

Public Participation in Health Education

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ABSTRACT

This article describes a unique two-part health education project that took place in Calgary, Alberta, with and for the general public. In Part I, adults were asked in focus-group discussions what they wanted to learn about health. Part II involved organizing and offering health education sessions in various communities around the city. The project evolved into a community-university partnership, based on strong interest and support from community groups.

Analysis of the project raised major questions, including ethical questions, about the application of a revenue-generation model to health-related continuing education for the general public. The author

RÉSUMÉ

Cet article décrit un projet unique entrepris pour et avec le grand public -- un projet en deux parties se rapportant à l'éducation sanitaire. Dans la première partie, on a demandé à des adultes, à l'intérieur de leur groupe de consultation, ce qu'ils voulaient apprendre en matière de santé. Dans la deuxième partie, on a organisé et offert des sessions en éducation sanitaire dans diverses communautés se trouvant aux environs de la ville. Un partenariat communauté-université s'est développé à partir du projet, étant donné le vif intérêt et le soutien particulier des groupes communautaires.

L'analyse du projet a provoqué des questions importantes y incluses

advocates a return to meaningful public participation for health-related learning.

des questions éthiques en ce qui concerne l'application d'un modèle de production de recettes sur l'éducation permanente en affaires de santé, et les répercussions de ceci pour le grand public. L'auteur préconise une participation sérieuse de la part du public dans l'apprentissage des affaires de la santé.

INTRODUCTION

Health care is once again at the forefront of the public agenda. The Mazankowski (Government of Alberta, 2001) and the Kirby (Senate Standing Committee, 2002) Reports, national public forums culminating in the release of the Romanow Report on health care in Canada (2002), and federal-provincial funding debates continue to keep health care in the public eye and to keep it viewed as an important fundamental value by the Canadian public.

Modern communication technologies have dramatically changed access to health information for the general public (Toffler, 1997). What was once the private domain of health professionals and doctors is now readily available and accessible to the general public and health professionals through numerous sources, including the Internet, television, and newspapers. Availability is further driven by the public's seemingly insatiable appetite for health-related information. However, often the media and newspapers are the public's main source, or even its only source, of health information.

Traditional health teaching has, to a large degree, consisted of health professionals deciding what the general public needs to learn about health, often with very little or no input from and no collaboration with the general public. People are often not consulted about what they **want** to learn or what they feel they need to learn. The public rarely becomes a partner in or a significant contributor to its own learning in health-related matters.

In continuing education, current fiscal realities increasingly dictate that educational offerings must generate revenue for the organization (Haughey, 1998; Lamble & Thompson, 2000; Thompson & Lamble, 2000). What the community deems to be of value or even needed is far less important. "During the 1990s, university extension was transformed; it is now a business first and foremost and subscribes to the money code of value" (Lauzon, 2000, p. 92). Further, "extension units are increasingly expected to become 'profit

centres' within the university" (Cruikshank, 1997, p. 6) and "the educational needs of people who cannot pay are ignored" (Cruikshank, 1997, p. 6).

Overview

This article describes and discusses a unique community-based health education project undertaken for and with the general public. Supported by two grants from C-CALA (Calgary-Community Adult Learning Association), a two-part project was conducted in Calgary through the Faculty of Continuing Education, University of Calgary. A process of needs assessment with community focus groups was undertaken in Part I, the primary purpose of which was to determine what the general public wanted to learn about health. Part II consisted of offering health education sessions in various geographic locations around Calgary, as determined by and in partnership with community groups. The project successfully demonstrated an alternate funding model for responding to individual and community health-related continuous learning needs. An analysis of the health education project concludes the article.

The focus-group sessions were conducted at a time when the local health authority was experiencing significant budget challenges, resulting from provincial government budget allocation reductions. The project thus took place during a unique and critical period in the evolution of the health system and health care in Alberta, and at a time of heightened public awareness and concern about health care.

PART I: FOCUS GROUP NEEDS ASSESSMENT

Part I of the project involved asking what adult Calgarians wanted to learn about health. In focus-group discussions, participants were asked to address specific questions related to health. The project proposal that was submitted for funding included the following description: "Specific activities for the project [for Part I] include (1) conduct a Needs Assessment with adult Calgarians to determine what adult Calgarians actually need and want to learn about the present health system, their health, and healthy living" (Hammond & Moghadam, 1997, p. 4).

