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A role for workforce competencies in evidence-based health promotion education
Lyn Talbot; Melissa Graham; Erica L James
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pg. 28

A role for workforce competencies in evidence-based health promotion education

Lyn Talbot[1], Melissa Graham[2] and Erica L. James[3]

Abstract: Education programs should be based on research about the knowledge and skills required for practice, rather than on intuition or tradition, but there is limited published curriculum research on health promotion education. This paper describes a case study of how workforce competencies have been used to assist evidence-based health promotion education in the areas of curriculum design, selection of assessment tasks and continuous quality assurance processes in an undergraduate program at an Australian university. A curriculum-competency mapping process successfully identified gaps and areas of overlap in an existing program. Previously published health promotion workforce competencies were effectively used in the process of selecting assessment items, providing clear guidelines for curriculum revision and a useful method to objectively assess competency content in an evidence informed framework. These health promotion workforce competencies constituted an additional tool to assess course quality. We recommend other tertiary institutions consider curriculum-competency mapping and curriculum based assessment selection as quality and evidence based curriculum review strategies. (*Promotion & Education*, 2007, XIV (1): pp 28-33)

Key Words: competencies, workforce, health promotion, curriculum, training

Résumé en français à la page 49. Resumen en español en la página 56.

It is widely accepted that the education of health professionals should be more evidence-based (Greenhalgh et al., 2003) and that learning and knowledge-production for public health needs to be comprehensive and include knowledge from multiple domains (Speller, Wimbush & Morgan, 2005). Health promotion practitioners need a range of core skills, including the ability to access and make judicious use of evidence about the effectiveness of health promotion interventions (Rychetnik, 2003). If we are expecting practitioners to practice in an evidence-informed manner, we must enable them to acquire and demonstrate the relevant competencies and we must develop curriculum programs in an evidence-based manner. That is, education programs should be based on research about the knowledge and skills required for practice, rather than on intuition and/or tradition.

As a relatively new area of university education there is limited published curriculum research on health promotion education (Mittlemark et al., 2000). A curriculum review of European courses has shown that health promotion training is becoming more widespread in various higher education settings and new courses in health promotion are being developed regularly (Clerking & Barry, 1998). Typically, programs are multi-disciplinary, are taught using interactive teaching methods, have an explicit research orientation and some have core performance competencies explicitly defined (Davies et al., 2000) or use workforce competencies to map curriculum content (Howat et al., 2000).

Greenhalgh and colleagues (2003) proposed a theoretical model for evidence based educational development based on the principles of evidenced based medicine. In this paper we argue that workforce competencies are a useful tool to assist the process of curriculum development, selection of assessment items and ongoing quality assurance for health promotion education. We outline the arguments for the use of health promotion competencies and then provide a case study that applies these competencies in curriculum development, assessment selection, and quality assurance mechanisms in an Australian University.

Key Points

- **Emerging professional practice roles in health promotion demand an evidence-based approach.**
- **Identification of core skills for health promotion professional practice can provide a benchmark for workers and employers.**
- **Health promotion workforce competencies can be used judiciously to guide educational curriculum planning.**
- **Implementing an evidence-driven curriculum audit cycle enhances curriculum quality and workforce outcomes.**

Health promotion competencies

There is increasing interest in the notion of competencies in the human services generally (Ife, 2002). Extensive work has been done to try and define the health promotion role and describe its core competencies, both in Australia (Shilton, Howat, James & Lower, 2001; Howat, Maycock, Jackson, Lower et al, 2001; Sheldon & Stoker, 1994; Mendoza, Parker & Fresta, 1994; Van Asselt, Howat, Henderson, & Shilton, 1993) and internationally (McCracken & Rance, 2000 (New Zealand); Becker & Loy, 2004 (USA); Moloughney, 2004 (Canada); Davies et al,2000 (Europe).

Competencies set performance expectations for professionals working in the field. For the purpose of this paper a competency is defined as 'a combination of attributes which enable a person to perform a set of tasks to an appropriate standard and is made up of attributes including knowledge, abilities, skills and attitudes' (Shilton et al, 2003).

Advantages of using competencies

Identification of core skills for health promotion is an important process because it can provide a benchmark both for practitioners in the field and their managers seeking to extend their knowledge and skills (Shilton et al., 2003). As Wise (2003: 4) has observed 'A knowledgeable skilled health promotion workforce is a key component of the capacity needed by nations to promote the health of their populations.'

