Articles

Continuing Education for Health Promotion: A Case Study of Needs Assessment Practice

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Abstract

In recent years, both practical barriers and conceptual problems have been identified concerning needs assessment work in adult and continuing education. This article provides an empirical study of needs assessment research that was conducted to support university-based continuing education programming in the field of health promotion in Saskatchewan. We describe the context of the Saskatchewan Heart Health Program (SHHP), narrate the development, findings, and

Résumé

Ces derniers temps, les obstacles pratiques et problèmes conceptuels du travail sur l'évaluation des besoins éducatifs en éducation permanente ont été identifiés. Cet article fournit une étude empirique sur la recherche d'évaluation des besoins éducatifs étant menée pour soutenir la programmation en éducation permanente universitaire dans le domaine de la promotion de la santé en Saskatchewan. Nous décrivons le contexte du Programme de santé cardiovasculaire de la Saskatchewan

Canadian Journal of University Continuing Education
Vol. 26, No. 1, Spring
pp 11-29

outcomes of a significant needs assessment process, and identify implications of our work for other university continuing educators. Although formal needs assessment practices such as those described in this article may not always be appropriate for university continuing educators, they can be beneficial to marketing and pedagogical efforts. The SHHP needs assessment process encouraged our learners to actively and collectively reflect upon their learning priorities, increased their receptivity to our continuing education efforts, and provided us with an opportunity to role model a collaborative approach to health promotion program development.

(PHHS), narrons le développement, les conclusions et les résultats de notre processus d'évaluation des besoins importants, et identifions les implications de notre travail pour d'autres éducateurs en éducation permanente. Bien que les pratiques formelles d'évaluation des besoins telles que décrites dans cet article ne soient pas toujours appropriées pour les éducateurs en éducation permenante, elles peuvent étre profitables en marketing et en pédagogie. Le processus d'évaluation des besoins du PHHS a encouragé nos apprenants à réfléchir activement et collectivement à leurs priorités d'apprentissage, a augmenté leur réceptivité à nos efforts en éducation permanente et nous a offert une occasion pour émuler une approche collaborative à l'élaboration de programmes en promotion de la santé.

Needs Assessment as Contested Terrain

The practice of needs assessment is fundamental to models and processes of program planning in university continuing education in Canada. In their review of program planning literature in adult and continuing education, Sork and Buskey (1986, p. 89) identified nine generic steps: analyze planning context and client system; assess needs; develop objectives; select and order content; select and design instructional processes; select instructional resources; formulate a budget and administrative plan; design a plan for assuring participation; and design program evaluation. Needs

assessment was the only program planning process to be addressed in all 51 book-length program planning models reviewed by Sork and Buskey (1986, pp. 91–93).

Inclusion of needs assessment as an integral component of program planning models does not mean, however, that continuing educators universally do so in their adult education practices. Percival (1993, p. 93) suggested that formal needs assessment procedures demand time, money, and specialized research and analysis skills. These resources are often scarce, and practitioners frequently perceive that informal and intuitive methods result in equally valuable information. Kowalski (1988) argued that since many practitioners either do not know how to conduct needs assessments or view needs assessment as a potential source of conflict, they tend to plan programs based on "tradition, public relations appeal, intuition, faddism, political pressure or the advantageous use of existing resources" (p. 121).

In addition to these practical barriers, recent theoretical and political arguments have suggested that the very concept of needs assessment may be inappropriate to adult and continuing education. Illich (1992) deconstructed the historical emergence of "needs" within Western discourses of progress and development, and asserted that " . . . needs, defined in terms of ostensibly scientific criteria, permit a redefinition of human nature according to the convenience and interests of the professionals who administer and serve those needs" (p. 97). In the domain of adult and continuing education, Edwards (1991) argued that the concept of "learner needs"

> . . .suggests a pathological view of the learner. We discover what is wrong with learners, what they need to learn to become better individuals, and then provide the relevant balms. In working with persons to discover learning needs, we are encouraging them to name certain of their experiences as needs — i.e., learning requirements which are fundamental to them — and then to give names to those needs. More importantly, we are encouraging them to view their needs as belonging to them as individuals, decontextualised from the social relations which frame their life possibilities. (p. 95)

Given contemporary challenges to the concept of learner needs, the legitimacy of the process of needs assessment has been contested. After an extensive critique of individualized and technocratic approaches to needs assessment, Collins (1991) concluded: "We would do well to entirely

remove formal needs assessment design approaches and their distorting effects from the arena of contemporary adult education practice" (p. 67).

