ABSTRACT

The issue of practice skills arose in the course of a process evaluation of the Heart Smart North Shore (HSNS) project in British Columbia. We created a Think Tank of researchers and community practitioners to make recommendations for improvement of our skills. These recommendations differed according to different values for health and opinions on how to create health in the community. Because the site reviewers of the HSNS project were clear this was a disease prevention project and not a community development initiative, HSNS's orientation to skill development after the Think Tank moved toward the Precede/Proceed model, the Transtheoretical model and social marketing approaches. The Health Unit has now been restructured into multidisciplinary service teams which must focus on population health, evidence-based practice and the social determinants of health, and thus need to consider health promotion from a community development perspective and empowerment model. We suggest that learning and the development of staff and community volunteers should be seen as a continuous and reflective process that takes place at the individual, community and organizational level.

ABRÉGÉ

La question des compétences pratiques a été soulevée au cours d'une évaluation du processus suivi dans le cadre du projet Heart Smart North Shore (HSNS) en Colombie-Britannique. Nous avons créé un groupe de réflexion composé de chercheurs et de praticiens communautaires chargés de formuler des recommandations visant à améliorer nos compétences. Les recommandations formulées différaient selon les valeurs accordées à la santé et les opinions quant à la façon de créer une communauté en santé. Étant donné que pour les évaluateurs du projet HSNS, il s'agissait clairement d'un projet de prévention des maladies et non pas d'une initiative de développement communautaire, l'orientation du HSNS en matière de développement des compétences s'est axée sur le modèle Precede/Proceed, sur le modèle transthéorique et sur les approches du marketing social. L'unité de soins de santé a maintenant été restructurée en équipes de services pluridisciplinaires qui se concentrent sur la santé de la population, les pratiques fondées sur des preuves et les déterminants sociaux de la santé, et qui doivent donc envisager la promotion de la santé du point de vue du développement communautaire et du modèle de l'habilitation. Nous pensons que l'apprentissage et le développement du personnel et des bénévoles communautaires doivent être vus comme un processus continu et réfléchi qui s'applique au niveau de l'individu, de la communauté et de l'organisation.

Health Promotion Practice and Public Health: Challenge for the 1990s

Nancy Hall, PhD,¹ J. Allan Best, PhD² for the Heart Health Think Tank Group³

"Consider doubling or tripling your training and retraining budget in the course of the next 25 to 36 months. Less serious consideration means a failure to come to grips with both the nature of the problem and the magnitude of the opportunity."

Tom Peters¹

Training and retraining are as critical a challenge for public health as Tom Peters¹ suggests they are for the private sector, particularly in light of the health regionalization initiatives that are currently in process across Canada. The implications of the dramatic restructuring into the "new" public health are profound. First, cutbacks in funding and subsequent restructuring has created a strong demand for increased cost containment and accountability, especially through greater responsibility to community needs and more local involvement in the allocation of health resources.^{2,3} Second, among the public there is a strong voice requesting more emphasis on health promotion and disease prevention at the community level.³⁻⁸

The need for public health to provide leadership in this transition is widely acknowledged, and conceptual frameworks have received considerable attention.^{4,7} Why, then, have we not made greater progress translating vision into reality? There are many reasons, and two pragmatic challenges are the focus of this paper. First, attention to training and retraining has been lacking in most popular health promotion frameworks. Second, the strategic directions outlined in the frameworks such as the Ottawa Charter, Achieving Health For All or even the Framework for Population Health⁸ have not been translated into day-to-day operations. For example, a recent evaluation of a health promotion training initiative for public health nurses found a need for more "how to" implementation support. As one nurse expressed it, "I still feel that it is not clear enough in a step-by-step way so that we can follow through."⁹ Recently, various groups have been grappling with this need to support workers within public health in developing a new practice.¹⁰⁻¹³ Our aims in this paper are to report on a planning process that explored this training issue, and to present a modest framework for planning public health training and building a "learning organization."¹⁴

Background

Heart Smart North Shore (HSNS) was initiated by North Shore Health (NSH) and in its second year was funded as one of four British Columbia heart health demonstration projects. The Heart and Stroke Foundation of British Columbia and the Yukon provided start-up funding for the project, and also funded an ongoing process evaluation. The project is a prototype for community health promotion,

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demonstrating a partnership between public sector organizations and the community.