1. School of Public Health, La Trobe University, Australia. Correspondence to Lyn Talbot: Department of Health & Environment, School of Public Health, La Trobe University, PO Box 199, Bendigo, Victoria, Australia (L.Talbot@latrobe.edu.au)
2. School of Health & Social Development, Deakin University, Australia
3. Centre for Health Research and Psycho-Oncology (CHRP), Cancer Counil. NSW/University of Newcastle, NSW, Australia.

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Identification of core competencies in health promotion provides evaluation criteria for ascertaining whether or not the competencies have been achieved by practitioners in the relevant workforce (Redman & O'Hara, 2003). In this respect competencies can be used as a policy lever to ensure adequate workforce development funds are allocated.

Identifying core health promotion competencies is advantageous for academic institutions. Within academic programs for postgraduate and undergraduate students it is important to keep searching for the combinations of competencies that best meet the needs of community groups and health agencies, and to share the results. However, it is also important not to use lists of competencies to divide disciplines and sectors into separate silos of practice. Instead, the aim should be to ensure competencies can be achieved by professionals graduating from a number of different discipline areas; they need the competencies to address the needs of the citizens who are at the centre of their attention, not as a means of putting their professional discipline at the "centre of the cosmos." The process of identifying and benchmarking competencies should not be used to back up 'skirmishes over jargon' or access to resources (Labonte, 2001).

Criticisms of the use of competencies

There is some controversy about the usefulness and appropriateness of defining competencies for health promotion (Cowan et al., 2005; Shilton et al., 2001) and some criticisms of the use of competencies for these purposes. The main criticisms raised in the literature are the lack of debate about the validity of national competency standards, and the tendency for their use to lead towards "universalism" in attributes (Mendoza et al., 1994: 9). When the term *competencies* is used synonymously with *skills*, a narrow and prescriptive approach to defining competencies can result (Ife, 2002). This narrow view is clearly inappropriate for community based workers, given the fluid and context-specific nature of community work skills (Ife, 2002). It is also important that generic competencies are not applied to a workforce as though they are homogenous in their practice. For example, Shilton and colleagues (2003) identified variations in perceptions of essential or core competencies between urban and rural health promotion practitioners in Australia. Within the university sector, use of competencies as a guide to vocational course design has also been criticised as it is seen as a narrowing of the purpose of a university education away from one of broad 'education in life' to a narrow 'training' for a particular vocation. We argue that the mechanisms outlined in this paper address this potential shortcoming. Whilst this paper details the use of competencies in an undergraduate program, the process could be equally useful in some post-graduate settings or programs. The curriculum-competency mapping process relates to facilitating students' opportunities to gain fundamental health promotion knowledge and skills, at whatever level the student enters study in the discipline. For example, a student entering a Master of Public Health program with an existing Bachelor of Medicine/Bachelor of Science background may have high level skills in critical analysis and application of the biomedical model, but they still require the fundamental knowledge, language and skills in health promotion that the use of a competencies framework helps ensure.

Shilton and colleagues (2001) identified the risk that there is the potential for competencies to be used for bureaucratic control. There is a risk that competencies may be used as a 'checklist' of behavioural tasks (Mendoza et.al, 1994). Mendoza and colleagues (1994) argue that a competencies framework leads towards a 'single model of vocational education.' We challenge that notion and instead argue that when competencies are used as a global guide they provide an appropriate and useful benchmark for curriculum planners. Health promotion competencies can provide a basis for assessing whether a university program is capable of preparing practitioners.

Unlike some other nations, Australia has an established and specialist health promotion workforce. This workforce is supported by a professional association, the Australian Health Promotion Association (AHPA, affiliated with IUHPE) and its national journal, the Health Promotion Journal of Australia (now indexed through Medline). Specialist health promotion positions were first created in Australia in the 1970s (Howat, Maycock, Jackson, et al., 2000). A number of studies have examined the knowledge, values and skills required by health promotion practitioners to plan and implement quality health promotion programs, (Public Health Association of Australia (PHAA), 1990; PHAA, 1993; PHAA, 1995).

This paper describes a case study of how competencies have been used to assist evidence based health promotion education in the areas of curriculum design, selection of assessment tasks, and continuous quality assurance processes in an undergraduate Bachelor of Public Health (Health Promotion) program at La Trobe University, Australia.

Case study of the application of workforce competencies to health promotion education

Via the use of a case study we describe three separate, but inter-related, phases where workforce competencies can be used to assist evidence based health promotion education. Firstly, we describe a process of 'competency mapping' where core workforce competencies are aligned against an existing curriculum program; secondly, we describe how competencies can be used to assist selection of assessment tasks, and finally, we describe how competency review can be integrated into continuous quality improvement activities.

