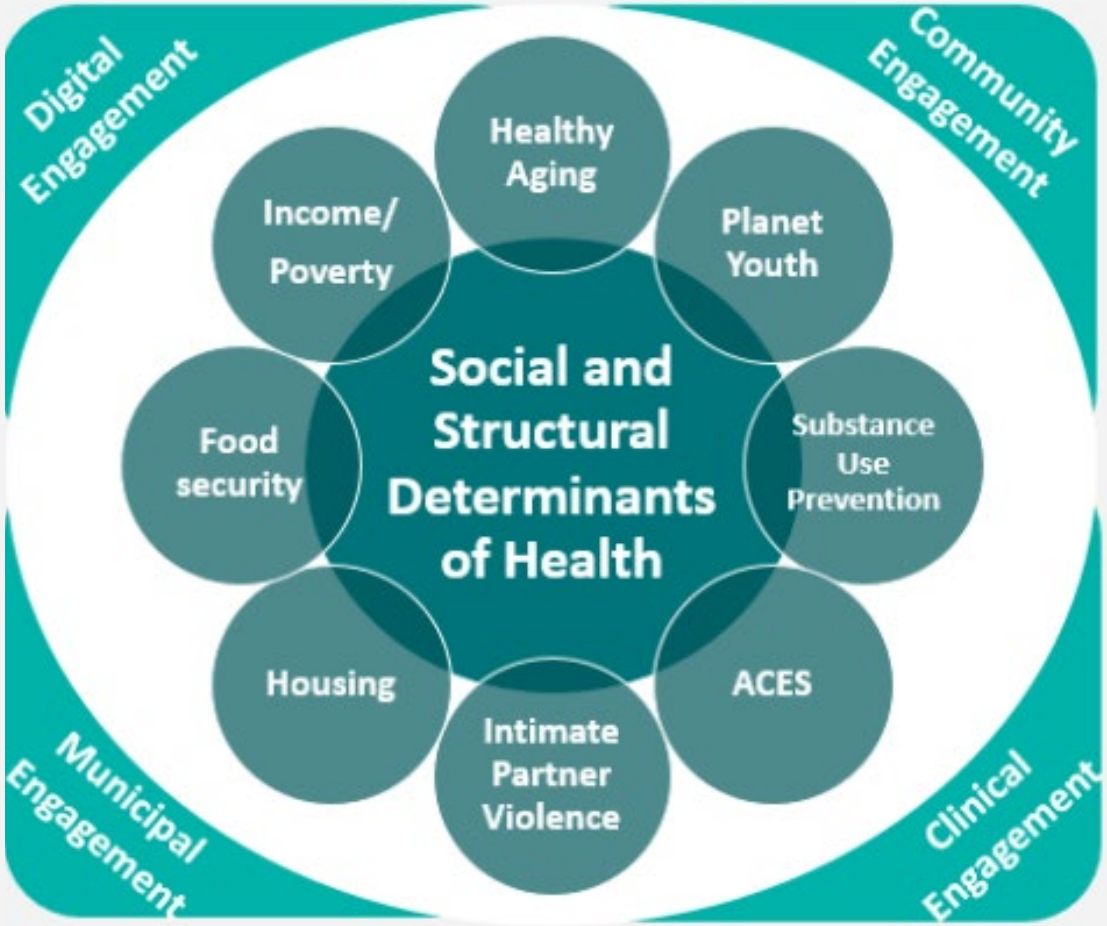
Public Health expertise:

- Balancing evidence and community wants and needs
- Upstream health promotion
- Population health approach




Strategic Priorities
Medium-term Operational Priorities
1
Equal opportunities for health
2
Impactful relationships
3
Excellence in public health practice
4
Healthy and resilient workforce
Sustainability of services
Strategic Priorities advanced 2 3 4
Leveraging technology
Strategic Priorities advanced 1 3
Orienting towards impact and outcome
Strategic Priorities advanced 3
Fostering culture and engagement
Strategic Priorities advanced 1 2 4
Implementing the Indigenous Engagement Strategy
Strategic Priorities advanced 1 2 3 4
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Comprehensive health promotion



In closing

PHSD's comprehensive health promotion model:

- Uses an evidence-informed decision making process to identify priorities
- Focuses on population health
- Works upstream to improve social and structural determinants of health
- Uses digital, community, and municipal engagement to enhance impact
- Emphasizes collaboration across priorities and with internal and external partners.

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SUPPORTING BETTER HEALTH FOR ALL

WECHU Program Prioritization & Planning Cycle

Program Review Overview

Formal process used to assess all active programs to inform priority setting and resource allocation.

What it involves:

- Development of structured program profiles
- Assessment across seven facets
- Multi-rater scoring and weighted analysis

How it is used:

- Identify relative program priority
- Support staffing and funding decisions
- Determines which programs remain active or require adjustment

Step 1: Program Profile Development

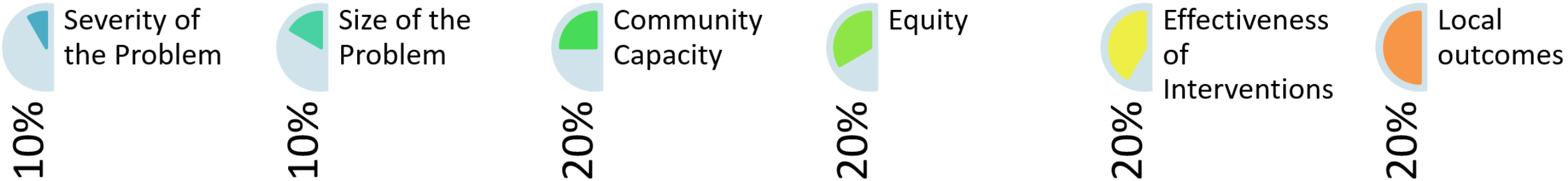
Managers and planning staff (Health Promotion Specialists are primary staff involved) complete structured Program Profiles which include information related to eight facets:

- Anticipated health outcomes
- Alignment with OPHS standards and protocols
- Severity of the health problem
- Community capacity
- Size of the health problem
- Evidence of effective interventions
- Health equity gaps
- Local outcomes and evaluation findings

Profiles synthesize:

- Population Health data
- Program and intervention evaluation data
- Situational assessments and environmental scans
- Relevant research and literature

Scoring/Weighting



Weighted index-based assessment:

- Each program is provided a score based on the weighted index
- Scores are aggregated and used to inform model generation and analysis

A model-informed analysis is applied:

- Predicted score (based on size/cost)
- Comparison of predicted vs actual score (Z-score)
- Comparison of predicted vs actual cost (Z-score)

Example

2026TotPerAv	TotalCost	ZPredCost2026	ZPredScore2026	PredCostDelta	ZPredCostDelta	PreScoreDelta	ZPreScoreDelta	ZScoreCostDiff	Z2026TotPerAv	ZTotalCost2026
71.11	3379573	3.64	0.22	-47221.64	-0.83	-5.74	-0.82	-3.05	0.80	3.85
57.78	1633552	1.15	-0.59	-18355.34	-0.32	2.88	0.41	-1.91	-0.61	1.30
48.89	740977	-0.17	-1.32	-38961.09	-0.69	7.51	1.07	-1.54	-1.55	-0.01
60	1255386	0.81	0.45	120839.74	2.13	6.73	0.96	-1.12	-0.38	0.74
51.11	537316.4	-0.39	-0.43	10640.23	0.19	10.49	1.50	-1.01	-1.32	-0.31
46.67	18300							-0.72	-1.79	-1.07
53.33	497034	-0.33	-1.33	93358.16	1.64	3.03	0.43	-0.72	-1.08	-0.37
58.89	878769	0.03	-0.55	-38501.71	-0.68	1.99	0.28	-0.69	-0.49	0.19
61.11	1008802	0.28	0.28	-1915.75	-0.03	4.66	0.67	-0.64	-0.26	0.38
57.78	638090	-0.26	0.21	-1669.65	-0.03	7.54	1.08	-0.45	-0.61	-0.16
57.78	509309	-0.49	-1.01	-33208.23	-0.58	0.40	0.06	-0.26	-0.61	-0.35
60	611508		-1.46			-4.43	-0.63	-0.18	-0.38	-0.20
56.67	337678	-0.75	-0.54	-38121.42	-0.67	4.30	0.61	-0.13	-0.73	-0.60
57.78	366902	-0.65	0.45	-1869.18	-0.03	8.97	1.28	-0.05	-0.61	-0.56
63.33	734159	-0.15	0.33	-21363.29	-0.38	2.68	0.38	0.00	-0.02	-0.02
73.33	1177192	0.55	1.57	16931.30	0.30	-0.07	-0.01	0.41	1.04	0.63
73.33	981689	0.30	2.53	39046.84	0.69	5.58	0.80	0.69	1.04	0.34
63.33	102486	-1.07	-0.48	-25247.16	-0.44	-2.01	-0.29	0.92	-0.02	-0.94
72.22	632809.36	-0.31	-0.56	-31842.27	-0.56	-11.39	-1.63	1.09	0.92	-0.17
74.44	749104	0.08	1.39	124636.51	2.19	-2.19	-0.31	1.15	1.15	0.00
77.78	873305	-0.09	0.43	-116706.73	-2.05	-11.17	-1.60	1.32	1.51	0.18
66.67	64395	-1.14	-0.83	-37095.79	-0.65	-7.40	-1.06	1.33	0.33	-1.00
67.78	102486							1.39	0.45	-0.94
80	832944.8	0.03	1.14	4965.99	0.09	-9.23	-1.32	1.62	1.74	0.12
77.78	26833	-1.08	0.09	41660.48	0.73	-13.12	-1.88	2.56	1.51	-1.06

Limitations

- Still lacking the new standards – straddling old OPHS and new OPHS in some cases.
- Iterative improvements in quality.
- New/modified programs.
- Difficulty assessing basic requirements for program operations.
  - Some require a certain allocation of resources to operate.

How Prioritization Results Were Used in FTE Planning - Example

Step 1: Program Prioritization

- Programs were assessed using a structured, evidence-informed prioritization process to identify relative program value, impact, need, and strategic importance.

Step 2: Resource Gap Analysis

- Prioritization results were compared against current program funding and staffing levels to identify areas that may be under- or over-resourced.

Step 3: Leadership Review

- The MOH and CEO reviewed requests through the lens of organizational priorities, operational pressures, public health risks, and strategic direction.

Step 4: FTE Decision-Making

- Prioritization results became one input into a broader FTE allocation process that also considered workforce capacity, service demands, available funding, legislative obligations, and operational realities.

Why?

To support transparent, evidence-informed staffing decisions rather than relying solely on individual opinion or historical allocations

Key Takeaway on Prioritization Process

Program prioritization is a decision-support tool, not a decision-making tool. Leadership oversight, professional judgment, and statutory accountability remain essential to ensuring resources are allocated appropriately across all public health programs.















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Fireside Chat



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Upcoming Webinars

Celebrating 40 Years of the Ottawa Charter Part Four: Reflecting on the Past, Shaping the Future

Thursday November 19, 2026
10:00 a.m. to 11:00 a.m.

Development of a Priority Populations Identification Framework

Tuesday November 24, 2026
12 p.m. to 1:00 p.m.

Andrea Bodkin

andrea.bodkin@oahpp.ca

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