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Creating workforce solutions

Evaluation of the Learning by Doing courses for CHETRE and SWSLHD

FINAL REPORT

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Acronym reference list

CHETRE	**Centre for Health Equity Training, Research and Evaluation**
HIA	Health Impact Assessment
LBD	Learning by Doing
LHD	Local Health District
MMAT	Mixed Methods Assessment Tool
NCVER	National Centre for Vocational Education Research
NGO	Non-Government Organisation
OECD	Organisation for Economic Co-operation and Development
PHERP	Public Health Education and Research Program
PHN	Public Health Network
SSWAHS	Sydney Southwest Area Health Service
SWSLHD	Southwestern Sydney Local Health District
UNSW	University of New South Wales
WILDC	Working in Locationally Disadvantaged Communities

Executive summary

‘Learning by Doing’ (LBD) is a term broadly synonymous with ‘active learning’, ‘experiential learning’, ‘project-based learning’ and ‘trial and error’ learning.

The Centre for Health Equity Training, Research and Evaluation (CHETRE), located administratively within the Southwest Sydney Local Health District (SWSLHD)[1], has been conducting ‘learning by doing’ training for the health and related workforces since 2005 to build workforce capacity to influence planning of projects, programs, and policies in population health and health equity. Two courses, one aimed at assisting personal to undertake health impact assessments (HIAs) in communities, and to support workers and community members ‘Working in Locationally Disadvantaged Communities’ (WILDC), have relied on LBD teaching principles.

Since that time there have been four HIA courses conducted and five WILDC courses completed with an estimated 180 number of total course participants. Apart from the early courses which were comparatively well funded, courses have had to be delivered with limited funds and inventive use of CHETRE and its partners’ resources.

Both HIA and WILDC courses had previously been independently evaluated (Hirono, 2015; Krishnan, 2018 respectively). The focussed task of this evaluation was to review both courses from the primary lens of LBD. The method involved an audit of past program effort, review of relevant literature, and interviews with course managers and coordinators, past participants in the courses and workplace managers of those participants and other stakeholders.

The findings of the evaluation first attempted to confirm that the courses were LBD, and if so, were they consistent with a ‘best practice’ LBD approach. While LBD is an old concept stretching back to the Greek philosophers, the acknowledged more modern champions of LBD have been Knowles (1984) and Kolb and Kolb (2013). Knowles posed a break-through conceptualisation of the way adults learn, which he encapsulated in four principles:

- Adults need to be involved in the planning and evaluation of their instruction
- Experience (including mistakes) provides the basis for the learning activities
- Adults are most interested in learning subjects that have immediate relevance and impact to their job or personal life
- Adult learning is problem-centred rather than content-oriented (Knowles, 1984).

Adopting these principles and additional thoughts from Kolb and Kolb (2013), Krishnan (2018) sought to develop a set of criteria for what would constitute best practice for learn-by-doing approaches for training. They identified six key components of LBD by which to assess best practice. The two courses were assessed against these criteria and were considered to have satisfied most if not all these criteria, thus approaching best practice LBD.

A critique of CHETRE’s efforts was that the courses have been conducted for many years but not yet been evaluated according to a structured M&E Framework and in a way that provides strong quantitative evidence about impact and outcomes. This might have been a consequence of the funding deficit. Qualitatively though, both the courses were valued and considered to be providing valuable (potentially career changing) learning outcomes for most participants. Some of the major positive impacts perceived by persons interviewed were the following:

[1] CHETRE is a designated unit within SWSLHD’s Population Health entity. Using LBD, a body of HIAs and all WILDC courses have been conducted within the SWSLHD geographical footprint and involving local participants.

- Development of intersectoral partnerships and collaborations between participants and with engaged employing organisations
- Positive impacts of HIAs in the development of major community projects
- Improved skills for trainees in project work, including planning, evaluation and reporting
- Greater awareness of the issues of health equity and disadvantage. Participants of both the HIA and WILDC training believed these outcomes were primarily obtained through the application of the LBD approach
- With some training projects, greater engagement between service providers and disadvantaged communities, with some projects/initiatives persisting over time and still subscribed to by the community

Most interview respondents agreed that LBD approaches were well suited to training in the workplace. It was felt that training in the public health and health promotion areas, where health equity is a key consideration, are amenable to LBD approaches, as asserted in the following comment from a trainer:

> *"It will be important to continue to focus efforts on health equity and working with disadvantaged communities. For this we need teams that can work for the development of such communities to achieve better health outcomes. LBD is a relevant and practical approach for the training of such teams."*

Other programs suggested by interviewees as being suited to the LBD approach included: the systems approach; citizen science; report writing and communication skills for cadets.

LBD seems especially helpful in facilitating learning about the issues of power relations and community empowerment. One trainee noted:

> "*There were many discussions on this topic throughout the training. Actually, working on the projects meant that everyone had to regularly think about how to engage the community, and also about the importance of empowerment and communities being active in their own development*"

Some other key findings from the evaluation were:

- The courses are too long, stretching over 12 months, risking participant dropouts and loss of participant motivation and momentum.
- Both courses, but especially the WILDC course, need to be reviewed and rearticulated to focus more on currently under-covered content. This is especially relevant to content on power and community engagement.
- Because of under-funding, the courses have been prevented from pursuing a quality improvement pathway and any potential for growth in demand has been undermined.

A range of recommendations have been provided for short-, medium- and longer-term interventions intended to improve the content, conduct, structure and quality consistency of the courses, improve the accountability and sustainability of the courses through tighter governance arrangements and quality improvement measures, and grow and promote a stronger vision for the future of the courses.

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1. Introduction

Background

'Learning by Doing' (LBD) is a term broadly synonymous with 'active learning', 'experiential learning', 'project-based learning' and 'trial and error' learning. The concept and process derive from Knowles break-through conceptualisation of the way adults learn, which he based on four principles that apply to adult learning:

- Adults need to be involved in the planning and evaluation of their instruction
- Experience (including mistakes) provides the basis for the learning activities
- Adults are most interested in learning subjects that have immediate relevance and impact to their job or personal life
- Adult learning is problem-centred rather than content-oriented (Knowles, 1984).

The Centre for Health Equity Training, Research and Evaluation (CHETRE), located administratively within the Southwest Sydney Local Health District (SWSLHD)[2], has been conducting 'learning by doing' training for the health and related workforces since 2005 to build workforce capacity to influence planning of projects, programs, and policies in population health and health equity. The training was initially aimed at assisting personal to undertake health impact assessments (HIAs) in communities. However, following a needs assessment undertaken by the Public Health Education and Research Program (PHERP) in 2006, CHETRE, with the support of SWSLHD, further adapted the training for 'Working in Locationally Disadvantaged Communities' (WILDC). The needs assessment had found there was a well-developed understanding of the social determinants of health in relation to locational disadvantage, but the workforce had only limited understanding of how to identify and implement effective interventions (Harris et al., 2009). Consequently, the WILDC training program is focused on enhancing the problem-solving capabilities of the health workforce and partner stakeholders and their ability to take on projects for change in communities of locational disadvantage.

The application of LBD in relation to the above two programs (HIA and WILDC) is certainly active learning, experiential and problem-based, requiring training participants to work on a problem (a proposal, or an issue in the community) and then through a set of structured steps to collect and analyse data and write a report or develop and implement a project. Both courses are described in more detail In Appendix A including data on the number of times the courses have been offered, participant numbers, and past data collection on participant perceptions of the courses.

Purpose of this evaluation

The review of the LBD program is a quality improvement initiative for CHETRE and SWSLHD and will provide recommendations supporting effectiveness of LBD training run by CHETRE and Population Health SWSLHD. It was required to undertake the following tasks:

- Investigate the performance of the CHETRE LBD training and identify its impacts
- Focus on experiences from HIA and WILDC within an LBD approach (internal and external to SWSLHD)
- Consider other methodologies that LBD may be a suitable training approach for e.g., program logic, systems approaches, or co-design

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[2] CHETRE is a designated unit within SWSLHD's Population Health entity. Using LBD, a body of HIAs and all WILDC courses have been conducted within the SWSLHD geographical footprint and involving local participants.

- Review CHETRE's program of LBD training, but also consider a wider geographical scope across Australia and potentially OECD countries
- Make recommendations for the practice of LBD in SWSLHD.

The review sought to ascertain the impacts of the LBD training, identify current strengths and weaknesses of the programs in relation to the impacts, and make recommendations to further develop the training programs to improve workforce capacity to bring about necessary changes in communities of locational disadvantage.