Despite significant debate about the nature and political implications of needs and needs assessment, continuing education programs at Canadian universities are still consistently rooted in some understanding of the needs, aspirations, demands, or priorities of individual learners, organizations, or communities. Constructing an adequate understanding of such needs, as a foundation for educational programming, is a practical challenge faced by continuing education programmers. Percival (1993) observed that, in contrast to theorists,

> . . . adult education practitioners seem much less confused and concerned about the meaning of need. For most practitioners, a need implies a discrepancy or gap between a desired condition or state of affairs and the actual or perceived condition or state of affairs. Educational programs are designed to close or narrow the gap between what is and what is desired. (p. 93)

Recent theories of adult and continuing education also recognize the practical grounding of much educational practice in concepts associated with needs. Davidson (1995) argued that the concept of "needs making activity" enhances ". . . our concern with the power relations that govern needs-meeting activity by focusing on the processes by which conditions are experienced, expressed and satisfied as educational needs" (p. 194). Although not using the term "needs," Cervero and Wilson (1994 p. 28-32) argued that responsible program planning practice involves "negotiating" the "interests" of program planners, learners, instructors, institutional leaders, and the public. Despite his critique of conventional needs assessment concepts and practices, Collins (1991) suggested that "true needs" do exist, and that one role of the adult educator is to ". . . organize pedagogical situations where it becomes possible to understand more clearly how needs are constituted, whose interests are served, and in what ways they emerge in the context of their everyday lives"(p. 68).

This article provides an empirical case study of needs assessment work that was undertaken to provide a foundation for continuing education programming for health promotion practitioners in Saskatchewan. We begin by describing the context of the Saskatchewan Heart Health Program, in order to explain why we engaged in a needs assessment process. We then narrate the process of the needs assessment itself, in order to detail how we went about assessing needs. We briefly describe selected results from our

research, and discuss continuing education activities that have been developed subsequently. Finally, we explore the implications of our experiences, which, although practical in their general orientation, speak to several of the conceptual issues identified in our introduction.

The Saskatchewan Heart Health Program[1]

The Saskatchewan Heart Health Program (SHHP) began in 1989 with a mandate to study and promote means to reduce cardiovascular disease in Saskatchewan. It emerged and evolved as one of ten provincial programs in the Canadian Heart Health Initiative, whose major partners include Health Canada, the Heart and Stroke Foundation, and provincial governments (Health and Welfare Canada, 1992; Stachenko, 1996). In 1989 and 1990, the SHHP conducted a provincial epidemiological survey (n=2,167) to determine the prevalence of heart disease and stroke and the distribution of "risk factors" (e.g., high blood pressure, smoking, physical inactivity, high blood cholesterol) for cardiovascular disease among adults from 18–74 years of age. From 1992 through 1997, community demonstration projects in Regina and the Coteau Hills region were undertaken in order to assess the effectiveness of a range of community-based initiatives in promoting heart health. In 1998, the SHHP began a five-year "dissemination phase," with the theme of "building health promotion capacity" across the province.

The evolution of the SHHP occurred within the context of substantial reforms to the health-care sector in the province. At a policy level, Saskatchewan Health (1992) elaborated four key principles of its "Wellness Approach" to health care:

- create a health system that is responsive to community needs by placing control and management responsibilities at a local level;
- balance the health system's current focus on treatment by emphasizing disease and accident prevention, consumer information, health education, health promotion, and early intervention;
- eliminate inequities in the health system by responding to the needs of women, families, the elderly, persons with low incomes, and others with special health needs; and
- make the health system more effective and efficient by integrating institutional, community-based, and preventive programs, and by

reducing waste and unnecessary duplication at all levels.(p. 11)

At an organizational level, the government of Saskatchewan passed the Health District Act in 1993 to restructure the health service delivery system through the formation of regional Health Districts and district health boards. Thirty Health Districts were formed in 1993, and three more were formed in northern Saskatchewan in 1998. Health Districts are responsible for a range of health care services, including acute care, ambulance services, long-term care, palliative care, home care, public health, health promotion, addiction and mental health services, physical and occupational therapy, nutrition counselling and education, chiropody, dental health education, and speech pathology. Most physicians work independently of districts. Boards that are composed of a majority of elected members and a minority of provincial government appointees govern the districts, which vary considerably in their size and characteristics. Districts consist of territories ranging from vast and sparsely populated rural areas to the urban centres of Saskatoon and Regina; over three-quarters of them have populations of between 11,000 and 21,000, while the two largest districts have populations of over 200,000.