Project Description

Project partners for Part I included the Faculty of Continuing Education, University of Calgary, as the lead institution, with the Calgary Regional Health Authority, Education Department, as a participating partner for Part I only.

Funding for the initiative was provided by C-CALA (a grant of less than \$5,000 for Part I). The grant was used to hire a staff member to organize focus groups. The job description for that person included contacting community groups and community associations to determine interest in participating in and structuring the focus-group sessions (date, time, place); attending and, in some sessions, facilitating focus groups; and contributing to the analysis. Over the course of Part I, two project staff were hired: one at the beginning and, following her resignation, a second individual. Both were paid from the project grant.

Focus Group Formation, Discussion, and Questions

There was a desire at the onset of the project to engage diverse groups of people, including different ages and ethnic backgrounds, in different geographic areas of Calgary. Potential focus groups were identified in a variety of ways, including from a C-CALA member organization list and the Calgary Community Association list. Initial contacts were made by telephone and letter.

The process of contacting various groups and ultimately structuring a focus-group session was a time-consuming and arduous task. Groups and community associations dealt with the request to participate in a variety of ways, ranging from informal discussions with individual people to formal agenda items and formal board decisions at board meetings. In one instance, the project leader was invited to attend a meeting of a community association board. In the end, some groups chose to participate; others did not. One group volunteered to participate, even though not on a list and not having been approached to participate. Had the time period for the focus-group sessions been able to be extended, potentially more groups could have participated. However, the amount of the grant limited the number of focus groups and the length of time staff could be hired for the project.

Nine focus-group discussions were held with organizations and individuals, including various ethnic and cultural groups, in different geographic sectors of Calgary. Participants spanned the age spectrum, from new mothers with new babies to seniors. In all, 62 people participated, with group size ranging from 3 to 14 people. One group discussion included two organizations, and another group chose to discuss the questions on their own and submit their responses in writing.

The predetermined questions for discussion by the focus groups were crucial to the needs assessment phase of the project. The proposed questions underwent a number of revisions, with review and input by various health groups and specific individual health professionals. This extensive review process produced refined questions related to the primary purpose of the project—to determine what participants wanted to learn about

health. Additional questions were included to obtain supplemental information about participants' health-related learning activities. These questions prompted discussion about the ways in which participants preferred to learn (i.e., workshop, television, classes taught by an instructor), their preferred teachers, and what sources they used for health information, as well as how the general public decided what was an accurate, current, and reliable source for health information.

Results of Focus Group Needs Assessment

The comments and suggestions from focus-group participants were noted in the report, *Health Education Needs Assessment of Adult Calgarians, Report to C-CALA for Part I* (Hammond & Moghadam, 1997). No statistical quantitative or comprehensive qualitative analyses were undertaken in reviewing the results. Rather, it was the process of doing the focus-group needs assessment and engaging the public in discussions about health that ultimately proved more important. Further, when community groups were choosing a topic for their education session, the final complete report and the collective results of the focus-group discussions were not central to their decision-making. In the end, people chose an education topic that was important to them.

There were seven focus-group discussion questions (see Appendix). Question 2, which specifically related to the expressed health education needs of the public, read:

What information do you want to learn about health? The information you want/need to learn could stem from many things. For example:

- it could stem from concerns you have about health or the new health system
- it could stem from problems, such as a health problem you have had
- it could stem from your desire to learn more about health
- it could stem from your desire to live a healthier lifestyle
- it could stem from information on TV or in the media

The responses to this question related to what people wanted to learn about health in general, what people wanted to learn about the health system, and what people wanted to learn about health information. It also required an additional category on what participants felt health professionals needed to learn. Many of the comments reflected public concern about funding and the perceived or real threat to the availability of health care services. This section centred around comments on the health system, in the context of major reorganizational changes and budget reductions that were occurring in the health system at that time.

Implications for Health Education Sessions

What emerged in the process of engaging people in the focus-group discussions was the desire and eagerness of community groups to continue to be involved in the project, particularly to be directly involved in the next phase of planning and offering the education sessions. Some groups wanted to hear the results of the needs-assessment discussions and what other people had said about health-related learning. In response, the project leader made a number of presentations to community groups, providing highlights from focus-group discussions.