2. Method overview

Overview of approach

The overall data collection approach adopted (mixed method) for this evaluation is outlined in Figure 1. More details are provided on each of these data collection activities in Appendix B.

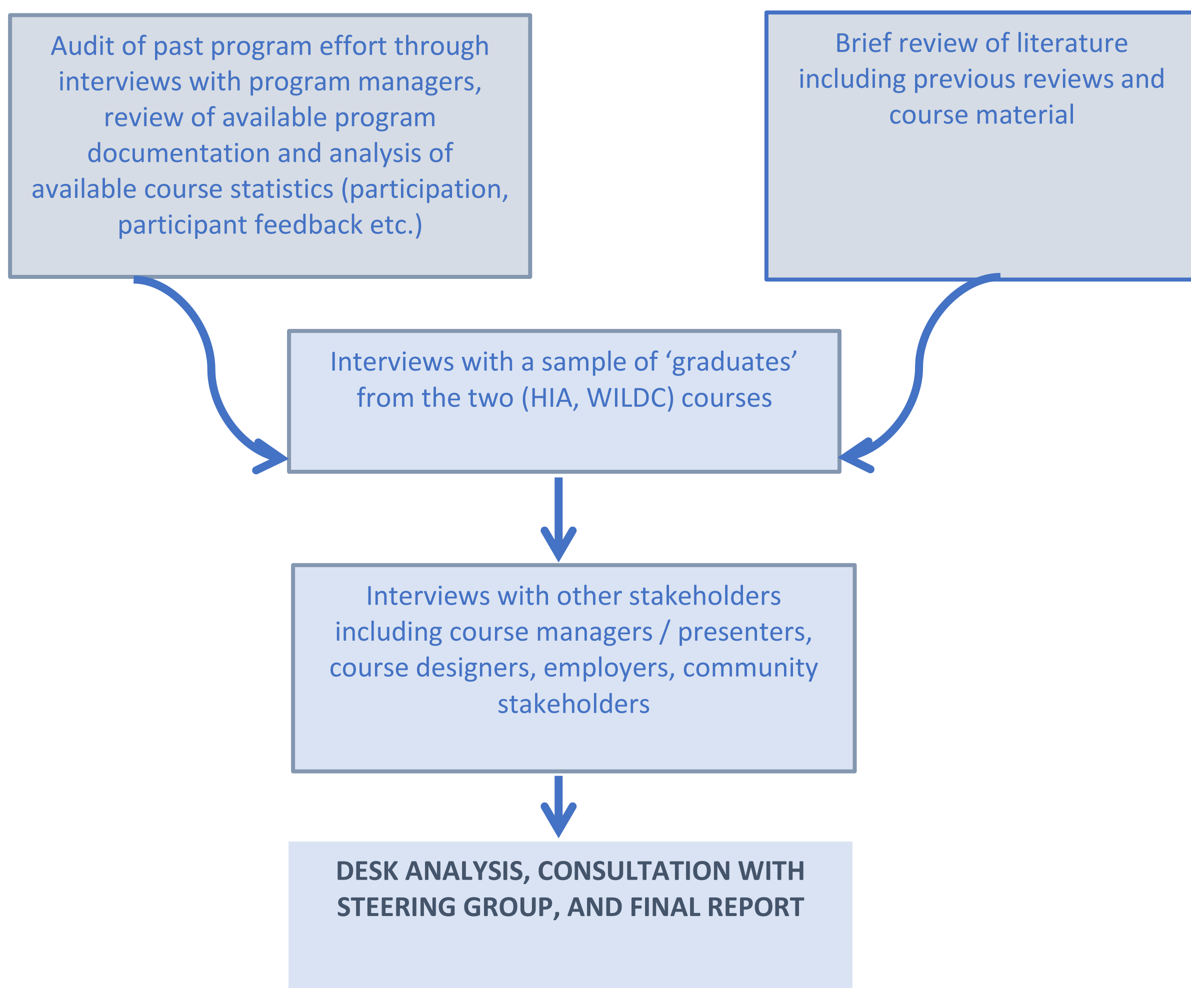

Figure 1: Diagrammatic overview of the mixed method approach

In the 'Data collection' section below, each of the approach elements seen in Figure 1 are briefly described.

Evaluation questions

Several key evaluation questions are provided below. These form the basis of data collection and analysis efforts:

- ➢ How impactful has learning by doing (LBD) run by CHETRE been? Why?
- ➢ What type of outcomes have been met or achieved through LBD (HIA and WILD) training, what has not been met or achieved?
- ➢ What are the facilitators and constraints to running effective LBD training as evidenced through the HIA and WILDC training? What is needed to better support effective LBD training?
- ➢ What other processes could be effective to run using LBD? Are these subject to similar or other facilitators and constraints?
- ➢ Does LBD investment develop capacity to change the way organisations do their business concerning health and equity outcomes?
- ➢ Can LBD activities and / or lessons and findings be adapted to be scaled up at a regional district level?

Data Analysis

This evaluation involved very little application of quantitative analysis. The purposive sampling of limited numbers of interview subjects did not support quantitative consideration or meaningful statistical analysis of LBD training outcomes.

Qualitative analysis was the focus in this project. A combination of content and thematic analysis (Ezzy, 2002) was used to identify themes and concepts from the interview data with the evaluation questions and interview schedule questions being used as a guide. Summary notes and impressions were developed at the completion of each interview, and these were included in the analysis.

3. Findings

Are the courses LBD?

What is LBD

Learn by doing, or experiential learning, is by no means a new concept, despite more recent terminology emerging to describe the process. Kolb and Kolb describe a long historical pathway of development stemming from John Dewey's *"…. call for a theory of experience to guide educational innovation"* (Kolb, p.10). Yet other authors cite a longer train of conceptual development, noting the great scholars who placed actual experience at the centre of their theories of human learning and development: William James, Kurt Lewin, Jean Piaget, Carl Jung, Carl Rogers, Paulo Freire and others. Even as far back as Aristotle in ancient times the notion of experiential learning was abroad *"… for the things we have to learn before we can do them, we learn by doing them."*

Put simply, learn by doing means learning from experiences resulting directly from one's own actions, as contrasted with learning from watching others perform, reading others' instructions or descriptions, or listening to others' instructions or lectures.

In 1984 David Kolb posited a theory of experiential learning, a four-stage cycle by which most adults learn, described as follows:

- First, immediate and concrete experiences serve as a basis for observation

- Next, the individual reflects on these observations and begins to build a general theory of what this information might mean
- In the next step, the learner forms abstract concepts and generalisations based on their hypothesis
- Finally, the learner tests the implications of these concepts in new situations.

After this step the process once again cycles back to the first stage of the experiential process.

Knowles (1980, p.41) coined the philosophy of 'andragogy', meaning the art and science of helping adults learn. He offered it as an alternative to 'pedagogy' which literally means the art and science of teaching children, and up until quite recent times was the dominant teaching form, even for adults. In an andragogy approach to education, the teacher is not all-knowing and the student not merely the passive recipient of bestowed knowledge. Other processes, such as experiential learning techniques, are utilised to empower students and maximise learning benefits. Experiential learning is firmly in the andragogical camp, acknowledging adult learners' desire to realise their own life goals and to be master of their own destiny (Knowles, p.43). As Knowles elaborates further on andragogy and why experiential learning works:

> *"People become ready to learn something when they experience a need to learn it in order to cope more satisfyingly with real-life tasks or problems. The educator has a responsibility to create conditions and provide tools and procedures for helping learners discover their 'needs to know.' And learning programs should be organized around life application categories and sequenced according to the learners' readiness to learn"* (Knowles, p.44).

Knowles considers both approaches – pedagogy and andragogy – as having relevant application depending on educational or training contexts. He therefore does not see pedagogy and andragogy as dichotomous approaches, but rather as "…. *two ends of a spectrum, with a realistic assumption in each situation falling in between the two ends*" (Knowles, p.43).

What is Best Practice LBD & do the courses comply?

Notably, one CHETRE trainer believes the LBD approach to be the strongest part of the training program provides, stating:

> *"LBD is best practice for teaching and training in the workplace. The project work undertaken is a collaborative, practical and meaningful effort to improve a project in community equity. It produces a good and efficient learning environment." (trainer)*

But this observation begs the question 'what are the best practice elements of the LBD approach?'. In her review of CHETRE WILDC training in 2018, Krishnan (2018) sought to develop a set of criteria from the literature on what would constitute best practice for learn-by-doing approaches for training in the public and community health field. She identified six key components of LBD by which to assess best practice, as follows:

I. ensure enhanced knowledge and practical skills
II. provide an authentic approach to learning and problem-solving based on real-world problems,
III. involve collaboration and teamwork,
IV. provide opportunity for reflective practices,
V. produce project deliverables to structured real-world deadlines and
VI. engage external support from mentors or professionals.