As identified above, in the second and third elements of its "Wellness Approach," Saskatchewan Health expects Health Districts to reorient the provision of health services from a medical model towards a health promotion model. As part of this expectation, each district is required to designate a staff person to function as a "Health Promotion Contact" in liaison with Saskatchewan Health and other districts. In the context of health reform, the SHHP works to promote heart health in Saskatchewan by helping to build the districts' capacity to operationalize the health promotion approach. The SHHP has two fundamental objectives: to help the districts build their capacity to plan, implement, and evaluate health promotion activities; and to understand the capacity-building process, so that practitioners in other disciplines and geographic areas might also enhance their capacity for related work. Figure One provides a graphic illustration of what the SHHP is trying to accomplish.

As Figure One indicates, the ultimate goal of the SHHP is to positively influence the health of people in Saskatchewan. We approach this goal through enhancing the "capacity" of health promotion practitioners, working with Health Districts, to engage in effective heart health promotion action. We conceptualize capacity as a set of knowledge, skills, and commitments required by individuals to conduct effective health promotion. Individual practitioners apply their capacity for action in the

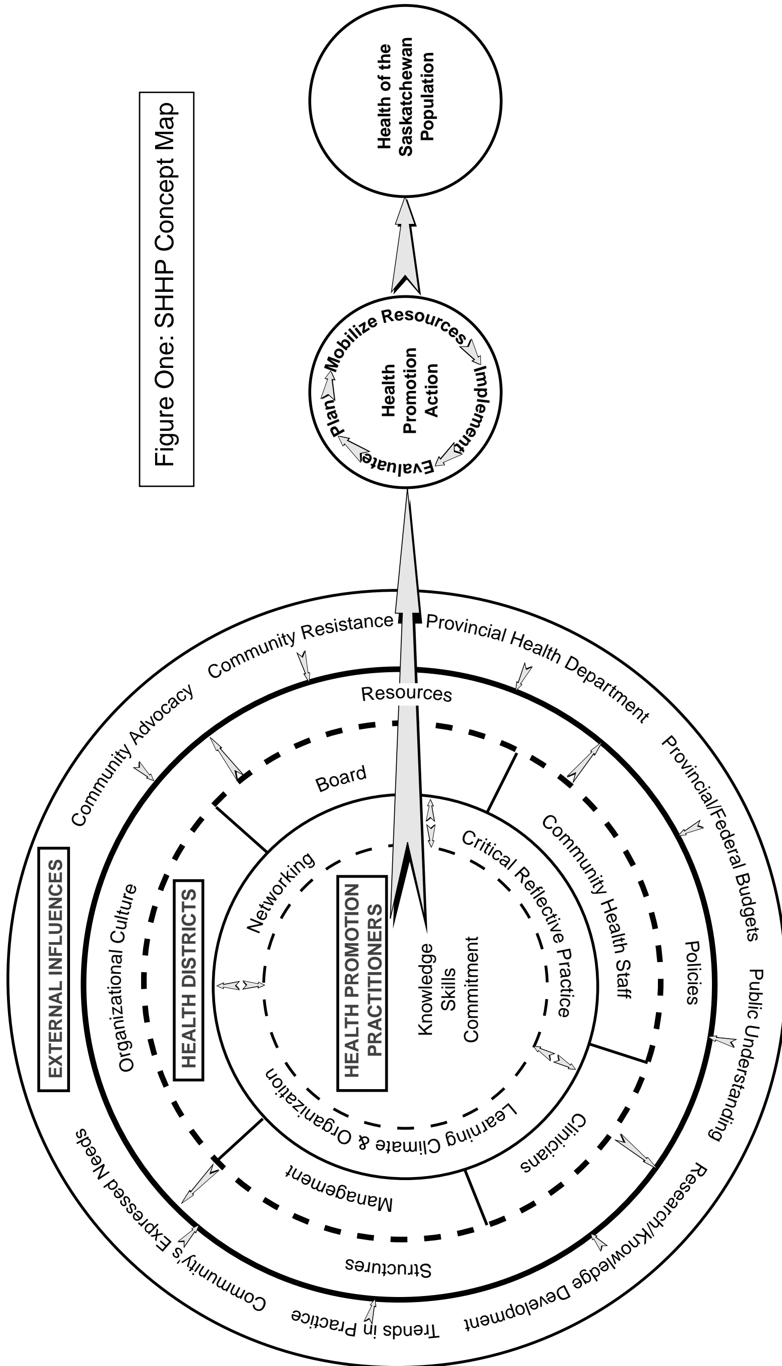

Figure One: SHHP Concept Map

context of the organizations with which they work. The capacity of these organizations is determined in part by the knowledge, skills, and commitments of the individuals who compose them.

At the organizational level, capacity also entails elements of organizational culture, structure, policies, and resources. These elements, in turn, help to promote and constrain the capacity of individuals working within the organizations. As Figure One indicates, both individual and organizational capacity for health promotion work are mediated by a range of external influences that either enhance or constrain health promotion action. Despite the impact of these external influences, we assert that increasing the capacity of individuals and organizations will enhance their action in health promotion, which, in turn, will have a beneficial impact on the health of the people of Saskatchewan.

The SHHP approach to building the capacity of health promotion practitioners is rooted in a continuing education strategy that is provided in three forms. First, we organize conferences, workshops, and other events at which practitioners can improve their knowledge and enhance their skills related to health promotion. Second, we provide consulting services through which practitioners can individually access information, resources, and advice concerning specific health promotion challenges. Third, we facilitate a peer networking system, through which practitioners interact with each other, both in person and on-line, for learning, resource sharing, and professional support. These three interventions are organized in conjunction with research activities designed to both understand the capacity-building process and ascertain the contribution of continuing education to that process.