Results clearly indicated that the general public was not interested in coming to the university campus for any health education sessions. Instead, they expressed a desire to have sessions in their own communities. Comments from participants on this issue included: "more central within community itself, i.e., community centre"; "sessions at health unit, community place, to accommodate larger groups with play area"; "accessible in front"; "some don't drive - then is difficult"; "easy to park"; "easy to get to"; "local neighborhood centre"; "make more accessible" (Hammond & Moghadam, 1997).

Participants also indicated that they would like sessions to be conducted in their own language, if English was not their principal language of conversation. Comments included "in different languages and dialects."

The results of the focus-group discussions and the process of engaging the public in the discussion were pivotal in determining what occurred in Part II and, in particular, how it was undertaken. All communities became partners in the process. All communities chose the topic for the education session in their communities and, in collaboration with project staff, decided on the date and location. The community groups chose the health topic they wished to address; university project staff did not choose the topics.

The collaborative relationship was ultimately shaped and cemented not by the critical analysis of the needs-assessment results, but rather by the process of involving the groups and listening to what they said. Community groups chose the educational session topic that was important to them and did not necessarily base their decisions on what was said in the needs assessment.

PART II: HEALTH EDUCATION SESSIONS

Part II of the health education project involved planning and offering health-related education sessions, as determined by and in collaboration with community groups.

Funding

An additional grant of approximately \$5,000 was obtained from C-CALA to conduct Part II of the project. A project coordinator was hired to organize the education sessions.

No fee was charged for any of the educational sessions, as the grant covered basic expenses. However, the amount of funding expanded considerably with actual dollars and in-kind funding contributed by the community groups. These groups willingly volunteered their time, money, and resources, although they were not specifically requested to do so. The logistics of not having a traditional fee produced some challenges, however. For example, one evening session had no learners in attendance, including none from the original group who had requested the session. Further investigation was required to determine why the individuals that requested and contributed to the session planning, in the end, did not attend.

Community groups provided marketing, both informally and formally, through community newsletters, posters, phoning community members, and a variety of other marketing activities. These were all done at the communities' expense. Chinese and Spanish translation was provided free of charge by community group members. Community groups, almost exclusively, provided refreshments; one group provided a feast and ethnic dancing during the session break. Space in community centres, church halls, and cultural centres was provided at no expense to the University of Calgary, with the cost, if any, paid for by the community group.

No honoraria were paid to individual instructors or presenters, a decision that was made at the onset of the project. Only one individual requested an honorarium; that individual was replaced by another equally qualified speaker who required no payment. Most presenters participated in their employment capacity within the health system and, as such, receiving no honorarium posed no difficulty. Other than the usual logistical organizing problems, no other problems were encountered in engaging numerous speakers for any of the sessions.

In the final analysis, community members volunteered and, indeed, undertook many of the organizational tasks often done by paid employees in traditional organizational structures. For the most part, community volunteers booked the facilities or space, contributed to the educational event

marketing/advertising in the community, arranged for coffee, food, and beverages, and provided translators. When expenses were incurred for these items, for the most part, the community paid for them. Thus, community participation and volunteers were both valuable and essential to the process.

Session Planning

Due to limited funding, only one session could be offered in each community, and community groups were given the opportunity to identify the health education session they wanted in their community. To this end, each community group was asked to prioritize the educational sessions of their choice. All sessions were open to all community members and to all members of community organizations.

Program planning and design, contacting of speakers, and arrangements with community groups were the responsibilities of the project coordinator, in collaboration with the respective community group. A list of the health education sessions that were organized follows.

Women's Health

Speaker: University Professor and a health professional
(Spanish translation provided)
Location: Church Hall
Attendance: 22

Understanding Recent Changes to the Alberta Health System

Speaker: CEO, Calgary Regional Health Authority (CRHA)
Location: Community Centre
Attendance: 8

Aging in Alberta

Speakers: Six health-care professionals from CRHA, the Kerby Centre (a seniors' centre), and a nursing home
Location: Community Hall
Attendance: 10

Making Healthy Life Transitions (women's health)

Speakers: Sexual and Reproductive Health Services, CRHA, and an exercise/kinesiology graduate student
Location: Community Centre
Attendance: 6

Aging in Alberta

In consultation with the community association in the specific community, this session was cancelled.