These would appear to be reasonable elements by which to assess the CHETRE LBD training programs in HIA and WILDC. To these we must add Knowles' cautionary note that the best training programs are likely to include both experiential and other training processes combined.

The background literature on the CHETRE courses suggests most of these elements of best LBD practice are addressed in one form or another. Regarding the first LBD element, '**ensure enhanced knowledge and practical skills'**, HIA trainees are required to consolidate their understanding of critical concepts in public health and HIA, such as health equity and the social determinants of health, and to apply technical skills including the ability to conduct a literature review and analyse data to create an evidence base. They must demonstrate their understanding of HIA methodology, including when and how to carry out a HIA, identify the relevant outcomes for development of recommendations, and how to produce a quality report on the HIA project (Hirono, p.4). Through the project work – learn by doing – and the attainment of both knowledge and specific skills through the training, the program seeks to "…… *empower organisations to feel competent to conduct HIAs as a result of their staff undertaking the training*" (Hirono, 2015, p.2)

For WILDC training, in relation to **enhancing knowledge and practical skills**, the trainees also undertake a collaborative project in a real community setting of locational disadvantage. The knowledge and skills are taught through lectures and workshops, expert support and a mentoring function. Trainees are taught negotiation skills in their project teams and learn how to manage change, and are provided with understanding of community needs assessment, locational disadvantage and practical skills in addressing consequent health inequities (Krishnan, 2018, p.15). They consolidate their learnings in these areas through the project work.

In addressing the notion of an **authentic approach within a real-world setting**, the CHETRE LBD programs seek to achieve this through their basis in project work. In the HIA training, projects are chosen by workers in the field, and/or by their employing agencies, to respond to and enhance planning of key project developments in prospect. The purpose is to ensure sufficient consideration of the issues of public health and health equity as priority goals within the planning and implementation of these community or public projects. These are important considerations in real world settings. Similarly, with WILDC training, the LBD approach requires the selection of training projects that address genuine needs in real communities. The authenticity of the projects derives from a focus on community engagement, where people from affected communities are represented in project planning and decision-making and volunteers and local community networks are drawn into the activity (CHETRE, 2004, p.27). To this end, the training promotes the development of negotiation skills in trainees and their project teams in their engagement with communities and other stakeholders (Krishnan, p.14).

Four of seven HIA trainees consulted noted the LBD training approach as being the aspect of the program that impressed them most:

> *"……… it enabled trainees to actually do something practical whilst learning at the same time - experiential learning on-the-job" (Trainee).*

Another HIA trainee respondent enthused that:

> *"The approach using an actual project was empowering and made me feel like an actual researcher doing something real and useful for the community" (trainee).*

A HIA trainer felt the training provided a great opportunity for service professionals and community or grass-roots workers to come together in project work in real settings. They saw this as being particularly helpful for health personnel doing the training:

> *"Health worker participants indicated it was good to get out into the community ... for some this was a surprisingly new (and important) experience." (trainer)*

The theme of **collaboration and teamwork** within the LBD approach is strong in the background literature for both the HIA and WILDC training. A key objective of HIA training is to:

"…….. better integrate HIAs and the concept of health equity into service organisations through the development of partnerships or collaborations across organisations and with community, and hence to facilitate follow-through of HIA project recommendations" (Hirono, p.3).

It is important that trainees learn the value of the partnership approach to draw in the diverse knowledge and perspectives of a range of stakeholders with different backgrounds and expertise (Hirono, p.2). Similarly, for WILDC training, there is a clear goal to facilitate inter-agency and inter-sectoral work in the attainment of health equity (CHETRE, p.27). The longer-term ambition through the CHETRE training is to foster sustainable ongoing partnerships in health equity between participating agencies and disadvantaged communities (Krishnan, p.14).

There was broad agreement amongst interview subjects that the LBD approach used by CHETRE, including project work, necessitated effective **'collaboration and teamwork'** amongst trainees, including participants from different backgrounds and agencies. As one trainee elaborated:

"The LBD team approach to HIA training was great in that it promoted inter-sectoral team working relationships, and a greater range of skills to be drawn on for projects. ….. with LBD you actually had to try out these things and work out problems along the way" (trainee).

The **opportunity for reflective practices** in HIA training is claimed in its requirement for trainees to reflect on how the HIA concept and practice fits within their own professional practice and organisation. It is also an aspiration that employing organisations reflect on their business and how they might integrate HIAs into their planning for health equity (Hirono, p.3). For WILDC, the training encourages participants and organisations to reflect on a shift towards community development approaches and community capacity building, as opposed to just one-on-one or clinical service provision (CHETRE, p.28). Such reflection is seen as important as a method of building workforce capacity in addressing health inequity (Krishnan, p.14).

In terms of a requirement to **produce project deliverables to real-world deadlines**, the LBD HIA training is particularly focused on structured stepwise learning and timeframes underpinning the project work. The trainees must understand each of the steps of HIAs and carry out each step to complete their project to agreed deadlines (Hirono, p.3). These steps include: HIA screening and scoping, review of literature, community engagement, creating a community profile, forming a project plan, implementation, recommendations and reporting (Hirono, p.3). Notably, the strictures around a structured approach seem less intense for the WILDC training and project work, with the conduct of local community health needs assessment and reviewing relevant literature being of core importance, but then less stepwise activity and looser constraints on project timeframes than is the case for HIA. In relation to the LBD element 'producing deliverables to real-world deadlines', one interviewee cautioned that LBD projects should be constrained in terms of duration, otherwise the project group can lose momentum and the collective energy fall away.

The structured approach from CHETRE to achieve project deliverables, at least in relation to the HIA training program, has been supported at interview. Two respondents liked the stepwise conceptualisation of health impact assessments, and the development of the training on similarly stepwise lines, one noting:

"……… the training was broken down to work through these steps. This was all consolidated by doing a real project of practical value – this was impressive" (BM).

The other advised the stepwise approach was:

"……. pretty well matched to the development of projects; that is, there would be a lecture program on some aspects of HIA, and then you would actually apply these learnings in the project you were doing" (SF).

Finally, the LBD element of **support and mentoring for trainees** is highlighted for both HIA and WILDC programs. For HIA, trainees are to be provided with specialist mentoring support, site visits

by CHETRE to each project team, and provision of help-desk support from CHETRE. In addition, whilst formal training takes place over six months, CHETRE support is provided for up to 18 months to enable satisfactory completion of projects (Hirono, p.3). Again, the WILDC program seeks to offer similar trainee assistance: expert support provided through a helpdesk and mentoring function, and some funding to support project teams. The goal is to build a more skilled workforce to work in contexts of locational disadvantage (Krishnan, p.14).

As evidence of **support and mentoring** being provided in the training courses, interviewees commented on the high level of support provided by the CHETRE training team and their enthusiasm as being strong features of the training:

> *"…….. they were passionate in their program and committed to applying a social justice and equity lens to the work and training. This was clearly evident in their approach to the training and their support for participants (trainee).*

and:

> *"They were right there all the time when needed for information or advice …. they were accessible and enthusiastic about the projects (trainee).*

Others were impressed with the quality of the training resources and speakers:

> *"The guest speakers were really good - knowledgeable, excellent quality presentations." (trainee)*

and:

> *"The training resources and lecture material used were really good standard." (trainee)*

However, some questions were raised about some of these elements of best practice. In particular, the **relevance of projects selected** for training projects was highlighted as a key issue for LBD training, and concern was expressed by some that projects selected were not sufficiently based on needs and issues in real communities.

> *" …….. it may not have worked out so well had I not had a clear idea for a HIA project when I entered the program. I saw others floundering a bit because they had to contrive a project to work on" Trainee).*

The implication here is that topic selection is vital, and there may need to be more effort focussed on ensuring that all training projects undertaken have clear associations and relevance to the jobs and workplaces of trainees.

Although most considered the **levels of support provided to trainees** as being excellent or adequate at least, a couple of respondents felt support for trainees in the programs needs some attention, one person commenting:

> *" ……. with LBD in an area like HIA, it is essential that adequate support is provided to the project teams throughout the training. If consistent, accessible support is not there, it is unlikely that the projects using LBD will be successful" (trainee).*

To summarise, it appears the elements of best practice LBD are being applied in the HIA and WILDC training programs, and that the area of building teamwork and intersectoral collaboration is particularly well appreciated. Some improvements could be sought in the areas of clear and relevant project selection, the allowable duration of training projects, and levels and types of support provided for trainees.