SHHP activities integrate research and continuing education in a cyclical manner, that is, research processes inform the design of our interventions, and evaluation of the interventions identifies areas to be investigated through further research. Within this cycle, the SHHP undertakes several main data-gathering strategies: annual surveys of both senior managers and Health Promotion Contacts with 30 Health Districts in southern and central Saskatchewan;[2] intensive interviews with representatives from two case study districts; a review of official documents from roughly one-third of the districts; key informant interviews with knowledgeable observers from across Saskatchewan; and evaluation of specific continuing education interventions using Kirkpatrick's (1994) "four levels" of evaluation (satisfaction, learning, behaviour change, and impact).

Needs Assessment with the Health Promotion Contacts

Three factors contributed to the foundation upon which the SHHP plans its continuing education services to health promotion practitioners across Saskatchewan. First, the past experiences of the SHHP team constituted a significant source of insight into the learning needs of health promotion practitioners. The six staff members have many years of experience as independent consultants and staff members with organizations such as the Prairie Region Health Promotion Research Centre, the Heart and Stroke Foundation of Saskatchewan, and the previous phases of the SHHP. Of the four faculty members, two are professors of Community Health and Epidemiology, one is a professor of Extension, and one is the province's Chief Medical Health Officer. At an informal level, our collective intuition, reflections, and conversations with colleagues constituted a form of needs assessment. More formally, team members had already participated in numerous research and education initiatives involving Health Districts, and so had previously taken part in efforts to assess the learning needs of district personnel.

Second, the SHHP engaged in a number of qualitative research processes to enhance its understanding of the capacity-building and learning needs of health promotion practitioners. These processes included interviews with key informants, case studies of two Health Districts, and numerous consultations with health promotion practitioners. Third, the SHHP designed and administered a largely quantitative survey of Health Promotion Contacts. The following discussion narrates the development of the "Health Promotion Contact Profile" survey instrument, while the subsequent section provides basic results from this formal needs assessment process.

Health Promotion Contact Profile

Our survey instrument involved more than two years of development. From July 1996 through April 1998, we reviewed existing literature and generated a theoretical understanding of the capacity-building process for health promotion practitioners. This process, required as part of our application for research funding from national agencies, created a solid foundation for engaging practitioners in discussions related to health

promotion practices and their implementation in organizational settings.

