Entry-to-Practice Public Health Nursing Competencies for Undergraduate Nursing Education

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1145 Hunt Club Road, Unit 450
Ottawa, ON
K1V 0Y3

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CASN Public Health Task Force

Ruth Schofield, RN, MSc(T) (Co-Chair)	Immediate Past President	Community Health Nurses of Canada
Donalda Wotton, RN, MN (Co-Chair)	College of Nursing, Faculty of Health Sciences	University of Manitoba
Andrea Chircop, RN, PhD	Assistant Professor, School of Nursing	Dalhousie University
Carol Rupcich, RN, MN	Clinical Consultant, Perinatal Mental Health Services, Child & Adolescent Addiction & Mental Health Program	Alberta Health Services
Denise Bowen, RN, MN	Director, Western Schools	CASN Board of Directors
Denise Donovan, MD	Chair, AFMC Public Health Educators' Network	Association of Faculties of Medicine
Gloria Merrithew, RN, MN	Senior Policy and Program Advisor, Public Health Practice and Population Health, Government of	Canadian Public Health Association (NB/PEI)
Jo Ann Tober, RN, PhD, CCHN(C)	Past President	ANDSOOHA Public Health Nursing Management
Lisa Ashley, RN, CCHN(C), M. Ed.	Senior Nurse Advisor	Canadian Nurses Association
Marie Dietrich Leurer, RN, PhD	Assistant Professor, College of Nursing	University of Saskatchewan
Morag Granger, RN, BSN, CCHN(C)	Manager, Public Health Nursing, Population and Public Health Services	Regina Qu'Appelle Health Region
Omaima Mansi, RN, PhD (cand)	Associate Professor, School of Nursing	McGill University
Robin Scobie, RN, MScN	Assistant Teaching Professor, School of Nursing	University of Victoria
Susan Duncan, RN, PhD	Associate Professor, Nursing	Thompson Rivers University

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Purpose

The Canadian Association of Schools of Nursing (CASN) *Entry-to-Practice Public Health Competencies for Undergraduate Education* are the core competencies in public health nursing that all nursing students should acquire over the course of their undergraduate education. Each competency is accompanied by a set of indicators that identify the specific knowledge, skills, and attitudes that nursing students must gain in order to develop the particular competency. The competencies and indicators provide direction for curriculum development and for educators teaching in the area of public health. They are intended to build on, but not replace, other curriculum elements.

Competency Framework

Competencies are **complex know-acts based on combining and mobilizing internal resources (knowledge, skills, attitudes) and external resources and applying them appropriately to specific types of situations** (Tardif, 2006). The *Entry-to-Practice Public Health Competencies for Undergraduate Education* are organized under five domains:

1. Public Health Sciences in Nursing Practice
2. Population and Community Health Assessment and Analysis
3. Population Health Planning, Implementation, and Evaluation
4. Partnerships, Collaboration and Advocacy
5. Communication in Public Health Nursing

The indicators under each competency statement are the **assessable and observable manifestations of the critical learnings needed to develop the competency** (Tardif, 2006).

The terms used in the competency and indicator statements are defined in the Glossary.

Background

In 2012, CASN began a project funded by the Public Health Agency of Canada (PHAC) titled, *Mobilising the Development and Implementation of Entry-to-Practice Discipline-Specific Public Health Nursing Competencies in Undergraduate Nursing Education*. One of the project goals was to support the integration of current and relevant public health content into baccalaureate nursing education by creating core competencies that would detail the knowledge, skills, and attitudes new nurses need to learn in this particular area of health care. A CASN Public Health Task Force of public health nursing experts from across Canada was struck in order to carry this out.

An environmental scan of resources regarding public health nursing in Canada was the first step in the process. A search of peer reviewed literature was conducted using various online databases: Cumulative Index to Nursing and Allied Health Literature, PubMed, and Science Direct. The search terms entered into the databases included "public health nursing competencies", "community health nursing competencies", "public health in nursing education", and "public health nursing". Publications were included in this literature review if: 1) they listed specific public health or community health nursing competencies and/or listed public health elements that the authors felt should be included in nursing curriculum, and 2) if they discussed public health education of registered nurses. A targeted grey literature search for public health competencies was also completed by visiting the websites of relevant institutions.