Impact of CHETRE LBD Training Courses

In considering the impact of the CHETRE courses in HIA and WILDC, we need to examine both the specific goals of these programs, and the role of the LBD training approach in aiding or hindering the attainment of these program goals.

Impact of Health Impact Assessment (HIA) Training

For the HIA training conducted in recent years by CHETRE, the training objectives for individual trainees have been described as the following:

I. Understand each of the steps in an HIA and where and how health equity is considered
II. Determine when and whether HIA is appropriate in each context
III. Describe HIA and its roles in improving health and health equity in populations
IV. Describe outcomes that can be achieved by carrying out HIA
V. Carry out each step and complete a HIA project
VI. Reflect on how HIA fits within one's own professional practice and organisation (Hirono, p.3).

Feedback obtained in the interviews indicates that most HIA trainees completed their training program, including completing a collaborative HIA within the training program (specific data on the drop-out rate of HIA trainees has not been obtained). Despite the absence of objective assessment, it seems likely that most trainees would have accomplished the six individual objectives for trainees described above because of undertaking and completing a HIA with other trainees. The following comments of one past trainee in relation to the stepwise HIA training program reassure on this assertion:

> *"We used the 4 key components of HIA in the stepwise process. This provided a well-structured tool to underpin a successful project. It gave my project team much more knowledge, information and insight than we would otherwise have been able to source for this work." (trainee)*

As well as individual participant objectives there are broader goals for the HIA course upon which to measure program impact. CHETRE objectives for the training were to:

- integrate HIAs and the concept of health equity into service organisations through partnerships and intersectoral collaboration
- empower organisations to feel competent to conduct HIAs because of their staff undertaking the training
- develop organisational skills in community and stakeholder engagement
- facilitate follow-through of HIA project recommendations and the initiation of future HIAs by relevant organisations (Hirono, pp.2-5).

With reference to the **development of partnerships and collaborations** across organisations, the HIA training has clearly had an impact, as the following comments attest:

> *"The most successful aspect was the relationship development that occurred between the organisations – LHD and Council. This was great and many of these relationships are still active today and have enabled people to come together for joint planning on current projects and work." (trainee)*

Ultimately some of these individual relationships have broadened over time to encompass partnerships and shared activities between the organisations from which trainees came:

> *"There is now a joint-funded position and a Healthy Environment Working Committee comprised of Council and LHD staff who bring their skills and efforts together for better health*

planning related to the environment. This probably wouldn't have developed without the CHETRE training all those years ago." (trainee)

Also:

"The HIA training program triggered a new process at the Council, a Social and Health Impact Policy, which is now applied to all new Development Approvals and major projects coming through the Council. This is a major improvement to Council planning processes." (trainee)

For **empowering organisations to feel competent to conduct HIAs**, because of their staff undertaking the training, the evidence of impact is less clear. Certainly, there has been enthusiasm for the influence some of the projects have brought to bear:

"Our HIA provided significant evidence for the Council to argue for equity and access issues, and community amenity within the project. It helped inform the Council campaign of 'A Great New Town, or No New Town at All'". (trainee)

In relation to another project, clear benefits were also claimed for the HIA:

"Our project had an important impact on the overall planning for the Western Sydney Airport – we are now able to make solid, robust recommendations for effective community engagement to the Airport project planners." (trainee)

Yet it is not clear that relevant organisations have initiated their own HIAs in the period following their staff undertaking the training. It also seems that for some HIA projects, the outcomes and impact have not been evident.

With the theme of **developing organisational skills in community and stakeholder engagement** as a consequence of the HIA training, again the evidence is equivocal regarding how well this objective has been achieved. Some respondents indicated significant engagement with community members in their projects requiring thinking around community engagement strategies, whilst others advised there were almost no community connections made as their projects were predominantly desk-top exercises aimed at promoting health equity at arm's length.

One interviewee expressed satisfaction with the ability to **follow-through on HIA project recommendations** when they spoke about their HIA project looking at a multi-purpose sports facility development:

"I believe our project was successful because we were able to produce 10 preliminary findings that were provided to the planners that ultimately informed the project that was eventually implemented: for example, recommendations for transport options, recreation, shaded car parks, whole community access, etc." (trainee)

In terms of achieving positive outcomes for HIA training, CHETRE trainers interviewed noted a range of relevant factors. One trainer saw success through a range of benefits to trainees, including:

- learning about the stepwise HIA process and where HIAs can be applied to improve planning for equity
- gaining deeper understanding of the factors that lead to health and wellbeing and equity in the community
- developing relationships across sectors which facilitate a broader team approach to health equity projects
- gaining stronger specific skills in project work, including planning, evaluation and reporting (trainer).

Major Benefits of HIA Training

For the current CHETRE HIA training programs, the major positive impacts perceived by interviewees appear to be the following:

- Trainees and their organisations Learning about the role of health impact assessments and its stepwise process
- Development of partnerships and collaborations between trainees and employing organisations
- Positive impacts of HIAs in the development of major community projects
- Improved skills for trainees in project work, including planning, evaluation and reporting

Impact of Working in Locationally Disadvantaged Communities (WILDC) Training

The specific knowledge areas for attainment required of individual WILDC trainees include the following:

- relationships between place of residence and health
- causes of locational disadvantage
- characteristics of locationally disadvantaged areas and how these impact health
- knowledge of types of intervention to address these characteristics (HCA, 2005, p.16).

The skills to be attained by trainees include to be able to:

- work collaboratively with colleagues, with other organisations and with community residents and organisations
- build productive relationships and partnerships in the field
- conduct community needs assessment
- undertake effective community consultations
- approach issues from a community perspective and take on a community development approach (HCA, p.9).

We have been able to find little data or evidence with which to measure attainment against the WILDC training goals. Perhaps the strongest indicator of successful training is associated with a perception of successful projects conducted within the training, as implied by the fact that several of these projects are still active today and being utilised and accessed by community members, even after several years since they were initiated. The following comments are indicative:

> *"I know our project was successful because it's still going today, supporting the community." (trainee)*

Interview feedback also inferred WILDC training brought **trainees and communities into closer connection and collaboration**, with one trainee stating:

> *"Our project has had ongoing benefits for community members who participated. The exercise programs were developed in the community and are still running today, and the demand is still high with people often asking to be signed up." (trainee)*

Another commenting on a high level of **engagement achieved with the disadvantaged community** in her project:

> *"The training facilitated a good level of community engagement and invited community leadership. This was refreshing because the health promotion programs, I had previously been involved with weren't really focussed on disadvantaged communities but tended to target the mainstream population. This CHETRE program was different." (trainee).*

One manager of some trainees was even stronger in her acknowledgement of the level of engagement achieved a training project:

> *"I know the project was successful because it is still functioning and active today in representing and advising community perspectives when the need arises. [The community group formed] …… are still regularly invited to various forums run by different agencies, and their views are still actively sought for projects and planning." (manager)*

There is some suggestion that the WILDC training also promoted a level of **intersectoral collaboration and partnership** development in the field:

> *"Working with the other organisations was also excellent, sharing ideas and experience in a team context." (trainee)*

Finally, one manager suggested a further potential measure of successful training is in relation to understanding the reasons for focusing efforts in disadvantaged communities:

> *"The training highlighted for people why it is important to focus efforts in disadvantaged communities, that special attention is required in these communities in the name of equity and improving health and wellbeing outcomes." (manager)*

However, it was unclear from interviews how well the WILDC training goal of **conducting community needs assessments** and, overall, the goal of **undertaking effective community consultations**, were realised.

Major Benefits of WILDC Training

For the current CHETRE WILDC training programs, the major positive impacts perceived by interviewees appear to be the following:

- Some projects/initiatives persisting over time and still subscribed by the community
- Improved intersectoral collaboration amongst organisations with participating trainees
- Greater awareness of the issues of health equity and disadvantage among trainees and their employers
- With some training projects, greater engagement between service providers and disadvantaged communities

Enablers & Constraints for Effective LBD training

Enablers for LBD

The Literature points to several facilitators or enablers for effective learn-by-doing training, for whatever topic being taught. For example, Reese (2011, p.14) highlight **three factors associated with effective LBD:**

- the ease or speed of the learning
- the relevance of what is to be learned
- the memorability of what is learned.