In May 1998, we hosted a two-stage think-tank of health promotion practitioners and researchers to review our conceptualization of capacity-building, and to explore our ideas about measuring capacity. The first stage was a one-day meeting of eight exemplary health promotion practitioners who were invited from the government, the urban and rural Health Districts, and the not-for-profit sector of Saskatchewan. They gathered to discuss the practice realities of health promotion in the Health Districts, to identify elements of health promotion capacity, and to discuss implications for SHHP strategic planning. This day elicited a Saskatchewan vision of a capacity-rich environment within which health promotion could flourish. It also helped identify assets, limitations, challenges, and opportunities, as well as possible actions and the qualities of an individual with high capacity for health promotion work. Subsequently, questions firmly grounded in the Saskatchewan context were developed for the Health Promotion Contact Profile.

The second stage of the think-tank brought together seven experienced researchers from across Canada for one and a half days. This stage was designed to draw on the experiences of others engaged in health promotion and capacity-building research in order to build on our conceptualization of health promotion capacity. Discussions were particularly valuable in developing relevant domains for our instruments—the surveys, as well as case study interview guides and key informant interviews.

Finally, from June to September 1998, we consulted with Health Promotion Contacts from across the province to determine their views about our conceptualization of capacity and to pre-test the survey we intended to use to measure it. All of them were invited to a dinner meeting in June 1998 to pre-test the survey instrument. Round tables of six to eight participants reviewed the draft survey section by section, and focused their discussions on question clarity, relevance, readability, and understandability. SHHP representatives served as facilitators and recorders of the discussions; responses were collated and suggestions incorporated into the draft survey instrument. The revised version was subsequently circulated to a sub-group of practitioners for their feedback. In October 1998, the Health Promotion Contact Profile Survey was sent out; 27 of 30 respondents returned their completed surveys.

Results of the Needs Assessment

The Health Promotion Contact Profile Survey generated a wide range of findings useful to our assessment of the learning needs of health promotion practitioners. In this article, we focus on three issues.

First, we learned more about the characteristics and diversity of this group of learners. The 27 survey respondents held a variety of different positions with the Health Districts. Specifically, 12 were employed as directors or coordinators of health promotion, five as community health educators, five as public health managers or nurses, three as directors of community services, and one each as social epidemiologist and public health nutritionist. A majority (24) of the Health Promotion Contacts were female. In terms of age, six were in their twenties, nine were in their thirties, seven were in their forties, and five were in their fifties; in terms of formal educational attainment, five had undergraduate certificates or diplomas, 17 had a bachelor's degree, and five had a master's degree. Not all respondents had health sciences backgrounds. Although 14 of them were educated as nurses, four graduated from commerce programs, four from home economics programs, and two each from education and health sciences fields other than nursing. A total of seven respondents had additional, formal qualifications in health care administration.

The Health Promotion Contacts had served in their current positions for an average of three and two-thirds years and had been employed in the health or human services sector for an average of over 15 1/2 years (see Tables One and Two for the full distribution). They had significant professional experience in the health and human services fields, but were fairly new to their current roles with the Health Districts.

Table One
Length of Service in Current Job

(n=27)	Frequency	Percentage
Less than 18 months	11	41%
18 months–3 years	8	30%
Over 3 years	8	30%

Table Two
Length of Service in Health or Human Services Professions

(n=27)	Frequency	Percentage
Less than 18 months	0	0%
18 months–3 years	5	19%
4–10 years	7	26%
11–20 years	6	22%
Over 20 years	9	33%

Second, we learned about the areas of health promotion work in which the Health Promotion Contacts had relatively more or less self-confidence in their knowledge and skill. To help us assess their learning priorities, we asked for their self-assessment concerning their capacity to understand, apply, and implement eight major health promotion strategies (identified on Table Three). Respondents were asked to rate themselves for each of these strategies according to three prompts: "I understand what it is," "I know when it is appropriate to use it" and "I am capable of doing it." Each prompt was rated on a five-point scale, with five indicating the highest level of confidence. Table Three reports the average of responses to the three prompts. For each of the three original questions, the ordinal ranking of the eight strategies was identical to that reported on Table Three.