CASN reviewed the public and community health content in the *Competencies for entry-level registered nurse practice* (College of Nurses of Ontario, 2014) defined by the provincial regulators, and the competencies used to create the current entry-to-practice exam (Canadian Nurses Association, 2010). As the entry-to-practice exam for Canadian nurses is changing in 2015, CASN also reviewed the NCLEX-RN test plan (National Council of State Boards of Nursing, 2013). The Public Health Agency of Canada (PHAC) has outlined public health competencies that should be possessed by all individuals working in public health (2009). Additionally, public health nursing competencies have been identified by nursing organizations such as the Community Health Nurses of Canada (CHNC) and the Canadian Nurses Association (CNA) certification program (CHNC, 2009; CNA, 2011), but they are not levelled for new nurses entering practice. These competencies, along with others that are detailed in the environmental scan, were consulted in the development of entry-to-practice public health nursing competencies that would provide a guide for faculty in developing a reasonable level of student competence in this area of nursing.

The environmental scan also included literature on the health needs of Canadians, and how the healthcare system is transforming to meet changing needs. Recently, the rise in chronic illness and the high costs of acute care have resulted in calls for a greater focus on health promotion and disease prevention, and for an increase in the amount of community-based service-delivery in Canada (CNA, 2012). In addition, concerns about globalization increasing the threat of communicable diseases worldwide have prompted discussions about the state of public health services in Canada (National Advisory Committee on SARS and Public Health, 2003). Moreover, in response to the Commission on the Social Determinants of Health, and the resulting call by the World Health Organization (WHO) to close the gap of health inequities within a generation, graduating registered nurses are expected to have the preparation needed to contribute to this effort (Commission on the Social Determinants of Health, 2008). Given the changing health needs of the population and the evolving health challenges Canadians are facing, it is imperative that all new nurses enter the workforce with a sound preparation in public health.

A Working Group of Public Health Task Force members with experience in competency development was formed to review the environmental scan and create a first draft of competencies. The Working Group and a full Task Force engaged in an iterative process of creating, reviewing, and revising competencies until they produced a first consensus based draft for stakeholder review and revision.

CASN used a modified Delphi process with the goal of achieving a broader national consensus on the competencies. The first round occurred at a Stakeholder Forum in October 2013. More than 35 stakeholders from different areas of public health (nursing education, public health nursing practice, provincial and federal public health associations, national nursing associations, and representatives from other health professions) attended the Forum. Attendees participated in a knowledge café exercise: in small groups the participants were asked to indicate their level of agreement with the competency and indicator statements and to provide feedback. Following the knowledge café exercise the group converged to discuss the competency framework organization.

Following the Stakeholder Forum, the Competency Development Working Group reviewed all of the feedback and produced a second draft of the competencies. Once again, the Working Group and the Task Force engaged in an iterative process until they were prepared to send the document out in a second attempt to achieve national consensus. During this round of feedback CASN reached out to a wider group of stakeholders for feedback using an online questionnaire. For each competency and indicator statement respondents were asked to rate the statement as “essential”, “important”, “somewhat important”, “not at all important”, or to indicate if they did not know. In order to achieve consensus, the Task Force established that 75% of responses should be categorized as “essential” or “important”.

CASN sent the online questionnaire to the Deans and Directors of CASN member schools and the Stakeholder Forum participants. The members of the Task Force were asked to circulate the online questionnaire to their colleagues. CASN received 207 responses to the online questionnaire. The majority of respondents were from universities or colleges (44%), but also included health authorities or health centers (18.8%), and regional public health organizations (14%). CASN received feedback from all the provinces and territories except for the Yukon. More than half of the responses came from Ontario (52.2%). Alberta (11.1%) and British Colombia (9.2%) had the second and third highest response rates.