The advice here is relatively straight-forward – constrain the training period to shortest reasonable timeframes, make sure the training maintains clear relevance to the trainee's work area, and ensure the training curricula and structure for delivery remains stimulating and sufficiently challenging.

In support of the Reese et al. focus on the relevance of what is to be learned as an enabler, one of Krishnan's best practice LBD elements was that trainees choose project topics they are passionate about, that have real-life implications and that are considered high priority in the community (Krishnan, p.18). For HIA, projects are chosen by workers in the field to improve equity planning in

real projects. To base the training in real world settings is enabling for learners and is a hallmark of the CHETRE LBD approach.

The relevance of the training project topic to the working lives of the trainees was also highlighted in interviews, as articulated in the following:

> *"The key thing for the training is that an appropriate, relevant, and manageable project topic is agreed with the trainees. An academic or abstract piece of work would not be sustainable – the project has to be live, relevant and practical with obvious potential benefits for the community." (trainee)*

Knowles describes **a three-phase andragogical process for LBD trainers** to apply to support good LBD outcomes, as follows:

- The first phase is for a teacher/trainer to devise a model of competencies or characteristics required of students to achieve the desired performance or outcome. This can establish important agreement between the trainer (or training institution) and the learner on the expectations of the training program.
- The second phase is for trainers to provide their students with an assessment of their current level of competencies in the topic being covered, which helps students assess how they are progressing against the training requirements – the strengths and weaknesses of their performance in the subject area at any given time.
- The third sequential phase is to help students measure the gap between their present knowledge and performance compared to the training program expectations, the purpose being to provide both student and trainer with direction for program areas requiring focus and further work.

This process supports an andragogical environment of mutual responsibility for both teacher and student as both aim to achieve the desired training outcomes for students (Knowles, p.50).

In line with this sense **of mutual responsibility for the learning context**, Sisselman asserts that experiential learning is most productive when it is a parallel process:

> *"…….. students learn and provide feedback on these learning experiences, but also with teachers learning from their teaching experiences and student feedback and interaction and adjusting their own methods and techniques in response." (Sisselman, 2017, p.11).*

Kolb and Kolb (2017) created a tool to assist educators to apply an effective experiential learning approach to their teaching settings called **the Kolb Educator Role Profile (KERP)**. This can be used in the future as a way of assessing training performance (See Box 1).

BOX 1:

The Kolb Educator Role Profile (KERP) is an assessment that helps trainers understand their training preferences and make choices about what works best for them in specific learning situations.

The KERP describes four roles that effective educators use (see diagram). Educators play these roles as they help learners maximize learning.

In support of these enabling ideas and concepts from the literature, the Review interviews confirmed key requirements for effective experiential learning. Perhaps the strongest linkage between the

literature and interview feedback is the importance of the **training and projects being based on health and wellbeing issues of prime relevance to the trainees** and their work areas.

Further enablers for the LBD approach to training were identified through the interviews. Structuring the training to embrace **collaborative approaches for trainees across sectors** has been highlighted as a key ingredient for successful outcomes. As previously noted, Krishnan identified diverse membership of project groups in training as allowing for exchange of ideas and skills, mutual encouragement and support, inter-professional dialogue, and encouragement for development of ongoing partnerships.

A key objective of HIA training has been noted by Hirono to be to:

> *"……… better integrate HIAs and the concept of health equity into service organisations through the development of partnerships or collaborations across organisations and with community" (Hirono, p.3).*

Similarly, for WILDC training, there is a clear goal to facilitate inter-agency and inter-sectoral work in the attainment of health equity (CHETRE, p.27). These are not just goals of HIA and WILDC training but are enablers of the training itself obtained through the application of the LBD approach. And the notion that CHETRE applies collaboration and teamwork in its LBD training programs was broadly supported by interview subjects in the review, as exemplified in the following comment:

> *"The collaborative environment of creating and developing a project together in a real-world setting, with the support of the other professionals and CHETRE, was impressive and effective" (trainee).*

Structured approaches to the CHETRE training also support experiential learning. As Krishnan has stated, a high level of structure for projects and training programs supports project feasibility and provides sequential markers for progress against learning goals (Krishnan, p.19). The HIA training is built around structured stepwise learning and timeframes underpinning the project work (Hirono, p.3). Two interview subjects specifically referred to the benefits of the HIA training structure as enabling sequential learning in manageable chunks and synchronised with issues and challenges as they arose in the training projects.

The LBD best practice element of provision of **support and mentoring for trainees** is a further enabler for the CHETRE LBD training. The CHETRE support mechanisms of specialist mentoring support, site visits to each project team, and provision of help-desk support each facilitate the LBD approach. Most interview respondents noted a high level of support provided by CHETRE trainers as a key feature of the LBD approach.

Haigh et al highlighted the benefits of **having champions for HIA projects located in influential positions** to promote the projects. It has been observed that priorities in contemporary health service provision are centred around clinical care and engagement with individuals rather than on population health or preventive activities (2015, p.15). Consequently, shifting focus to health equity work with communities, rather than servicing individual clinical needs, could seem like too great a challenge for the health system. For this reason, CHETRE has argued that the success of WILDC projects is often dependent on the existence of champions for health equity in the system, to forge *"……. alliances with other managers to develop multi-disciplinary and multifunctional programs and services*." (CHETRE, p.39). This concern is well-expressed in a quote from a CHETRE report:

> *"……. interventions to address the needs of disadvantaged communities in new ways is often marginal to the workings of the mainstream health system and highly dependent on staff within the system who can secure resources and protect staff time to do things differently" (CHETRE, p.70)*

A final enabling feature of note is the necessity to include an appropriate mix of both didactic lecture style teaching of theory and skills as well as the essential learn-by-doing approach centred on the

planning and implementation of a project in a real-life setting. A pure learn-by-doing approach from first principles to the exclusion of providing information and stimulating thought on the work of all the experts and scholars that have come before, would be inefficient and naïve. This supports the CHETRE focus on lectures and workshops, as well as the projects, in their programs.

BOX 2: SUMMARY

The enabling factors identified for effective CHETRE LBD training include the following:

- ensure the training and project topic has clear, real-world relevance to the trainee's work area,
- Apply Knowles three-phase andragogical process for trainers
- Apply Kolb's self-assessment instrument, the Kolb Educator Role Profile (KERP)
- Adopt collaborative project approaches in training to stimulate intersectoral engagement and promote ongoing partnerships
- Adopt structured and stepwise approaches to the training to support trainees to learn sequentially in manageable chunks
- Utilize a judicious combination of lecture style theory work as well as the LBD projects
- Ensure a high level of trainee support in terms of accessible expert mentoring and advice
- Secure management support for trainees undertaking the program
- Establish constructive relationships between participating organisations and target communities

These same enablers for effective LBD training must be considered as important factors underpinning effective training in HIA and WILDC.

Constraints for LBD

The constraints or barriers to CHETRE LBD training are clearly the obverse of what has been listed and discussed above as enablers. However, some of these constraints need additional comment, and some additional barriers are added to the list.

The first issue to consider is that **a pure application of LBD for either HIA or WILDC training is unlikely to meet the needs of trainees**. Reese et al. have argued that learning by doing is not enough by itself, and that the gaining of knowledge and skills often requires more explicit guidance and discussion (Reese, 2011, p.4). They assert that learning is facilitated if students can ask questions, and have these questions knowledgably answered, if efficient learning is to take place. That is, a process of 'learn by doing as instructed' may be more efficacious, where students refine their knowledge/skill through their own praxis combined with the knowledge of teachers. (Reese, 2011) observes "…… *life is too short for direct learning of all the particulars that are relevant to successful practice"* and that it is best to combine both practice and theory, where theory is "……. *a distillation of previous persons' direct experiences and it is needed to guide present seekers of direct experiences*".

Fortunately, the CHETRE training programs offered are both rich in diversity of training modalities offered, built around the LBD component of a shared project, but ably supported with lectures, workshops, and mentoring support.

In relation to HIA training in particular, Haigh et al. (p.7) have observed problems arising when there are **differences or misunderstandings between stakeholders** about what changes a particular HIA is intended to facilitate. This can occur when the parties engaged have not clearly negotiated the aspects of a situation or program which are requiring change or modification. Such failure to achieve consensus at an early stage can mean that different stakeholders can hold diverging expectations about what the HIA is meant to achieve.