Table Three
Knowledge and Skill in Eight Health Promotion Strategies

(n=27, unless noted)	Mean	Standard Deviation
Health education at the individual level (n=26)	4.31	0.65
Public awareness campaigns	4.30	0.54
Small group development	3.95	0.69
Coalition or partnership building	3.94	0.77
Mutual support or self-help	3.84	0.98
Community organizing or community development	3.74	0.70
Healthy public policy development or advocacy (n=26)	3.69	0.77
Social marketing	3.32	0.71
Overall (n=25)	3.89	0.56

The Health Promotion Contacts were more confident with regard to traditional approaches to health promotion, such as individual health education and public awareness campaigns, than with approaches such as social marketing and advocating for public policy change. In addition to the differing levels of confidence expressed by the respondents for different approaches to health promotion, there was a clear and substantial gap between what they understood and what they were capable of doing. Across the eight health promotion strategies, the mean response, on a five-point scale, for understanding the strategy was 4.33. In contrast, the mean for knowing which contexts in which to apply the strategy was 3.84, while the mean for being capable of using it was 3.54. As Table Three indicates, the overall mean for the index of all three prompts was 3.89.

Table Four
Health Promotion Process Skills

(n=27, unless noted)	Mean	Standard Deviation
Providing training for others	4.15	0.72
Sharing power	4.00	0.68
Collaborating with grassroots people	3.89	0.97
Advocating within the District (n=26)	3.85	0.78
Facilitating a group	3.81	0.96
Working with diverse groups	3.78	0.75
Building linkages within communities	3.70	0.87
Nurturing relationships with leaders	3.70	0.87
Critically reflecting on my practice	3.63	0.97
Disseminating innovations	3.63	0.74
Mobilizing people around an issue	3.52	0.89
Assessing needs of people in my District	3.44	0.93
Strategic planning	3.33	1.11
Using research findings in work	3.22	1.09
Resolving conflict (n=26)	3.19	0.80
Evaluating health promotion initiatives	3.04	1.02
Overall (n=25)	3.63	0.57

In addition to asking respondents to assess their capabilities with regard to broad approaches to health promotion, we also asked them to assess

their abilities in functional skill areas. For each of 16 different skills, we asked them to rate their abilities from low (1) to high (5) on a five-point scale. Table Four summarizes the results of this question by ranking the skill areas as indicated by respondents from that in which they were most confident to that in which they were least confident.

Several of the weakest process skills of these respondents involved the integration of research skills with health promotion processes, while several of their relative strengths involved the use of social and educational skills.

Third, the survey provided information about the learning strategies preferred by the Health Promotion Contacts. We asked respondents to rate, on a five-point scale, how they would prefer to engage in future professional development. Table Five ranks, from high to low, their preferences for nine different professional development strategies.

Table Five
Preferences for Professional Development Processes

(n = 27, unless noted)	Mean	Standard Deviation
Health Promotion Contacts' meetings	4.30	0.87
Conferences, workshops, seminars	4.11	0.70
Health Promotion Summer School	4.07	0.83
Talking with peers or consultants (n=26)	4.04	0.72
Using the Internet (n=26)	3.73	1.12
Mentoring	3.70	1.03
Satellite training	3.63	1.11
Enrolling in formal training or classes	3.41	1.28
Reading on my own	3.19	1.08
Overall (n=25)	3.86	0.52

The Health Promotion Contact Profile that resulted from the survey enabled the SHHP to learn about who our target audience was, what their learning priorities were, and how they preferred to accomplish their learning. These findings subsequently allowed us to craft guidelines for organizing and delivering continuing education to our adult learners. The practical implementation of these guidelines was discussed and refined at a think-tank of Health District representatives in June 1999. Based on our stronger understanding of what the Health Promotion Contacts' learning

priorities were, and the strategies through which they preferred to undertake their professional development, we planned continuing education activities, using a variety of delivery strategies, for 1999–2000. In August 1999, we delivered a four-day summer school concerning the transition from principles (conceptual understanding) to practice in population health promotion. In September 1999, we delivered, via satellite telecast with learning sites, a one-day workshop on evaluating intersectoral programs. In subsequent months, we plan to deliver regional workshops, to interdisciplinary audiences from several Health Districts, on specific issues in health promotion practice. We also continue to have a regular SHHP session at the biannual Health Promotion Contacts meeting. Finally, we launched an Internet list-server to connect practitioners in health promotion and related fields, and advertised a toll-free number for accessing our health promotion consultants.

Implications for Needs Assessment Work

The experience of our needs assessment research with health promotion practitioners in Saskatchewan has several useful implications for other university continuing educators. At a most basic level, our approach offers a number of insights about the technical procedures of conducting a needs assessment. Our blending of formal and informal, quantitative and qualitative methods enabled us to construct a rich understanding of our learners, their priorities, and their learning preferences. The collaboration of learners throughout the process both improved the rate and quality of the responses to our formal survey and enhanced the relevance and validity of the survey questions. It also gave us greater confidence that the respondents understood the questions, and had responded to them in a manner consistent with our original intentions. During the instrument development process, respondents had several opportunities to pose queries about the survey, and to talk with their peers about what the survey questions meant. Finally, the ongoing, cyclical nature of our continuing education and research activities provided the opportunity for the cumulative improvement of our efforts in both areas.