La Trobe University has eight campuses across the state of Victoria. The Bachelor of Public Health (BPH) program described here is provided at the Bendigo campus. The City of Greater Bendigo is situated in central Victoria 150 kilometres north-west of Melbourne. It is one of the largest regional municipalities in the state with a population of just over 94 000 (Greater Bendigo City Council, 2006). The Bendigo campus caters for about 4 000 students. The Bachelor of Public Health program at Bendigo provides education and training for the health promotion and environmental health workforce. As the first such program in rural Victoria, it was established in 1993 to provide relevant, accessible and high quality public health education for regional and rural students. It has played a key role in building the health promotion capacity of the rural workforce in Victoria. The BPH course is informed by a primary health care philosophy; the values and principles for health promotion practice, as set out in the World Heath Organization Declaration of Alma Ata (1978). Themes in social, behavioural, and life sciences, research and epidemiology, health systems and health policy provide a theoretical framework developed throughout the course. The World Heath Organization Ottawa Charter (1986) provides the basis informing development of students' health promotion skills for practice. Students complete a number of applied health promotion units covering the continuum of health promotion approaches from policy action, community development and health education through to social marketing and individual risk assessment. The curriculum can be viewed at www.latrobe.edu.au.

Curriculum-competency mapping

Individual teaching and learning objectives from each unit (subject) in BPH were extracted from hard copies of all twenty core unit outlines. Each unit was reviewed against the published competencies (Shilton et al., 2002). A three stage process

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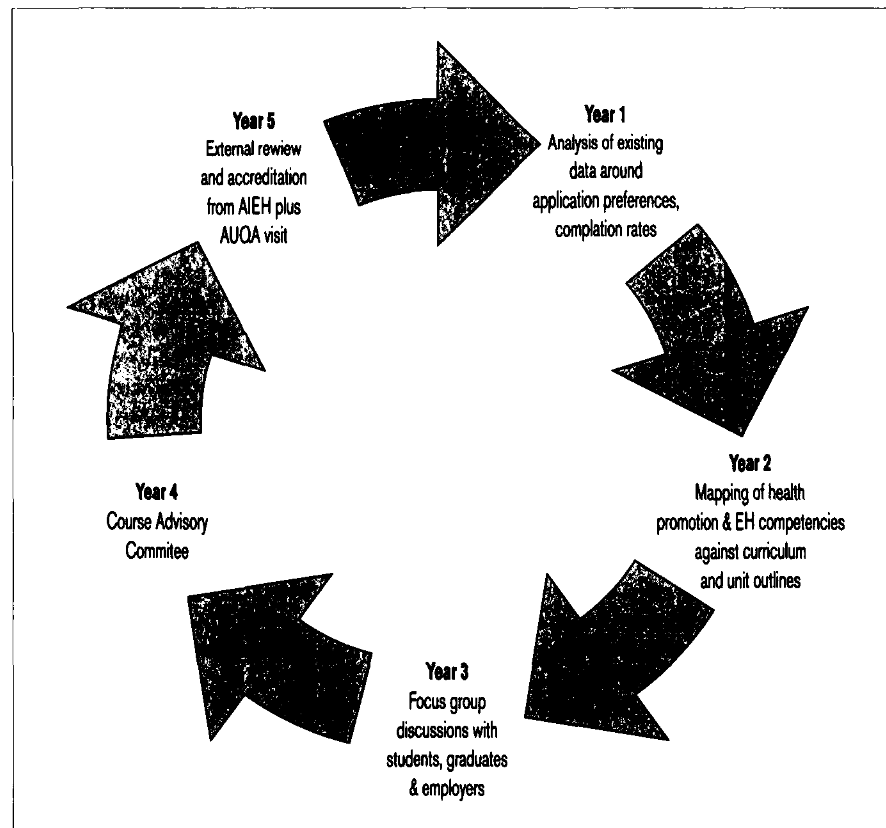
Table 1. **The type and number of competency areas covered by the Bachelor of Public Health**

Competency area	Number of Competencies in area	Number of Competencies met by degree	Proportion of competency area covered
Needs assessment	6	6	100
Planning	10	10	100
Implementation	12	7	58
Communication	14	11	79
Knowledge	12	11	92
Organisation and management	9	6	67
Evaluation and research	11	8	72
Use of technology	8	8	100

was used to identify the competencies that were met. First, teaching staff were asked to review the stated aims, objectives, assessment and content of each unit. Second, a review of all of the units against the health promotion competencies was undertaken by independent non-teaching staff and the unit maps were developed. The non-teaching staff member was a graduate of the program who was specifically employed for this purpose. These unit maps were then distributed for comment by teaching staff for consensus and/or revision, as appropriate. An assessment was made as to whether the competency was fully met, partially met, or not met. Assessment was also made as to whether the unit overall, contributed to the development of health promotion competencies. This process enabled unit maps to be developed.