The results of the survey indicated that CASN had reached consensus on all of the competency and indicator statements. The Working Group reviewed the statements that received more “important” than “essential” responses for any issues that might be causing them to be viewed as non-essential. The group also reviewed additional comments from stakeholders. As a result of the online questionnaire, minor revisions were made to this document, in most cases to increase clarity of the competency and indicator statements.

This final draft of the competencies was reviewed and approved by the CASN Public Health Task Force, the CASN Standing Committee on Education, and the CASN Board of Directors.

Entry-to-Practice Public Health Nursing Competencies for Undergraduate Nursing Education

Domain 1 | Public Health Sciences in Nursing Practice

Competency 1

Applies public health sciences in nursing practice

Indicators

1.1 Describes the history and current structure of public health, public health nursing, and the health care system in the context of local communities, Aboriginal peoples, provinces/territories, nationally and globally.

1.2 Describes federal and provincial/territorial regulatory legislation and policy relevant to public health nursing.

1.3 Applies knowledge about the following concepts: the health status of populations, vulnerable populations, population health ethics, cultural safety, determinants of health, social justice, and principles of primary health care.

1.4 Applies knowledge of strategies for health protection; health promotion (including mental health), communicable and non-communicable disease, injury prevention and, health emergency preparedness and disaster response.

1.5 Describes the inter-relationships between the individual, family, community, population and system.

1.6 Articulates the intersection between economic, social, political, cultural and environmental factors, and the health of populations to inform healthy public policy.

Domain 2 | Population and Community Health Assessment and Analysis

Competency 2

Assesses and analyses population and community health using relevant data, research, nursing knowledge, and considering the local and global context.

Indicators

2.1 Describes the importance of collecting nursing, community, and environmental data on the health of populations.

2.2 Recognizes the impact of the social and environmental/ecological determinants of health on groups/communities/populations.

2.3 Uses a population health lens to assess and analyze group/community/ population health trends.

2.4 Participates in group/community/population health assessment and analysis identifying opportunities and risks by using multiple methods and sources of knowing in partnership with the client.

2.5 Recognizes trends and patterns of epidemiological data, to identify gaps in service delivery, as well as capacities and opportunities for health.

Domain 3 | Population Health Planning, Implementation, and Evaluation

Competency 3

Participates in the planning, implementation, and evaluation of one or more of the following: population health promotion, injury and disease prevention, and health protection programs and services within the community.

Indicators

3.1 Uses evidence to inform planning of population health programs and services.

3.2 Applies health promotion, injury and disease prevention strategies across the lifespan.

3.3 Participates in the monitoring and evaluation of the outcomes of population health programs and services.

Domain 4 | Partnerships, Collaboration and Advocacy

Competency 4

Engages with partners to collaborate and advocate with the community to create and implement strategies that improve the health of populations.

Indicators

4.1 Engages with the community, in particular populations facing inequities, using a capacity building/mobilization approach to address public health issues.

4.2 Collaborates and advocates with the community to promote and protect the health of the community.

4.3 Seeks opportunities to participate in coalitions and inter-sectoral partnerships to develop and implement strategies to promote health.

Domain 5 | Communication in Public Health Nursing

Competency 5

Applies communication strategies to effectively work with clients, health professionals and other sectors.

Indicators

5.1 Applies health literacy when working with clients.

5.2 Uses social media, community resources and social marketing techniques appropriately to disseminate health information.