The Think Tank project was initiated within HSNS when the results from the process evaluation indicated that the capacity (i.e., the knowledge and skills) of the organizers was a critical issue. A change of planning focus in midstream at HSNS affected the roles, requirements and expectations of committee members, creating a need for further training. Although it was unstated, we began with a health belief model that assumes that individuals will take action to improve their health if they believe that a medical condition has serious consequences and that a recommended action will reduce their risk of acquiring it.¹⁵ We soon realized that a general awareness-raising strategy would not be sufficient to lead to specific changes in community health status.

In addition to HSNS's experience, the need for professional training and development at NSH has been highlighted by a current initiative to restructure operations around multidisciplinary neighbourhood teams. Staff training and development has been identified as a key challenge to the shift toward greater emphasis on population health, health promotion and disease prevention. We suggest a pressing need for the development of practice skills in this changing environment and describe here our progress to date.

Conceptual framework

Figure 1 shows the conceptual framework developed for our Heart Smart North Shore process evaluation. It builds on a study summarizing the experience of 10 community health promotion projects over the first two years of their development, and the variables identified as key to the projects' process.¹⁶ We defined capacity as the knowledge and skills required to work together at the community level to improve health. After two years of work in our heart health project we recognized that capacity was a foundational determinant in our community's ability to mobilize action.

The task of training in HSNS, then, is to strengthen the ability of public health

Figure 1. Model of community heart health action

Figure 2. Logic model for capacity development brainstorm

professionals and citizens to contribute effectively to these key processes in the community. The following Delphi Survey and Think Tank were planned around three levels of health promotion training: for medical health officers and Board of Health members; for public health managers; and for front line public health professionals.

METHOD

Faced with this challenge of designing staff and citizen development for community health promotion in the midst of a project, we began by seeking expert advice. A heart health conference was being held in Vancouver, so we took the opportunity to invite leaders from it to a one-day, results-

TABLE I
Issue Identification Survey Results

<i>Question</i>	<i>Response</i>
1. Vision If community health promotion is everybody's business, what is the best way to explain the purpose and nature of community health promotion to public health professionals?	People agree that community health promotion involves sharing of responsibility, authority and expertise to provide knowledge, skills, and opportunities which will ultimately determine issues and solutions in the areas of preventing illness, promoting health and improving quality of life.
2. Training Priorities What are the top priority community health promotion knowledge and skills which public health professionals need?	<p>The priority community health promotion skills were (in rank order): community development/mobilization, collaboration and coalition, advocacy, program planning and evaluation, conflict development resolution, organizational development, policy development, social marketing, public policy strategies, ways to acquire and use community health data, and group facilitation.</p> <p>Priority knowledge areas were: factors influencing behavior change at an individual and population level, characteristics of effective interventions, strategies for strengthening community, planning models, and methods for individual and organizational decision making processes.</p>
3. Challenges Why aren't public health professionals making this transition as quickly, easily and effectively as we'd like?	<p>Resistance to change: reluctance to give up ways of working that are known and are comfortable, relief by the call to action but anxious to do the right thing, reluctance to give up something that one helped to create, and loss of prestige that comes with giving up a formerly valued behavior.</p> <p>Systems barriers: the "medically oriented" initial training and insufficient training in social science theories and methods; the disciplinary focus within public health units which hinders learning from other disciplines; the false expectations of many for quick solutions to complicated community and national social problems which determine health; lack of senior management leadership to move to new paradigm.</p> <p>Training Barriers: Lack of time, lack of funding, management support, work site opportunities, wrong continuing education model.</p>

oriented workshop or Think Tank. Local university professors, a medical health officer and front line staff were also invited, making a total of 13 participants. To identify issues for this planning workshop, a Delphi survey of participants collected information characterizing the current vision of community health promotion, training needs and training barriers. A content analysis and summary of the consensus existing before the workshop was then produced, after the participants had ranked the training needs and barriers. The Think Tank then took place in the form of a day-long facilitated meeting. Because of the diversity of opinions on community health promotion strategies, the agenda was designed to take the group through a logical decision-making process, as depicted in Figure 2.