Unit maps provided a visual representation of the unit and how it met or contributed towards the development of the previously identified and published health promotion competencies. The unit maps also enabled gaps to be identified in the core curriculum for individual units as well as for the degree program overall. Each unit map included the unit name and code, aim, objectives, details of assessments and relevant competencies. Unit maps also enabled a series of recommendations to be made regarding each unit and how they fitted into the wider degree program. This process of curriculum-competency mapping allowed a distilling of competencies against the stated objectives of the curriculum so that areas of both strength and limitation were identified.

Figure 1. **The Department of Health & Environment quality data collection cycle**



Health promotion competencies fully met in the curriculum

Health promotion competencies cover eight broad areas of health promotion theory and practice. Of the 83 health promotion competencies identified by Shilton and colleagues (2002), 81% (n=67) were fully met by the BPH core curriculum (Table 1).

Some competencies were covered in multiple units. For example, just over half (54%) of the 83 competencies were addressed by two or more core units within the Bachelor of Public Health (Table 2).

Health promotion competencies partially addressed in the curriculum

Some competencies were addressed in part by the units. For example, students were provided with knowledge and taught the skills necessary in areas such as *program implementation* although they were not necessarily able to put these skills into practice in the University environment. Thus, some competencies were considered covered by the curriculum if knowledge of these skills could be demonstrated through unit assessments even if the practical component could not be demonstrated.

Health promotion competencies not addressed in the curriculum

The 16 competencies not met by the core curriculum are presented in Table 3. The main reason these competencies have not been met is their applicability to the workforce rather than a learning institution. A core component of the BPH is a Field Experience unit undertaken in the final semester of enrolment. This involves the student undertaking a community work placement where, under supervision, they complete a defined project. As such, a number of these competencies *may* be met during field experience placements, although this is dependent on the specific organisation and project being undertaken and therefore this is difficult to assess globally. Some of these competencies could easily be incorporated into core units, for example, *be able to articulate health promotion jargon into salient language* and *prepare research/evaluation proposals for funding.*

Following identification of these gaps, unit outlines and the overall curriculum was revised accordingly. This competency-curriculum mapping exercise was useful in demonstrating the evidence-base for the curriculum content of the BPH.

Selection of assessment tasks

Professional competencies can also be utilised when selecting assessment tasks for health promotion curriculum. As Ramsden (2003; 182) has observed 'from our students' point of view assessment always

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defines the actual curriculum', so, selection of assessment tasks is important not only from the lecturers' perspective in assessing student learning, but also in terms of facilitating student motivation to learn specific topics and tasks (Crooks, 1988). The role of assessment has been emphasised by Crooks (1988) who stated that 'Work which is assessed, and particularly work which counts towards a final grade, often is undertaken more seriously and diligently than work which is not assessed'. Workforce competencies that have a practical component (rather than purely a knowledge component) can be identified and transferred to an assessment task in a relevant unit.

Summative assessments, that is, assessment tasks that are used to grade students (Biggs, 2003) within the Bachelor of Public Health have been designed to clearly reflect the aims, objectives and content of the unit as well as the relevant health promotion competencies. The assessments aim to assess the students' learning and understanding of the content, specifically those competencies which are essential to practice. Assessment focuses on developing understanding of the content and is relational rather than descriptive, as the latter lends itself to a surface approach to learning (Biggs, 2003). For example, in our *Epidemiology* unit, assessment tasks ask students to source, analyse and interpret data. These assessments relate to higher order learning such as analysis, synthesis and evaluation (Ramsden, 2003), as well as addressing a number of the health promotion competencies, including:

- identifying and sourcing data on the health needs of individuals/communities/populations;
- determining priorities for health promotion from available evidence using regional, state and national data;
- applying and interpreting statistical methods / analyses, and;
- using the internet as a work tool.

In our *Public Health Research B* unit, assessment focuses on practical skills which are essential for health promotion practice and address a range of the health promotion competencies, such as:

- developing proposals for large and small scale health promotion programs;
- writing submissions, grants or applications for funding;
- identifying appropriate evaluation designs;
- selecting and developing evaluation instruments, and;
- interpreting evaluation findings.