5.3 Documents population health nursing activities.

5.4 Uses appropriate communication techniques to influence decision makers.

Glossary

Term	Definition
Aboriginal peoples	In the Canadian context this term refers to First Nations, Inuit, and Métis populations (Royal Commission on Aboriginal Peoples, 1996).
Capacity building	The development of a set of attributes that enable a community to take action (MacLellan-Wright et al., 2007).
Client	The term may refer to individuals, families, groups, communities, populations or systems; the way the term is used depends on the context in which it is used (CPHA, 2010).
Collaboration	A recognized relationship among different sectors or groups, which have been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by the public health sector acting alone (PHAC, 2010).
Community	An organized group of people bound together by social, cultural, job, or geographic ties. It may be as simple as a number of families and others who organize themselves to survive, or as complex as the world community with its highly organized institutions (CPHA, 2010).
Community ethics	The branch of philosophy dealing with distinctions between right and wrong, and with the moral consequences of human actions. Much of modern ethical thinking is based on the concepts of human rights, individual freedom and autonomy, and on doing good and not harming. The concept of equity, or equal consideration for every individual, is paramount. In public health, the community need for protection from risks to health may take precedence over individual human rights, for instance when persons with a contagious disease are isolated and their contacts may be subject to quarantine. Finding a balance between the public health requirement for access to information and the individual's right to privacy and to confidentiality of personal information may also be a source of tension (PHAC, 2010).
Community development	The process of involving a community in the identifying and strengthening those aspects of daily life, cultural life, and political life which supports health. This might include support for political action to change the total environment and strength resources for health living. It could also be work that reinforces social networks and social support within a community or seeks to develop the community's material resources and economic base (CPHA, 2010).
Culturally-relevant (and appropriate)	This is a process and state of recognizing, understanding, and applying attitudes and practices that are both sensitive to and correct for working with people with diverse cultural socio-economic and educational backgrounds, and people of all ages, genders, health status, sexual orientations, and abilities (PHAC, 2010).

Cultural safety	Goes beyond cultural awareness and the acknowledgement of difference. Surpasses cultural sensitivity (which recognizes the importance of respecting difference). It is an understanding of the power differentials inherent in health service delivery and redressing these inequalities through educational processes (A.N.A.C., 2009).
Disease and injury prevention	Measures to prevent the occurrence of disease and injury, such as risk factor reduction, but also to arrest the progress and reduce the consequences of disease or injury once established. Disease and injury prevention is sometimes used as a complementary term alongside health promotion. (PHAC, 2010).
Ecological health	The connection between healthy functioning ecosystems, the valuable services they provide, and human health and well-being (Metro Vancouver, 2011).
Emergency preparedness	The readiness for unexpected lethal or harmful events involving more casualties than health care infrastructures are normally designed to handle (CEEP, 2009).
Environmental health	Environmental health addresses all the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviours. It encompasses the assessment and control of those environmental factors that can potentially affect health. It is targeted towards preventing disease and creating health-supportive environments (WHO, 2013).
Epidemiology	The study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems (WHO, 2013a).
Harm reduction	Taking action through policy and programming to reduce the harmful effects of behaviour. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills resources and supports for individuals, their families and communities to make informed decisions to be safer and healthier (BC Harm Reduction Strategies and Services, 2011).
Health equity	The absence of unjust, unfair and avoidable systematic inequalities in health or in major social determinants of health. It is concerned with creating equal opportunities for everyone to attain their full health potential. No one should be disadvantaged from achieving this potential if it can be avoided (WHO, 2008).
Health literacy	The ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course (PHAC, 2011).