In her review of CHETRE HIA training, Hirono identified a few barriers or points of resistance to the conduct of HIAs in training. Some respondents to the review felt they were **granted insufficient time from their management** to dedicate to the HIA, thus leading to concerns that those undertaking the

projects would not have capacity to complete the tasks and continue with related work resulting from HIA recommendations (Hirono, p.19). Related to this, other pressing work priorities were seen as an obstacle to dedicating adequate time and energy to the HIA. In addition, **HIA projects and teams were granted limited funding and support** to undertake this work (Hirono, p.13). Context was given to this concern in the following comments from interview respondents:

> *"The LBD project approach is good, exciting, powerful. However, it is time and resource intensive, and therefore challenging as an approach for agencies to commit to." (trainee)*

and,

> *"HIAs are complicated and challenging. It's a big ask to complete a HIA that has strong relevance and application. LBD may be better suited for smaller, more straight-forward types of activities and projects." (trainee)*

Still others perceived that their managers were resistant to the conduct of the HIA, fearing that they would be tied to having to address the negative findings and consequent recommendations. Clearly, ambiguous management commitment to addressing the findings and recommendations of HIAs can constitute significant obstacles to the HIA concept and practice. In addition, for management in some organisations involved in the HIA projects, it seems they saw the LBD HIA training as principally a learning exercise rather than as an initiative that could benefit the work of their organisation. In sum, these issues could be said to arise from **a lack of management support for staff undertaking HIAs**, and this constitutes a key barrier to effective HIA training using LBD.

For WILDC training specifically, CHETRE has identified a further barrier – **lack of background expertise of trainees and project groups** to undertake WILDC projects in engagement with communities of locational disadvantage. This issue may be associated with the deep-rooted nature of problems in WILDC, including social determinants of health and upstream health challenges, and perception of current bias towards clinical care and direct treatment of illness; that is, less focus on public health, prevention and health promotion activities and strategies for the current health workforce. A key question is: "Do staff in population health, health promotion, and indeed in local government councils and other stakeholder organisations have the training and skills to work proficiently in and with affected communities?"

Skills required for this work include establishing relationships of trust with community people; listening to communities to negotiate priority concerns and transferring relevant knowledge and skills to the community to foster community

BOX 3: SUMMARY

The barriers or obstacles to effective CHETRE LBD training include the following:

- Differences or misunderstandings between stakeholders about what changes a particular HIA is intended to facilitate
- Insufficient time for HIA training and projects granted to trainees from their management
- Limited funding allocated to support HIA trainee teams and their projects
- A lack of management support for staff undertaking HIAs
- Lack of a clear leader identified within training project groups
- Unclear expectations upfront for trainees of what their involvement in HIA projects was likely to entail
- Concerns about safety of trainees, particularly with WILDC LBD training
- Competition for limited resources affecting work priorities in a range of service agencies
- A general lack of background expertise of trainees and project groups undertaking WILDC training projects
- Challenges to actively engage community members and volunteers to participate in the training programs

action (CHETRE, p.47). These are skills acquired with experience by health and community services workers. Early career practitioners may feel inadequately prepared and require additional training and support. It may be a challenge for the CHETRE training alone to make up the ground.

Finally, Krishnan has highlighted challenges to actively **engage community members and volunteers to participate in the training.** Involvement from these groups has been limited and where community people entered the training, it was found that their knowledge and skill level was generally lower than required to satisfactorily undertake the training. On this basis, training participants with health promotion backgrounds has been preferred for WILDC courses (Krishnan, p.12). This issue bears relationship to the ongoing challenge for CHETRE WILDC training to respond effectively to the diverse needs of the participants and projects and being able to pitch the training to meet all needs. The range of backgrounds of trainees undertaking the training, and being able to meet various participant needs, persists as a program challenge.

Other Activities to which LBD could be applied

Most interview respondents agreed that LBD approaches were well suited to training in the workplace. Learning on the job in real-world settings is seen as a good fit for training in busy service organisations. It was felt that training in the public health and health promotion areas, where health equity is a consideration, are amenable to LBD approaches, as asserted in the following comment:

> *"It will be important to continue to focus efforts on health equity and working with disadvantaged communities. For this we need teams that can work for the development of such communities to achieve better health outcomes. LBD is a relevant and practical approach for the training of such teams." (trainer).*

In supporting LBD approaches one respondent stipulated that LBD training must be well-planned and negotiated with stakeholders – a loose application would struggle:

> *"It is important that the LBD training is well-organised and structured, and that there be strong buy-in from the managers of staff undertaking the training." (trainee)*

Additional programs suggested by interviewees as being suited to the LBD approach included: the systems approach; citizen science; report writing and communication skills for cadets. Regarding the Systems Approach, applied by SWLHD recently and led by Professor Steve Allender at Deakin University, one manager explained:

> *"This activity seeks to engage key stakeholders in local councils to focus on the issues of obesity in the community when they undertake their various planning work. For this, council and LHD staff need to get together to share information, discuss the issues and challenge each other for best solutions and ways forward. Once this is done, community engagement is invited. This is very innovative work, and had started in 2019 using LBD, but then COVID hit, and it was all put into abeyance." (manager)*

Another program undertaken in SWSLHD, 'Healthy Streets', was mentioned by a couple of respondents as being amenable for LBD training and was described as follows:

> *"In the Healthy Streets program council staff, urban designers and others are trained up by an on-line program from an expert in London. This training is useful and really relevant, but would lend itself to collaborative LBD approaches, including project work." (trainee)*

The Health in Planning process developed by UNSW was mentioned as a possible area for LBD. One respondent felt that LBD approaches could also be used to train staff working in multi-cultural communities (trainer).

Finally, a CHETRE trainer felt there might be good applications for LBD in smaller-scale, less ambitious areas than HIA:

"HIA is quite a big process. LBD is a good approach to learning about HIAs in a real setting, but perhaps HIAs are too big a challenge in this training context. Some organisations are not so keen on doing full HIAs but would be keener to use LBD for smaller level projects, like health-related decision-making for councils." (trainer)

Does the CHETRE training support change to organisational approaches to health & equity?

Based on the limited information and data available on outcomes and impacts of the CHETRE training programs, there is no objective means of evaluating whether the programs are supporting organisational capacity to address health equity issues or mediating productive change.

Despite this evidence vacuum, there are some subjective pointers to the value of the training programs. A previously described, most trainees speak highly of the HIA and WILDC programs, believe they have obtained value from undertaking the training, and wish to see the training continue for their colleagues. Unsolicited, all seven HIA trainees expressed favourable comments about the LBD approach to HIA training. The following quote sums up this positive view:

"LBD is a good training approach – practical and effective. It's a good way to go for on-the-job training for the workforce." (trainee).

Five of six WILDC trainees were also very positive and are keen for the training to continue to be offered. One highlighted that the program was important because it achieved involvement with community people. Another spoke of the positive impact of the training in bringing together a range of players:

"The WILDC training should continue and should be encouraged. We need more of it ... it brought different stakeholders together in a positive way so that everybody learnt things by working together and sharing ideas and skills." (trainee)

Managers of trainees were also positive, most believing training programs provided additional skills for health planning and equity, and importantly brought people together across sectors to share their skills and experience in collaborative community projects. One manager went as far as to say:

"HIA should become business as usual when considering any major new projects in health and in community services." (manager)

All five CHETRE trainers interviewed felt the training programs represent useful approaches to improving capacity to address health equity issues in project planning and working in disadvantaged communities. All asserted that the programs should continue to develop and be offered to relevant workforces in health and social services.

Interview information was also collected on training benefits accruing to the trainees themselves. Several HIA trainees spoke about the cross-sector relationships they developed through the training, and how these relationships continue to assist them in their professional practice today:

"I use the ongoing connections with the LHD through the shared planning processes that have been maintained." (trainee)

And another:

"The HIA project work has broadened my work possibilities through the establishment of on-going relationships with staff from public health and the LHD, and a sense of partnership between the Council and the LHD to work collaboratively on projects. Many of the relationships established in the HIA training are still relevant today." (trainee)

Learning the actual concept and practice of HIA has also been useful, as described:

"The HIA training has given me useful knowledge to comment and advise on policy and planning in my area, and even at the state level. Now, knowing the types of projects where HIAs are relevant and useful, I have been able to suggest that an HIA be undertaken." (trainee)

Another trainee also makes the case:

"The HIA trainings gave me great exposure to using evidence to support my arguments in planning and projects. It has given me a lot more rigour in my thinking, and I feel more competent in this regard." (trainee)

Others spoke of actual career advancements because of the training:

"I feel the HIA training has opened new doors in my career. As a consequence of the training, the Council sent me off to do a Social Planning course at UTS, and this has really helped my progress at work. It all seemed to come out of the original HIA training, and the relationships started there." (trainee)

For WILDC trainees, one spoke of skills developed during the training that remain relevant for her now:

"The WILDC training gave me more skills and I'm more aware now of things like project planning, evaluation, and reporting. It has also helped with skills/strategies for community engagement." (Trainee)

Trainee managers confirmed a training outcome of skill acquisition, particularly in areas of project planning and evaluation and program logic, which are still applied to good effect by staff today.