The assessment tasks in this unit consist of the development of a comprehensive research proposal including methodologi-

Table 2. **The number of competencies addressed by two or more units within the Bachelor of Public Health**

Competency	Number of units that address competency*
Needs Assessment	
Identify and source data on the health needs of individuals/communities/populations.	4
Identify behavioural, environmental and organisational factors that promote or compromise health.	13
Review and interpret needs assessment data.	3
Identify processes that are effective in setting priorities for health promotion.	5
Determine priorities for health promotion from available evidence using regional, state and national data.	4
Planning	
Critically analyse relevant literature.	9
Involve community members and stakeholders in program planning and evaluation.	2
Establish appropriate partnerships and facilitate collaborative action.	3
Develop logical, sequenced and sustainable health programs based on theory and evidence.	2
Formulate appropriate and measurable objectives.	2
Select and account for the implementation of appropriate (proven/best practice) strategies.	2
Develop funding proposals for large and small scale health promotion programs.	2
Implementation	
Coordinate production of appropriate program support materials (pamphlets, posters and other audio-visual materials).	3
Apply community development processes.	2
Apply structural / environmental strategies.	2
Communication	
Apply a range of approaches to health education.	3
Write for professional audiences.	3
Participate in the policy process.	2
Write reports.	4
Present to a range of audiences and tailor communication to consider cultural and other differences (culture, gender, age, ethnicity).	4
Apply political advocacy skills.	3
Knowledge	
Examine and apply knowledge of societal values in planning and implementing health promotion programs.	6
Consider and apply theory to health promotion planning, implementation and research.	7
Apply knowledge of the structure and function of the human body to health issues and diseases.	5
Examine and synthesise information on different health issues / topics, diseases and prevention.	3
Analyse the behavioural, social, political and environmental determinants on the health of individuals and populations with due consideration to equity and social justice.	9
Demonstrate knowledge of the health system and broader systems that impact on health.	9
Be aware of national and state priorities and determine how these impact on local plans.	5
Stay abreast of national and international developments in the health promotion field.	2
Organisation and Management	
Apply interpersonal skills (negotiation, team work, motivation, conflict resolution, decision-making and problem solving skills).	5
Work as part of a team.	3
Evaluate and Research	
Identify appropriate evaluation designs.	
Select evaluation instruments.	4
Develop evaluation instruments.	3
Apply and interpret statistical methods / analyses.	2
Interpret evaluation findings.	3
Communicate evaluation findings.	3
Identify research methods applicable to health promotion.	5
Use of Technology	
Create written / graphic presentation materials via PC.	4
Use basic computer based statistical programs.	2
Use the internet as a work tool.	5
Use technology based systems to identify and review the literature.	2
Demonstrate use of computerised health information / resources.	2
Operate audiovisual / multimedia equipment.	3

* Competencies which were partially or not met, or were only met by one unit have been excluded from this table

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Table 3. **Health promotion competencies not met by the Bachelor of Public Health core curriculum**

Competency	Description of competency
Implementation (Implement appropriate health promotion interventions).	
I1	Establish and facilitate community partnerships within and outside the health sector.
I4	Assist, support and build capacity in service providers and clinical workers to adopt health promotion methods and programs.
I6	Coordinate health-related screening and risk appraisal.
I11	Apply health sponsorships strategies.
I12	Devolve programs to community.
Communication (Communicate effectively with other professionals and clients).	
C8	Apply interview skills on radio.
C9	Apply interview skills on TV.
C14	Facilitate / provide various styles of professional development (eg workshops, conferences).
C15	Be able to articulate health promotion jargon into salient language.
Knowledge (Demonstrate appropriate knowledge necessary for conducting health promotion).	
K9	Demonstrate knowledge of organisational development and change.
Organisation and Management (Organise and manage health promotion interventions).	
O1	Manage projects effectively including resource management, achieving and reporting progress within budget and on time.
O5	Facilitate meetings.
O6	Coordinate volunteers.
Evaluate and Research (Evaluate health promotion).	
E4	Monitor programs and adjust objectives.
E9	Prepare research / evaluation proposals for funding.
E11	Coordinate validation of instruments.

cal, logistical and ethical considerations and the design and development of a questionnaire. The questionnaire design project begins with the students conducting a focus group discussion and transcribing the results. They then thematically analyse the transcripts to form the basis of questionnaire items and format the questionnaire according to recommendations for the specific target group.