Understanding Osteoporosis

Speaker: Physician (Chinese translation provided)
Location: Chinese Cultural Centre
Attendance: 33

Common Childhood Illnesses

Speaker: Pediatrician (Chinese translation provided)
Location: Chinese Cultural Centre
Attendance: 16 adults and 5 children

Aging in Alberta

Speakers: Four health-care professionals from the CRHA, the Kerby Centre, and a nursing home
Location: Church Hall, Northwest Calgary
Attendance: 13

Common Childhood Illnesses

Speaker: Pediatrician
Location: Community Association, Northeast Calgary
Attendance: 0

Alberta Health System and Newcomers to Canada

Speakers: Physician, Administrator, and others
Location: Calgary Immigrant Aid Society
Attendance: unknown, no record kept
This session was held after the project had officially been completed. It could not be scheduled during the project time frame.

In all, 10 sessions were organized, many of which focused on aging/seniors' health services and women's health issues. Sessions were structured to provide an opportunity for community members to express their concerns about health care directly with health professionals and to engage in active dialogue with the presenters about their particular health topic. Many sessions included a number of speakers in order to present various jurisdictional perspectives, as well as to provide comprehensive and diverse expertise on the health topic. A complete description of Part II of the project is detailed in the final report to the funding agency (Hammond & Harris, 1999).

Discussion of Educational Sessions

Feedback from focus-group discussions and ongoing program planning continuously shaped the development of the educational offerings. Participants clearly indicated that they wished to be involved in the planning and offering of educational sessions and that they did not want to travel to the university to attend these sessions. As a result, all sessions were held in communities around the city, specifically, in facilities of the community's preference, close to their homes.

The process of collaboration with community groups was more time consuming than an individual programmer-driven approach. However, responding to focus-group suggestions and adapting to community interest for continued involvement yielded a far-greater richness in focus-group feedback, resources, and learning that was focused on community needs than was originally conceived.

Because participants indicated in the focus-group discussions that paying a registration course fee was problematic, a different financial model was employed. No presenters were paid, no fee was charged, grant monies were directly applied to project staff and project activities, generous financial contributions and in-kind support were received from all community groups, and community members undertook many of the organizational administrative tasks on a volunteer basis.

The project leader and project staff focused on the educational component. Given their experience and background in the health sector, they were able to connect community educational requests and concerns with appropriate people in the health system. Their role became one of bridging the community and its concerns with the health system. They focused on being advocates for the community and on facilitating community-health system professional dialogue for learning, better understanding, and, optimistically and where appropriate, change within the health system.

The process of priority identification and program planning required greater flexibility, thus, evening and weekend meetings were held across the city. These meetings were held at a time and place of the community's choosing, not for institutional convenience.

SUMMARY AND DISCUSSION

This article describes a unique health education initiative for and with the general public, undertaken during a period of major restructuring and province-wide funding reductions in the Alberta health care system. The project demonstrated the interest of community people in health and their commitment to participating in health-related learning. Due to the expressed interest and concerns of the community, the project adapted to community requests. It evolved into a community/university collaborative partnership for the educational phase, during which educational sessions selected by community members were organized and offered in communities around the city. Two grants were received from the C-CALA (Calgary-Community Adult Learning Association), a funding agency. These grants were substantially and voluntarily supplemented by community organizations, which contributed real dollars and in-kind support for space, marketing, snacks, feasts, and ethnic dancing, as well as volunteer time. The grants also provided the opportunity to employ a different funding model, a deviation from the predominant revenue-generation model of continuing education funding, which, if required, financially contributes revenue to the larger educational institution.

The project focused on expressed community wants and needs and on community collaboration and partnership in health-related continuing education. Community interest and support were strongly evident throughout the entire project.

The project was a reaffirmation of the adult literature that states "that adults bring ... cherished values to learning" (Brundage & MacKeracher, 1980, p. 3), which, in this instance, is the fundamental value of health care. Further, "adults are highly motivated to learn in areas relevant to their current developmental tasks, social roles, life crises, and transition periods" (Brundage & MacKeracher, p. 103) and "adult learning is facilitated when the material to be learned or the skills and strategies involved in the learning process can be applied immediately to real-life experiences" (p. 103). The motivation of individuals was tangibly demonstrated by their involvement in focus groups and the planning and development of educational sessions and in their contributions of time, money, resources, marketing, site arrangements, and advertising. They did so because of their interest in health-related learning, rather than as a response to specific requests for support and resources.

Green and Raeburn (1990), wrote in *Health Promotion at the Community Level* that "Increasingly, health policy initiatives seek to work with people in the context of their everyday environments ... appropriate health promotion requires a balance of individual, institutional, community, societal, and political perspectives" (p. 34).