Importantly, one trainee described now having more confidence to try different things and speak up:

"I now go to all the Council forums and I'm comfortable being a voice for the community to make sure projects under consideration are relevant for the community and accessible." (trainee)

This observation was backed up by a manager of trainees:

"It was great for my staff to do the HIA training and explore different ways of doing things and engaging with people beyond the LHD and health promotion. This intersectoral relationship development was the key thing." (manager)

All these training benefits and success factors outlined above certainly suggest a contribution to improved staff and organisational capacity to address planning for health equity and the potential at least to improve health and wellbeing parameters in WILD communities. None, however, produce quantifiable metrics to confirm either individual trainee or organisational benefits, and certainly not quantifiable community benefits. To address this uncertain picture, the HCA reviewers suggest **setting up clear evaluation processes for training outcomes going forward, with a focus on longitudinal impact focussed case studies of training projects**. Key areas for exploration in these case studies would include:

- Benefits obtained by individual trainees, such as skill acquisition and intersectoral work capacity
- Benefits accruing to employing organisations, in terms of partnership development and reform to service planning and provision
- Benefits to communities based on measures of health equity and changes achieved for health and wellbeing parameters in targeted disadvantaged communities.

Power Relations and LBD Training

Locationally disadvantaged communities are geographical aggregations of people – individuals, families, networks, communities – with combinations of low socio-economic status, limited educational attainment, high unemployment, low standard housing stock, poor public or private transport options, limited access to a range of services, higher crime and incarceration rates, poorer health outcomes, and lower life expectancy than the national averages for these social indicators of health and wellbeing. In short, these are communities made up of individuals and collectives with limited power and agency over their lives compared with the mainstream.

Yet, many of the providers of services to these communities of disadvantage – health, council, housing, etc – are not members themselves of these disadvantaged communities. They are instead people with professional training, relatively high incomes, and a degree of control in their day-to-day and longer-term decision-making and life choices which might be considered rare amongst people from the disadvantaged communities they are servicing.

Such a circumstance implies an imbalance of power and agency between the provider and the recipient, or between the service agency and the target community. These power differentials need to be ***explicitly*** explored in the training curricula of both courses but especially in the WILDC course. Such a focus in training would assist trainees engage with community stakeholders to establish mutual trust and confidence with which to explore services and project opportunities based on shared priority setting and decision-making.

The course outline for the 2018 CHETRE WILDC course includes sections on Community Engagement, Community Participation in Action, and Principles and Practices of Co-design, but nothing explicit on power relations in the field of health and social services provision in disadvantaged communities. That absence leads to the question of how the various stakeholders involved in the CHETRE WILDC training programs considered the issues of power relations and community empowerment to be addressed in the training.

Of the six WILDC trainees interviewed for this review, two recalled that the issues of power relations and community empowerment were addressed in the training program, one stating:

> "*There were many discussions on this topic throughout the training. Actually, working on the projects meant that everyone had to regularly think about how to engage the community, and also about the importance of empowerment and communities being active in their own development. CHETRE are strong on community engagement and equity*" (trainee).

One other trainee felt these issues were addressed in an indirect way:

> "*I can't recall it being part of the lectures, however it was a regular theme of conversation in the workshops and trainees regularly discussed the issue of differential power on an informal basis in our project work. In my group there were several WILDC consumers, and they were very strong on the power issue, making sure it was a hot topic in developing strategies for community engagement*" (trainee).

However, two others couldn't recall power relations being directly discussed in the lectures at all. A couple of respondents, being part of the communities they were now working in, advised they were already aware of the power differences and how to work effectively in WILD communities.

Of particularly note were the comments of a consumer participant of the training:

> "*Politics and power dynamics are always a part of community projects. As I have explained, I was somewhat overlooked, or not seen, as a trainee before I was properly introduced and acknowledged for my previous leadership roles in the community. Community people can easily be ignored or overlooked by agency staff and professionals. The power differentials were right there from the start*" (trainee).

Managers of CHETRE trainees offered a similar range of views about the positioning of power relations and community empowerment in the WILDC course. Three of the four managers interviewed couldn't recall that the issues of power relations in service provision and planning were explicitly addressed in the training programs. Some managers thought their staff were skilled in community engagement already and so didn't really require a lot of extra work on how best to consult and engage community members and organisations.

However, a more critical view was expressed by another manager:

> "*I think the training was a bit under-powered on this issue of power relations. For working in disadvantaged communities, you must deal with and train for genuine community engagement, and the sharing of power, the setting of priorities, and decision-making. The training was LBD, but it wasn't really hitting the mark around genuine community engagement*" (manager).

Similarly, in relation to the HIA training program, only one of seven interviewees could recall the issues of power relations being directly addressed in the HIA training curricula. However, there were several different reactions to this lack of specific focus on 'power' in the course. A couple of people felt that such a topic was not really needed, as little community engagement was required in the HIAs they had been involved in.

However, a couple of respondents expressed concern about the lack of consideration of power relations for HIA projects, one stating:

> "I was *a bit surprised power relations in HIA work didn't get more focus. I don't think Council staff are automatically good at community engagement. I feel it's something that needs to be taught and learnt. Community consultation does not equal community engagement – they are a different order of things."* (trainee)

Two CHETRE HIA trainers felt there may not be adequate focus in the training programs on this issue of power relations between service providers and disadvantaged community members, and therefore the challenges of empowering communities to actively engage in their healthcare programs and development. One trainer reasoned that, given that effective community engagement is a key component of best practice HIA, the issues of power relations and community empowerment could be given more coverage in the training.

In summary, the two courses currently at best ***implicitly*** cover power issues and only then primarily because of the LBD focus.

There are several good sources of content to explore power relations, but Health Impact Partners in the United States are at the forefront of a movement for community-led solutions to inequitable distribution and allocation of public services. They make the case for community stakeholders themselves to learn about power imbalances and structural oppression - as mediated through racism, patriarchy, capitalism, and others — and to develop strategies to combat these oppressive structures to: *"……. access the collective resources we need to thrive and live free and healthy lives*" (Health Impact Partners, 2022, p.4).

Health Impact Partners argue that having a clearer understanding of power relations can produce multiple benefits, including combating feelings of powerlessness; supporting more effective strategies to make necessary changes; improve accountability of all stakeholders, and assist those who have been excluded by power relations to gain their share of power and decision-making in matters that affect their lives (HIP, 2022).

With regard to how WILDC and HIA training may influence the institutional dynamics of equity in the health system, if the theme of power relations were introduced into the training curricula, it is difficult to foresee. Certainly, having more graduates aware of power dynamics as a consequence of

the training, and dispersed widely through the public and population health units, shire councils and related departments, may elevate discussion and improve public health planning with regard to health equity and the broader determinants of health. But as Friel et al (2020) assert, in recent decades in Australia there has been little action on the structural drivers of health inequities within the health system, as the influence of neoliberalism and bio-medicalism have prevailed in the policy domain over efforts to improve the living conditions of whole communities. Some stakeholders interviewed for this evaluation were of the view that prevailing structural context may be undergoing change and a more favourable context required to address health inequities is emerging.

Can LBD activities be scaled up at a regional district level?

WILDC courses have been conducted over a decade, during which time there have been at least five courses. It is estimated that about 100 people have participated in these courses, a mixture of LHD/Area health staff, persons from other sector organizations and a small number of community members. Over a slightly shorter period four HIA courses have been conducted (there may be others that were run for specific organizations) with approximately the same number of total course participants. This is an average of 20 course participants per year in total.

This is clearly an insufficient number to establish and sustain a critical mass of course resources (trainers, materials, mentors, help desk, etc.). Accordingly, both courses have survived over the years on a mixture of a dedicate core of 'volunteer' course contributors (academics and senior practitioners associated with the original locational disadvantage and HIA research) who essentially provide their time at no cost and 'parttime trainers' who are employed by CHETRE for a range of tasks and support course implementation and coordination as part of the broader duties. This level of resourcing is not conducive to long term sustainability of either course and does not provide the support needed for continuous quality improvement and the building of a knowledge base.

It is difficult to know if the current course participation levels reflect the genuine level of demand (that is, a small niche population of potentially interested health and cross sectoral workers and community members) or reflect more that neither course has been promoted to the full potential audience.