Integration of competency expectations in to quality processes

When academic institutions offer programs in applied fields such as health promotion, nursing or environmental health, they have an obligation to prepare practitioners to be able to fulfil the performance expectations of those disciplines. Likewise students enrolling in such courses of study have expectations they will be able to function in their chosen field of practice; otherwise they would enrol in a generalist arts or social sciences course.

Workforce competencies can provide an additional quality assurance tool for university courses. Australian university quality assurance and course review processes require a regular cycle of review that includes consultations with experts and practitioners from the field. It provides a mechanism for creating a link between theoretical frameworks and applied practice. Involving experienced practitioners in course review processes also serves a mutual education process, where the plans, needs and constraints, affecting both domains can be brought together towards a mutually beneficial outcome. This is a necessary link in the course review processes of academic programs because otherwise they can be too inwardly focussed and lose sight of the external realities of practice.

Curriculum-competency mapping can be integrated in continuous quality improvement activities. For example, the mapping exercise discussed earlier in this paper has since been integrated into our Department's quality assurance data collection cycle (Figure 1) so that the competency curriculum mapping will be repeated every five years. This will ensure that the course continues to meet the changing needs of the workforce as the professional competency documents are revised and updated.

Conclusion

The competency curriculum mapping process successfully identified existing gaps and areas of overlap in the current program. Workforce competencies were effectively used in the process of selecting assessment, provided clear guidelines for curriculum revision and a useful framework to objectively assess curriculum content in an evidence-based framework. The results of these processes are now used to market the course to prospective students and to promote the knowledge and skills of graduates to potential employers.

The development and promotion of health promotion competencies provides a way of benchmarking standards for workers in the field and enhances arguments for recognition of health promotion as a professional discipline. It is also a way of bringing the expectations and professional roles of workers in the field into line with academic programs. Training in health promotion needs to be evidence-based and informed by identifiable attributes and abilities, rather than on the intuition of academics or the traditions of University courses. The process of curriculum-competency mapping and competency-based assessment selection described here is one mechanism to help achieve evidence based health promotion education. We recommend other tertiary institutions consider curriculum-competency mapping and curriculum based assessment selection as quality and evidence based curriculum review strategies.

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Comment utiliser les compétences des professionnels pour développer la formation en promotion de la santé fondée sur des preuves ?

L. Talbot, M. Graham et E. L. James, p. 28

Les programmes d'enseignement doivent se fonder sur les résultats de recherche sur les savoirs, les savoir-faire, les compétences requis pour la pratique, plutôt que sur l'intuition ou la tradition. Cependant, il existe peu de recherche publiée sur des programmes de formation en promotion de la santé. Cet article décrit une étude de cas sur la manière dont les compétences identifiées chez les acteurs de la promotion de la santé a servi à développer un enseignement en promotion de la santé fondé sur des preuves qu'il s'agisse de la conception du programme d'enseignement, de la sélection des tâches d'évaluation, ou des processus d'assurance qualité continus, dans le cadre d'un programme de formation d'étudiants de premier cycle d'une université australienne. En répertoriant et en analysant les compétences à enseigner tirées de la pratique et en les rapprochant de celles d'un programme de formation existant, on a pu identifier les manques et les chevauchements de ce programme. Les compétences identifiées dans la pratique de la promotion de la santé préalablement publiées ont été effectivement utilisées dans le processus de sélection d'éléments d'évaluation, fournissant des directives claires pour la révision du programme, et une méthode utile pour évaluer objectivement le contenu du cursus, dans un cadre de référence fondé sur des preuves. Ces compétences ont finalement constitué un outil supplémentaire pour évaluer la qualité du cours.

En conclusion :

Les pratiques professionnelles émergentes en promotion de la santé réclament une approche fondée sur les preuves.

L'identification de compétences essentielles pour la pratique professionnelle de la promotion de la santé peut apporter des éléments de référence essentiels à la fois pour les employeurs et les employés.

Les compétences de la main d'œuvre en promotion de la santé peuvent être utilisées judicieusement pour orienter la planification des programmes de formation.

La mise en place d'un cycle de contrôle des programmes d'enseignement fondés sur les preuves ne peut que contribuer à améliorer la qualité des programmes de formation et les performances des professionnels formés.

Les auteurs recommandent à d'autres institutions de service de considérer stratégiquement ces approches pour réviser la qualité et les contenus de leurs formations en se fondant sur des preuves d'efficacité tirées de la pratique.