The Think Tank agenda addressed four areas:

- the criteria for a vision of community health;
- the vision of the Think Tank participants;
- specification of the unique role a local public health unit can play, in partnership with other agencies and citizens;

- priority training needs for different staff within the health unit.

RESULTS

Issue identification: Delphi survey

Two surveys were sent to Think Tank participants in the weeks leading up to the event. Participants were first asked to identify key issues to be addressed at the meeting, then to rank order them. The consensus is summarized in Table I.

Overall, our experts agreed on a definition of community health promotion, and the responses to Question 1 follow quite closely the Epp framework⁴ and the Ottawa Charter⁷ (see Table II). In contrast, the health promotion strategies for achieving this vision were very much determined by the individual participant's theoretical identification(s) or background. For example, participants adopted different positions with respect to Labonte's¹⁷ distinction between community *development* and community-based *programming*. Those with a community development-based strategy were more process oriented, focusing on people working together and developing

trust, leadership and empowerment, whereas those with a community-based programming approach focused on behavioural change, assessing readiness for change and preparing the community for greater participation.

Thus, it came as no surprise that there were striking differences in specific knowledge and skill priorities, since these specifics derive from theoretical perspectives and priority strategies. Given this diversity, it becomes clear that the challenge of capacity development must begin by seeking consensus on how we define health and health promotion, and which people need to learn to carry out health promotion, before we focus on how best to facilitate this learning.

Roles for public health

Two working groups at the Think Tank identified strategies for public health to work within the vision of a healthy community, and roles coincident with those recommended by the 1986 Ottawa Charter.⁷ Both groups identified the need to understand and apply models that suggest how individual and group change

occurred. In discussing roles for public health, the following functions were suggested: strengthening community action by convening community members to examine their issues; providing secretariat support and coordination, information and technical support as well as community activation; facilitating healthy public policy; and creating supportive environments with community regulation and protection, health surveillance and monitoring.

Recommendations from the Think Tank

Our problem-solving process was designed with two aims: to help us refine our process model of community health promotion program development and to investigate the issue of skill development, which was one of the five project capacities identified in our model. The consensus on training needs and delivery strategies is summarized in Table III.

DISCUSSION

New roles for public health

As practitioners involved in a BC demonstration project of the Canadian Heart Health Initiative, we observed in the second year of our project that we did not have all the knowledge we needed to plan and carry out our project. Our task was further complicated because we began our dialogue with community members with the intention to engage in a community development project, only to find two years later that the federal funders recommended an approach that focused more clearly on evidence-based decision making and that called upon the skills of community-based programming.¹⁷ The Think Tank served to reinforce our intuition that we needed more technical support, but it also served to highlight that there is significant disagreement as to what the health promotion practice of public health actually looks like. Some thought our business was disease prevention, while others thought that strengthening local action by using community development strategies was more appropriate. In the year following the Think Tank, in response to the NHRDP site visit review, the principal investigators of the BC demonstration project hired a coordinator who assumed responsibility for