Beyond technical issues, this case study of needs assessment research contributed to the practice and theory of needs assessment in adult and continuing education. In the introduction to this article, we identified both practical barriers and conceptual resistance to undertaking needs assessment in adult and continuing education. At a practical level, we

identified practitioners' hesitance to devote scarce resources to processes that may not result in better-quality programming. Clearly, the resources and time invested by the SHHP in the process described in this article were unusually high for non-credit programming activities, but the investment makes sense for our purposes, which involve both continuing education programming and formal research responsibilities. Would it also make sense for university continuing education programmers without such research responsibilities? When it comes to the conventional reasons for needs assessment, it probably would not. We likely would have come to similar conclusions about the substance and process of our continuing education strategy had we relied on our past experiences, intuition, and informal consultation processes. However, our efforts resulted in three distinct outcomes of substantial benefit to the SHHP continuing education effort.

First, our work had a tremendous marketing impact. The collaborative nature of our research process improved awareness of, and receptivity towards, our continuing education activities. By actively involving the target audience of learners in the process, we not only made them aware of our intention to offer continuing education events, consulting services, and peer networking facilitation, but also assured them that our offerings would reflect their priorities and preferences.

Second, the needs assessment process itself had a substantial pedagogical impact. SHHP's overall goal is to help build capacity for health promotion work in Saskatchewan. Through our research process, we brought together Health Promotion Contacts, asking them to think about, and talk collectively about, what capacity for health promotion means, and how to build such capacity. Thus, in addition to its research and program-planning roles, this process served a direct pedagogical purpose: it encouraged learners to systematically reflect on their health promotion experiences and think about how they might become more effective in health promotion work.

Third, the process of developing the Health Promotion Contact Profile provided the SHHP with an opportunity to role model a participatory, community development approach to health promotion program development. We believe that becoming more committed to, and capable of, undertaking collaborative and democratic processes is a significant component of capacity to engage in health promotion. In effect, we tried to "walk the talk" of our approach to health promotion program development. This explicit role modelling has been acknowledged and appreciated by

several Health Promotion Contacts.

At a conceptual level, our introduction identified objections to the nature and political implications of needs assessment activities. In contrast to claims that these activities are typically manipulative, individualizing, and focused on people's deficiencies, we argue that our needs assessment work was transparent, group-building, and focused on people's capacities. From the outset, our target audience of learners was aware of our objectives in the areas of capacity-building and research. Although individuals ultimately responded to our survey, we actively organized group processes and encouraged peer communication about the nature of capacity, and capacity-building, in the area of health promotion. By using "capacity" instead of "needs" as the organizing concept of our communication with the Health Promotion Contacts, we shifted the focus of our discussion away from deficiencies and towards assets. While open to criticism, we suggest that the SHHP needs assessment process had a positive impact both on our learners and for our work. Discovering their learning needs may have been our intention, but building and enhancing relationships with the learners has been an equally important outcome.

Notes

1. The Saskatchewan Heart Health Program is funded by the National Health Research and Development Program of Health Canada, the Heart and Stroke Foundation of Saskatchewan, and Saskatchewan Health.

2. The SHHP makes its continuing education interventions available to all Health Districts in Saskatchewan. However, since three districts were formed in northern Saskatchewan in 1998, five years after the other 30 districts, we decided to focus our research efforts on the districts in southern and central Saskatchewan. We believe that the context and capacity-building processes in the newer districts would be sufficiently distinct that we could not include them in the same research methods as the others. We also believe that we do not have sufficient resources to adequately study both sets of Districts.

Acknowledgment

The authors acknowledge the contributions made by the following colleagues in the development and delivery of the program described in this article: Joan Feather, Meredith Moore, Lorraine Khatchatourians, Georgia Bell-Woodard, Bonnie Sproat and Karen Schmidt. Funding for our research has been provided by Health Canada's National Health Research and Development Program, the Heart and Stroke Foundation of Saskatchewan, and Saskatchewan Health.

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