Synthèse, traduction et échange des connaissances en santé publique et en promotion de la santé : le rôle d'un Groupe d'Étude Cochrane

E. Waters et R. Armstrong, p. 34

La Cochrane Collaboration est une organisation internationale sans but lucratif qui vise à produire des analyses systématiques de haute qualité sur l'efficacité des interventions dans le domaine de la santé. Ce travail est mené par 51 Groupes d'Etude qui portent sur un large éventail de sujets (par ex. grossesse & naissance, VIH/SIDA). Le rôle des différents « Champs » ('Fields') au sein de la Collaboration a été d'engager activement différents acteurs pertinents à l'échelle internationale pour améliorer la qualité et la pertinence des analyses.

Depuis le lancement en 1996 du « Champ » consacré à la santé publique et à la promotion de la santé, la Cochrane Collaboration a commencé à s'intéresser à des études liées à la santé publique et à la promotion de la santé, et s'adapte depuis à l'évolution des besoins des usagers. Les analyses s'orientent vers le développement de données probantes pour l'équité et la réduction des inégalités, et pour mieux répondre aux besoins des décideurs, des acteurs et des consommateurs.

Pour assumer ce rôle, nous avons été amenés à travailler avec une grande variété de partenaires parmi lesquels des réviseurs, des chercheurs, des praticiens et des consommateurs. Il en est ressorti qu'il fallait approfondir davantage la synthèse, l'état des lieux, la traduction et les échanges de connaissances (KSTE, Knowledge synthesis, translation and exchange) pour que les pratiques puissent influencer les décideurs, et que les politiques puissent influencer les praticiens.

2007 va être une année très intéressante pour une Promotion de la Santé et une Santé publique informées, fondées sur des preuves, à la fois au sein de la Collaboration Cochrane et pour nos partenaires au niveau des politiques, des pratiques et de la recherche.

Des activités antitabac entre pairs pour les adolescents

D. Aslan et A. Sahin, p. 36

Dans cet article, nous avons pour but d'évaluer et de discuter les détails d'un programme de formation à l'éducation par les pairs d'une durée de cinq jours, incluant des techniques créatives de jeux de rôle qui ont été ensuite utilisées pour mener des activités de lutte contre le tabac auprès d'un groupe d'adolescents en classe de seconde dans un lycée d'Ankara, en Turquie. Des méthodes et des approches participatives ont été utilisées au cours de la formation des pairs. Des techniques d'art dramatique interactives ('icebreakers', bilan quotidien de la formation, jeux de rôle, séances de 'brainstorming', études de cas, enregistrements vidéo, etc.) et créatives ont été les deux méthodes principales de formation utilisées au cours de ce processus. Bien que la prévalence du tabagisme n'ait pas diminué de façon significative dans l'école observée après l'intervention, cette méthode a contribué à sensibiliser les élèves par rapport aux problématiques de la lutte contre le tabagisme. Les changements constatés dans les connaissances et les attitudes des lycéens de l'école observée étaient sensiblement différents de ceux constatés dans l'école de référence. Cette étude a également été l'occasion pour les pairs leaders de participer à une activité éducative agréable. Ses résultats suggèrent que les pairs conseillers, bien formés et supervisés de façon continue, peuvent avoir un effet positif sur les 'connaissances'et les 'attitudes'de leurs amis face au tabac. Changer les comportements peut nécessiter plus de temps. Il est recommandé de mener des programmes de conseils par les pairs parmi des groupes similaires et pour des périodes minimum de 6 mois.

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Proyecto Heartfile de prevención de las enfermedades cardiovasculares en Lodhran: cierre de la evaluación de proyecto