TABLE II A Working Vision of a Healthy Community	
<ul style="list-style-type: none"> • Health and Sustainable Policy and Environment. Health is a priority for policy makers, and the health vision is integrated with the larger community vision. A lot of progress is being made towards revitalizing institutions—breaking down barriers, creating self empowering staff with enthusiasm and energy, and encouraging organizations which look outward at the real outcomes of their work. • Involving. It is easy to involve people in the life of the community. It is creating a “research society” where every household can have direct, daily access to community planning through TV or the telephone. Interactive programs in the home offer health information. • Enabling. Everyone has the information, skills, and support they need to do what they know is healthy. Everyone has meaningful work with as much control as is possible, and people feel less alienated. Educational systems are proactive and interactive, socializing students to work and live in less reactive ways. • Supporting. Both technical expertise and experience-based “know how” are honored. Professionals “let go” and create appropriate community care systems to look after, support and empower people who are ill. Volunteer networks support individuals with a wide range of needs, and people feel supported in their daily lives. • Resourcing. There is a significant shift in economic resources to address determinants of health—from acute to preventive services, and then to poverty and housing issues. • Accessible. We’ve stopped professionalising and started talking common sense. Health information is available in one’s own language. There is easy access to health promotion activities for all, including the disenfranchised. There is “one stop shopping”, and help across program boundaries. When people have easy access to the health system, they feel engaged in their own care. • Act Local, Think Global. The world-wide “ecological footprint” is taken into account locally, and the North Shore is moving towards a more appropriate “sustainability ratio”. • Healthy People. Both risk factors and quality of life are seen as important aspects of health. There is evidence of healthy people and tangible signs of behavior change—more healthy versus non-healthy foods in supermarkets, more bikes, etc. People are actually starting to engage in healthier behaviors and to use the health care system more appropriately. 	

technical assistance. This helped community members to select approaches that were grounded in learning how to use the Precede/Proceed Model,¹⁸ the Trans-theoretical Model¹⁹ and social marketing strategies.

With the demonstration project in the final year of its operation, the landscape for public health practitioners continues to shift. The provincial policy group responsible for health promotion, the Office of Health Promotion, was first renamed the Population Health Resource Branch, and most recently was eliminated from the provincial Ministry of Health structure altogether. Many of the services that were once public health are now integrated with child rehabilitation, child protection, and alcohol and drug services as part of the new Ministry of Children and Families. Remaining services are decentralized and integrated with acute, mental health and continuing care services under a Regional Health Board. Although the structures have changed, many of the same workers are still in place and the fundamental challenges facing the public’s health remain unchanged if not sharpened in focus.

Dialogue at the federal/provincial and territorial level⁹ and with the Canadian Institute for Advanced Research²⁰ suggests we now need to focus on the health of populations and that our practice must be evidence-based. Further, the recent National Forum on Health suggests a strong need to operationalize the information on the social determinants of health.²¹ Fundamentally, although the organizational names have changed, public health workers are still engaged in the business of promoting the public’s health, and within this new setting are required to work at the individual and the community level. The options are still those of community development or community-based programming, and, as is depicted in the Action Statement for Health Promotion,²² we are beginning to understand that at the heart of the issue are individual values as to how people grow and change and which environments foster optimum health.

Relationships between theories, roles, project goals and interventions

Our initial questions that led us to investigate roles and skills were practical con-