Health promotion	The process of enabling people to increase control and to improve their health. This not only refers to the skills and actions of individuals, but to changing the environment, social, political, and economic conditions that impact population health (PHAC, 2010).
Health protection	A term used to describe important public health functions in the areas of food hygiene, clean water, environmental sanitation, drug safety and other activities that remove, as much as possible, the risk adverse impacts on health that are linked to environmental hazards (PHAC, 2010).
Inclusiveness	Community solutions should be inclusive of all people regardless of societal limitations and perceptions. Their individual insights and experiences are a valued component of the planning process and can be used to generate program ideas, maintain a focus on the person-centred approach, and draw upon the lived experiences of the community (Stamler & Yiu, 2012, p. 443).
Mental health	Mental health means striking a balance in all aspects of your life: social, physical, spiritual, economic and mental (Canadian Mental Health Association, 2013).
Occupational health	Occupational health deals with all aspects of health and safety in the workplace and has a strong focus on primary prevention of hazards. The health of the workers has several determinants, including risk factors at the workplace leading to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress related disorders and communicable diseases and other (WHO, 2013b).
Population health assessment	Understanding the health of populations, including underlying factors and risks. This is frequently manifested in community health profiles or health status reports. Assessment includes consideration of physical, biological, behavioural, social, cultural, economic and other factors that affect health (PHAC, 2010).
Population health ethics	Population health ethics can be distinguished from bioethics by its primary focus on: (1) populations rather than individuals; (2) a wide range of interventions that often occur outside of the health care setting; (3) prevention of illness and disease. Population health ethics brings equity to the forefront, addresses deeply embedded (upstream) social determinants of health, and considers health issues as part of interconnected global systems (CIHR, 2012).
Primary healthcare	The ultimate goal of primary health care is better health for all. WHO has identified five key elements to achieving that goal: reducing exclusion and social disparities in health (universal coverage reforms); organizing health services around people's needs and expectations (service delivery reforms); integrating health into all sectors (public policy reforms); pursuing collaborative models of policy dialogue (leadership reforms); and, increasing stakeholder participation (WHO, 2013).

Public health	An organized activity of society to promote, protect, improve, and when necessary, restore the health of individuals, specified groups, or the entire population. It is a combination of sciences, skills, and values that function through collective societal activities and involve programs, services, and institutions aimed at protecting and improving the health of all people. The term “public health” can describe a concept, a social institution, a set of scientific and professional disciplines and technologies, and a form of practice. It is a way of thinking, a set of disciplines, an institution of society, and a manner of practice. It has an increasing number and variety of specialized domains and demands of its practitioners an increasing array of skills and expertise (PHAC, 2010).
Public health nurse	Combines knowledge from public health science, primary health care (including the determinants of health), nursing science, and the social sciences; focuses on promoting, protecting, and preserving the health of populations; links the health and illness experiences of individuals, families, and communities to population health promotion practice; recognizes that a community’s health is closely linked to the health of its members and is often reflected first in individual and family health experiences; recognizes that healthy communities and systems that support health contribute to opportunities for health for individuals, families, groups, and populations; and, practices in increasingly diverse settings, such as community health centres, schools, street clinics, youth centres, and nursing outposts, and with diverse partners, to meet the health needs of specific populations (CPHA, 2010).
Upstream investments	The identification and definition of health issues and the investment decisions within a population health approach are guided by parameters based on evidence about what makes and keeps people healthy. A population health approach directs investments to those areas that have the greatest potential to influence population health status positively. A population health approach is grounded in the notion that the earlier in the causal stream action is taken, the greater the potential for population health gains (PHAC, 2013).
Social determinants of health	The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries (WHO, 2013c).

Social exclusion	Exclusion consists of dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural - and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities (WHO, 2014).
Social justice	The fair distribution of society's benefits, responsibilities and their consequences. It focuses on the relative positive of one social group in relationship to others in society, as well as on the root causes of disparities and what can be done to eliminate them (CNA, 2006 p. 7).
Social marketing	The design and implementation of health communication strategies intended to influence behaviour or beliefs relating to the acceptability of an idea such as desired health behaviour, or a practice such as safe food hygiene, by a target group in the population (PHAC, 2010).
Stakeholders	An individual, group, or organization having a 'stake' in an issue and its outcome. Stakeholders, interested parties and affected parties are considered to be segments of the public (Health Canada, 2007).
Surveillance	Systematic, ongoing collection, collation, and analysis of health-related information that is communicated in a timely manner to all who need to know which health problems require action in their community. Surveillance is a central feature of epidemiological practice, where it is used to control disease. Information that is used for surveillance comes from many sources, including reported cases of communicable diseases, hospital admissions, laboratory reports, cancer registries, population surveys, reports of absence from school or work, and reported causes of death (PHAC, 2010).

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