At the onset, the project focus included the application of adult education principles to practice (Brookfield, 1986; Brundage & MacKeracher, 1980), such as needs assessment and program planning based on learners' needs. However, the project increasingly transformed and became a community-based, education-partnership approach to health education, integrating adult education planning principles and expanding to become a community focus for education, specifically health education.

This health education initiative focused on community needs and expressed wants; it was not driven by the need for financially lucrative continuing education. The departure from the dominant institutional revenue-generation model was made possible by the initial grant from C-CALA, which was generously augmented by numerous in-kind and actual financial contributions from community groups. Their tangible commitment allowed far more to be done than would have been possible if activities had been limited by the original grant. Community groups also decided where their money was spent; none of it was allocated to university infrastructure or institutional revenues. A traditional course fee would have required continuing education staff to organize all the arrangements, such as space, and paying an honorarium to presenters would have been a significant financial burden given the number of speakers. The author recognizes this as a departure from the revenue-generation financial model for continuing education.

This health education project raises fundamental questions about the revenue generation model of funding continuing education for health related learning. Is it morally right to generate revenue to financially subsidize a continuing education unit, or the larger educational institution, by exploiting the misfortune and ill health of individuals? Should those who are sick or whose loved ones are sick be required to pay a registration fee to obtain education that may improve their health or ease their suffering? Such a registration fee could contribute to institutional revenue, which could then be applied in a discretionary manner to general university expenses, for example, to support future engineers, teachers, and scientists or for administrative salaries. Should only those with higher incomes and the ability to pay have the opportunity to obtain such health-related education? Should only financially lucrative health education sessions be offered, particularly when these sessions are decided upon solely on the basis of their potential for economic gain, rather than on community input or a focus on community needs?

Adult educators have a leadership role to play in shaping the future of lifelong learning in society. Engaging the public in discussions about the role and functions of publicly funded institutions in meeting the public mandate is an important part of this leadership role. Lamble and Thompson (2000) wrote that a reconceptualization of university extension "will position those involved in, and responsible for, university extension to provide much

needed leadership for enhancing the university's engagement with its larger community" (p. 119). They also suggested that "it should be fundamentally determined and defined by our understanding of the basic academic functions of a public university and its service mission to its larger community" (p. 113).

However, the time for meaningful debate about the revenue-generation model for funding continuing education has long since passed. The provision of health education has no place in, nor does it belong in, educational institutions that have a revenue-generation, entrepreneurial approach to funding continuing education units, which may then contribute to surplus or financial quotas for general, broader institutional revenues.

This health education project demonstrated a need to return to the community for meeting health-related education needs and, in the process, identified the mutual benefits in a collaborative community-education partnership. Health care is an important fundamental value for Canadian people. It should not be another source of revenue for an educational institution; rather, it should be an opportunity for meaningful public participation in health-related learning.

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APPENDIX

Focus Group Questions

1. What does health mean to you?

What comes into your mind when you hear the word “health”?

2. What information do you want to learn about health?

The information you want/need to learn could stem from many things. For example:

- it could stem from concerns you have about health or the new health system
- it could stem from problems, such as a health problem you have had
- it could stem from your desire to learn more about health
- it could stem from your desire to live a healthier lifestyle
- it could stem from information on TV or in the media

3. What ways would you prefer to learn about health?

This could include all ways of learning, including the following, for example:

- workshop
- group discussion
- classes taught by an instructor
- written material
- computer
- newspaper
- Internet/WWW
- technology hook-up
- television

If they suggest a class, workshop, or lecture (group of learners together), follow-up with “Where would you prefer this session to be held?”

4. Who would you prefer to teach (lead, facilitate, instruct) you about health, including health topics and health issues?
5. What sources of health information do you use?

(or)

If you need to obtain information related to your health, your family, or others, where/from whom do you get the information?

6. What is a good source of health information for you?
7. How do you decide what an accurate, current, reliable source for health information is?

BIOGRAPHY

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Mary Hammond est professeur agrégé à la Faculté de l'éducation permanente de The University of Calgary où elle œuvre en éducation permanente relative à la santé. Antérieurement, elle était commissaire d'une autorité rurale de santé ainsi que présidente fondatrice d'une fondation de collecte de fonds pour des services de santé.