TABLE III
Consensus on Training Needs

Training Priorities	Working Group Recommendations
Line Staff	
<ol style="list-style-type: none"> 1. <i>Facilitation.</i> Convening community group meetings to plan and establish goals and priorities. Working to facilitate community development & collaboration. 2. <i>Technical Support.</i> Understanding and advising on relevant research, program design to produce individual behavior and systems change, communications, and social marketing and diffusion. 3. <i>Advocacy.</i> Skills required to use advocacy to influence policy development. 4. <i>Evaluation.</i> Methods to design evaluations which guide intervention planning and program improvement. 	<ul style="list-style-type: none"> • Combine academic training and applied practice, through self-paced, distance education integrated with on-site mentoring and consultation • Commit sufficient resources. For example, with a public health unit the size of North Shore Health (185 full- and part-time staff), it was estimated that the equivalent of 5 FTE positions over one to two years was a realistic expectation
Managers	
<ol style="list-style-type: none"> 1. <i>Shared Planning Model.</i> Working competence with one or more models for community health promotion planning (e.g. PRECEDE/PROCEED). 2. <i>Management Role.</i> Focus on the things unique to public health managers: visioning, community action and development, advocacy, and policy implementation and evaluation. 3. <i>Leadership Development.</i> Develop a management support network to ensure both leadership and professional development, organization development, community mobilization and development and health promotion. 4. <i>Staff Support.</i> Focus on providing support for innovators by clarifying expectations, creating networks, and determining the reinforcing factors for different workers in order to build morale 	<ul style="list-style-type: none"> • Mentoring for managers • Provide workshops, technical assistance, and networking as necessary to develop capacity
Medical Health Officers	
<ol style="list-style-type: none"> 1. <i>Executive Information Management.</i> Find ways to distill real information from the masses of data and package it persuasively. 2. <i>Public Leadership.</i> Build the confidence, commitment, and skills to speak out on politically sensitive issues, frame public policy, engage in advocacy, and work with the media. 3. <i>Community "Politicking."</i> Develop the political understanding and skills to access points of power and leverage, acquire trust and credibility, and build partners and allies. 4. <i>Progressive Management.</i> Develop the abilities needed to design and manage complex, "flatter" organizations, including strategic planning and team building, and methods for ongoing performance planning. 5. <i>Knowledge Base.</i> Ensure a strong knowledge base of chronic disease epidemiology, social science theories, and health promotion principles. 	<ul style="list-style-type: none"> • Use a structured curriculum within the community medicine residency program, including problem-based experiential learning, case studies, role playing, and mentoring. • Emphasize self-instructional learning and networking
All Groups	
<ol style="list-style-type: none"> 1. <i>Vision.</i> Create a collaborative vision and mission. 2. <i>Transdisciplinary Training.</i> Train groups together in population health, critical appraisal, and broad theories such as PRECEDE/PROCEED, Stages of Change, and Social Learning. 3. <i>Planning and Management Skills.</i> 4. <i>Evaluation and Feedback.</i> 5. <i>Advocacy and Policy Development.</i> 6. <i>Social Marketing.</i> 7. <i>Human Relations Skills.</i> Communications, situational leadership. 	

cerns: Should the coordinator of a community project initiate change or play the role of mobilizing community members and encourage critical thinking to lead to collective action? We realized that roles emerged from different theories, although

we needed technical assistance to name those theories.

Like Freudenberg and colleagues,²³ we were struck that most available theories emphasize individual change at the expense of social structural change. We also knew

we were striving for a role in which, rather than being the source of the change process, we saw ourselves enabling the community to define the goals of change and methods to achieve those goals. We were encouraged to change individuals'

diets, exercise and smoking rates but our volunteers wanted to focus on reducing stress and increasing social support. When we began, we did not know enough about the range of social science theories that we could potentially use (see Hyndman²⁴ for a useful review) to make useful links between our roles as practitioners and the project goals and interventions.

The challenge of creating reflective practitioners

The Think Tank members recommended fairly traditional methods of learning that took staff off site to seminars and summer schools for health promotion. Considering the magnitude of the skill gap we do not think that in the long run this will achieve the necessary result nor would this educational model fit the particular model we want to use with the community. As described by Williams,²⁵ those who value empowerment as a practice philosophy are also challenged to think about their own method of learning as an empowerment issue. Within this perspective, education and learning become a dynamic process involving critical examination of received wisdom and taken for granted values and beliefs. The focus is on moving away from individual lifestyle change issues to realizing the potential of people and removing the structural barriers that inhibit development, such as barriers related to race, class, gender, age, ability and so on.

The format of this kind of education moves away from traditional classroom-based learning, where the learners sit in rows and are filled up with information, to that of critical thinkers or reflective practitioners.²⁶ In implementing a graduate course in health promotion that followed empowerment education principles, Williams found that students changed how they related to existing knowledge and actively engaged in their own development.²⁵ They demonstrated a new way of learning that was less reliant on experts and more directed toward working in groups and learning with and from each other. We suggest that this is the kind of practice we would hope to see practitioners creating with their communities.