S. Nishtar et al., p. 17

Las intervenciones de prevención convencionales no consiguen llegar a las poblaciones pobres de Pakistán con elevado riesgo de enfermedades cardiovasculares (CVD, en sus siglas en inglés). Heartfile, en colaboración con el Programa Nacional de Apoyo al Medio Rural, estableció un proyecto de base comunitaria para la prevención primaria de las CVD con el fin de elaborar enfoques que redujeran los factores de riesgo en dichas poblaciones, concretamente en el distrito de Lodhran. El proyecto implantó una gama de actividades integrándolas en los mecanismos existentes de los servicios sociales y de salud a lo largo de un periodo de intervención de tres años (2000/01-2003/04). Las actividades iban destinadas a 4 entornos clave: educación para la salud comunitaria, intervenciones en los medios de comunicación, formación de los profesionales de salud y educación para la salud a través de las Trabajadoras de Salud (Lady Health Workers). El proyecto recibió apoyo del Departamento para el Desarrollo Internacional de Reino Unido. A nivel comunitario, se utilizó un diseño pre-test, post-test casi experimental para examinar los resultados del proyecto en relación con el componente comunitario de la intervención. Se llevaron a cabo evaluaciones previas y posteriores a la intervención (de la actividad de formación) en las que participaron todos los agentes de atención de salud en talleres seleccionados al azar, para determinar los niveles básicos de conocimientos y el impacto de la actividad de formación en el nivel de conocimientos. Para evaluar las prácticas de los agentes de salud, ya fueran médicos o no, se realizaron entrevistas a pacientes con comparaciones de control, en todos los centros de atención primaria. Se observaron cambios significativos positivos en los niveles de conocimiento de la comunidad del distrito en el que se había realizado la intervención, en comparación con el nivel de conocimientos básico, especialmente en relación con la dieta saludable para el corazón, los niveles de actividad física saludable, las causas de la hipertensión y de los infartos y los efectos de la hipertensión y del tabaco (fumador activo y pasivo) en la salud. Respecto de las conductas, no se detectaron cambios significativos en la práctica. No obstante, el proyecto desempeñó un papel decisivo porque espoleó al gobierno a llevar a cabo acciones nacionales encaminadas a la prevención y al control de las enfermedades no transmisibles y a introducir intervenciones sostenibles de salud pública dirigidas a las comunidades pobres de Pakistán.

La determinación de las competencias del trabajador es importante en la enseñanza de la promoción de la salud de base empírica

L. Talbot, M. Graham y E. L. James, p. 28

Los programas de enseñanza deberían basarse en estudios sobre los conocimientos y las habilidades necesarias para la práctica profesional, más que en la intuición o en la tradición, pero hay escasa investigación publicada sobre la docencia de la promoción de la salud. Este trabajo describe un caso práctico en el que explica cómo se han utilizado las competencias esenciales de un trabajador de la promoción de la salud para ayudar a la enseñanza de base empírica de esta materia en las áreas del diseño curricular, en la selección de las tareas de evaluación y en los procesos permanentes encaminados a asegurar la calidad en un programa de licenciatura de una universidad australiana. Mediante un proceso de planificación del plan de estudios y de las competencias se logró identificar las lagunas y las duplicidades del plan de estudios existente. En el proceso de selección de los elementos a evaluar, se utilizó con éxito una lista de competencias esenciales del promotor de salud previamente publicada, lo que ofreció orientaciones claras para la revisión del plan de estudios, y un método para evaluar de manera objetiva el contenido del plan de estudios en un marco empírico. Estas competencias esenciales del promotor de salud constituyeron una herramienta más para evaluar la calidad del curso. Recomendamos a otras instituciones de enseñanza superior, que se planteen la posibilidad de realizar la planificación de las competencias y del plan de estudios y su correspondiente evaluación, en tanto que estrategias de calidad para la revisión de los planes de estudios basada en las necesidades reales.

Síntesis, traducción e intercambio de conocimientos en salud pública y promoción de la salud: el rol de un Grupo de Reseñas Cochrane

E. Waters y R. Armstrong, p. 34

Cochrane Collaboration es una organización internacional sin finalidad de lucro que pretende elaborar reseñas sistemáticas de gran calidad acerca de la efectividad de las intervenciones de salud. Llevan a cabo esta tarea 51 Grupos de reseñas que abarcan un amplio abanico de temas (p.ej.: embarazo y parto, VIH/SIDA). El papel de los Campos (Cochrane Fields) dentro de la organización ha sido implicar de manera activa a todas las partes interesadas internacionalmente para mejorar la calidad y la relevancia de las reseñas.

Desde el inicio, en 1996, del grupo de reseñas de salud pública y de promoción de la salud, la Biblioteca Cochrane ha experimentado un cambio en las reseñas relacionadas con estos temas y se está adaptando a las necesidades en continuo cambio. Las reseñas se orientarán a consolidar pruebas a favor de la equidad y de la reducción de las desigualdades y a asegurar que el material teórico satisface las necesidades de los responsables de tomar las decisiones en materia de salud pública.

Nuestro rol como Campo nos ha llevado a trabajar con una gama de colaboradores, entre los que se incluyen los redactores de las reseñas, investigadores, médicos y consumidores. La síntesis, traducción e intercambio de conocimientos (KST&E, en sus siglas en inglés) ha surgido como una cuestión que necesita ser estudiada para que la práctica incida en la toma de decisiones y para que los políticos incidan en los médicos.

2007 será un año muy interesante en el que la promoción de la salud y la salud pública estarán configuradas por la evidencia tanto en el seno de Cochrane Collaboration como en relación con nuestros colaboradores en el ámbito de las políticas, de la práctica y de la investigación.

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