This is an opportunity for public health, as we move from the old rhetoric to the

new and continue to face even more than before the need to understand and enact community development and community-based programming. Once again, we need to examine our supports for learning about practice. Learning in the old model is typically "single loop learning",²⁷ in which a manager decides that workers need to know certain skills and arranges for the required training. This kind of learning assumes a steady state environment that no longer exists for practitioners. The world of today requires "double loop learning", which asks staff to pay attention to context such as cultural and economic circumstance and reflect on the larger community system and how it determines health. It also challenges values, norms and policies at all levels, and thus for management and staff alike requires a new kind of organization that puts at its heart the community-based stories and practice-based wisdom of the front line staff.²⁸

Thus, education does not have to be off site and involve experts at considerable expense. Rather, it has to be continuous learning within the organization or the project. Individual learning is nested within team learning, which is in turn nested within organizational learning. The learning organization commits itself to continuous improvement. As individual reflective practitioners engage in a reflect, connect, plan and do cycle, work teams in the organization engage in a similar cycle.¹⁴

In moving to a new setting, the first author of this paper found that learning can involve bringing peers together in learning dyads or triads to tell their practice stories, make connections, reflect on their meaning and implement them in action.²⁹ Staff and management have found it useful to have an outside facilitator trained in techniques for building self reflection and inquiry skills as well as dialogue facilitation. Others have tried this facilitated process for reflection in off site workshops for health promotion practitioners.³⁰

CONCLUSION

This paper addressed the experience of a heart health demonstration project, HSNS, in coming to terms with the staff's and volunteers' skills for community practice and

whether they were adequately prepared to become involved in the new public health. Within a Think Tank, a group was convened to discuss the training required for public health employees engaged with community health promotion. We have made some modest proposals for addressing this gap according to the input from our experts and our own ongoing process evaluation.

We suggest that the challenge may not be as difficult as it seems if we are prepared to think of learning as an organizational function rather than an individual task. We believe the transformation to a learning organization is a necessary prerequisite to create the kind of climate that will encourage staff to become "reflective practitioners" and enable them to work effectively in community initiatives. In meeting with researchers to examine our learning needs, we observed that the theories and models of change are not always immediately relevant to practice demands, but we remain committed to maintaining a dialogue between the research community and practitioners.

We suggest that this transformation to a learning organization, though clearly requiring a shift in power relationships between management and staff, need not be a costly enterprise. With restructuring endemic to the health sector at the present time, we have an opportunity to select a new kind of management that will allow a learning organization in public health. If we look to the leaders of the private sector learning organizations, this involves selecting leaders committed to five essential learning disciplines: developing personal mastery, uncovering shared mental models, building shared visions, developing team learning, and engaging in systems thinking.¹⁴

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La page titre de l'original doit comporter : 1) le titre et un bref sous-titre de 40 caractères au maximum; 2) les noms et prénoms des auteurs; 3) leurs diplômes d'études; 4) le nom du service ou de l'organisme dans le cadre duquel le travail a été effectué; 5) les organismes auxquels les auteurs sont affiliés, autres que ceux cités en 4); 6) le nom, l'adresse et le numéro de téléphone de l'auteur chargé des accords de publication du manuscrit; 7) une renonciation aux droits, le cas échéant; 8) le nom et l'adresse de l'auteur à qui les demandes de réimpression doivent être envoyées; et 9) les divers types d'assistance, notamment les subventions, le matériel et les médicaments.

Les documents sont acceptés en anglais ou en français. La page deux doit comporter un bref résumé du texte, pas plus de 150 mots, écrit dans la même langue que l'article. *Il est également nécessaire de fournir une traduction professionnelle de l'abrégé.*

Nous vous encourageons à écrire à la Rédaction, en vous priant d'envoyer des lettres aussi courtes que possible.

La Rédaction se réserve le droit de modifier les articles.