In the case of the WILDC course promotion has almost exclusively been directed to workers and community members within the SWSLHD footprint, even though the course contents would be relevant to workers in all NSW LHDs. Even within the SWSLHD there are sizable 'untouched' workforces that would arguably benefit from attendance at a WILDC course as an integral part of their professional development (for example health promotion workers, multicultural health workers, community liaison workers, etc.), if not the whole course, then modules especially those related to community engagement and power relations. In the case of the HIA course, the opportunity for much wider promotion of the course to the local government, community services and welfare and even the commercial sectors are possible. The value of the course in facilitating cross-sectoral partnerships was oft mentioned.

Both courses were considered by most participants as relevant to a wider audience.

The courses are at cross-roads in many ways. There is reasonable evidence that they are effective in achieving their learning objectives, but they cannot continue long with the current level of both financial and management time investment. It could be argued not so much CAN the courses be scaled up, but that they MUST be scaled up to make sense of future implementation.

Prior to the commencement of the WILDC course in 2009 a proposal was developed for funding the course. The initial investment estimate for each WILDC course at that time was $33,225. This included the cost of a Part-time project officer, the professional development of the course materials and workbooks, work assessing course participants and liaising with trainers, venue hire

and catering, remuneration of Course Contributors and Trainers (this was estimated as an 'in-kind' contribution) and infrastructure / administration costs. Today the cost would be much higher. A similar cost for each HIA course (unless conducted as a shorter course with minimal LBD) would be anticipated.

This provides a guide as to the level of investment or revenue that needs to be obtained to make the courses sustainable. Some consideration of the charging of a fee for course attendance (if not to community members, then at least to the organisations employing participants) is required or at least a hybrid revenue base of investment and fees.

It is estimated that at least two courses of each of WILDC and HIA per annum would need to be conducted to achieve long term sustainability. The possibility of undertaking more training per year after building the necessary infrastructure (trainers, materials, marketing) should not be precluded.

Discussion & Recommendations

Summary of findings

In the previous sections the findings from the quantitative and (mostly) qualitative data collection and analysis was provided. Many large and smaller issues were explored but the key findings were:

- The courses have been conducted for many years but not yet been evaluated according to a structured M&E Framework and in a way that provides strong quantitative evidence.
- Nevertheless, findings based on qualitative data provides confidence that the courses are valued and are providing valuable (potentially career changing) learning outcomes for most participants.
- The courses are, by definition, learning by doing (LBD) and indeed satisfy most of the criteria for LBD 'best practice'. The LBD component of the course, especially the WILDC courses, is critical to achieve much of the key learning outcomes.
- The courses are too long, stretching over 12 months, risking participant dropouts and loss of participant motivation and momentum.
- Both courses, but especially the WILDC course, need to be reviewed and rearticulated to focus more on currently under-covered content. This is especially relevant to content on power and community engagement.
- The courses have been run for many years on insufficient resources and reliance on the goodwill of CHETRE and 'voluntary' support of many content experts located in SWSLHD, UNSW and CHETRE. This has prevented the courses pursuing a quality improvement pathway and undermined any potential for growth in demand.
- There has accordingly been limited attempt to promote and expand the reach of the program.
- As well, support for participants and the relationship between participants and their organisations / programs has been under-nourished.

When the CHETE courses were designed and developed in the early parts of this century, it was recognised that the goal of health equity for disadvantaged communities needs the redress of unequal distributions of power, money and resources which shape the condition of people's lives. Both courses approach participant learning through a strong health equity lens.

Friel et al (2020) argue that the work to address the factors of inequality, as championed by the WHO Commission on the Social Determinants of Health in 2008, has been slowly marginalised over the intervening years in favour of a focus on health care delivery and individual behaviours. It has

been argued by course stakeholders though that recently there has been a shift at NSW Heath back towards a social equity and determinants of health perspective.

It would seem essential therefore that those working in WILDC develop insight into these broader considerations, in order that they might facilitate more constructive strategies to support communities in focus to achieve better health and wellbeing.

On the basis that the CHETRE LBD training programs in HIA and WILDC are to continue to be developed and delivered, the following recommendations are made for improvement of training preparation, implementation and evaluation. The recommendations are ordered according to timeframe (short-, medium- and longer-term interventions) and against the original six purpose of the review, as shown in the Table below.

Evaluation questions / findings	**Timing of recommendations**		
	Short term	Medium term	Longer term
Impact of courses	(1), (2), (3), (4)	(8), (9), (10), (13), (14)	(14), (17), (18)
Enablers and constraints to running effective training	(4), (5), (6), (7)	(10), (11), (12)	(15)
LBD course investment		(8), (10), (11), (13)	(15), (16)
Scaling up of LBD course capacity		(13)	(16), (17)
Other areas in which LBD could be appropriate		(13)	(16)

Recommendations to improve the performance of the CHETRE training courses

1. Continue to **develop and deliver the HIA and WILDC training programs** in Southwest Sydney using the LBD approach built on undertaking training projects in real-world settings.
2. **Review and revise the original course description and module descriptors** (see Ridoutt and Santos, 2006) according to current understanding of course need and content. Specific content (through lecture sessions) to the WILDC course on power relations between consumers and service providers and community empowerment should be introduced.
3. **Develop a Trainer Guide for each of the programs** to assist training providers to maintain training programs' consistency of delivery and quality. The Guide should be based on the revised module descriptors and include learning objectives; lecture content and summaries; facilitator notes; audio-visual resources; relevant reading materials; linkages to other relevant courses; pro-forma material for evaluation; etc.
4. **Develop an assessment framework** for the CHETRE training programs to ensure adequate and meaningful assessment of the pre- and post-course knowledge and skill of participants[3].

[3] An example of how to assess locational disadvantage competencies was created through a 2009 project *Assessment Tools: Working in Locationally Disadvantaged Communities Pilot*

Assessment methods and tools will need to be based on the course module descriptors and will vary between courses and within courses between modules / learning outcomes.

5. **Identify the benefit of the training** to employing organisations and to communities through an evaluation report on each course. The Evaluation Framework should include:
   - Level of attendance and participation
   - Survey of trainees at conclusion of the program
   - Assessment of change in skills and knowledge
   - An exit interview with each trainee to further assess learning and suggest further work required
   - Survey of managers of trainees to consider organisational benefits of the training
   - Reporting on project outcomes after 6 and 12 months.
6. **Limit the training program timeframes** for both courses to six months for the actual training programs and up to 12 months to complete projects. This constraint is to ensure engagement of training participants for the duration of training and to sustain momentum of group projects.
7. Consider the possibility of **participants attending single modules** within a course. This would allow participants from the community who may just wish to engage in the project activities to ensure community voice and participation.

Recommendations for the future practice of LBD in training courses

8. **Create a governance arrangement** (outside of CHETRE and at as high a level as possible) to oversee the training outcomes and resources use and to support the marketing of current and future courses. Membership of the governance arrangement should include the SWSLHD (possibly Directors of Population Health and Community Health), CPHCE, UNSW School of Public Health & Community Medicine, NSW Ministry of Health (possibly Directors of Vulnerable Populations).
9. The governance arrangement will need to develop the value proposition for the courses, including more overt career outcomes for participants.
10. Obtain stable funding for the courses at least until they can be self-funded (the initial estimate for each WILDC course estimated in 2008 was $33,225). This is essential to developing and maintaining the critical mass capacity to support consistent quality outcomes.
11. Commence **charging a fee to training participants** (or their employers) to signal the value of the programs within the health and community services sectors and to establish funds to support activities in the training projects.
12. Aim to deliver **at least two training programs in each of HIA and WILDC per calendar year** to increase the visibility and relevance of the programs to the market and stakeholders. Course promotion (see below) will need to go beyond the boundaries of the SWSLHD and maybe even beyond the public sector to sustain this level of course demand. Running more regular courses will also help build a stable resource base for current and future course opportunities.
13. With a heightened focus on the courses' quality there is a need for **an equity focussed training and education officer** as part of the CHETRE training team. This would be someone who is well versed in adult education practice, has strong content knowledge (especially regarding power), and can support monitoring and evaluation and research efforts. Alternatively, the training program can partner with the School of Public Health & Community Medicine who could contract out this type of input.

Longer term investments in CHETRE LBD training courses

14. Develop a **clear future vision and associated promotional campaign strategy** for the training programs for targeting relevant agencies and organisations.
15. Establish **communities of practice** for LBD, HIA and WILDC and offer these alumni forums in which graduate trainees can share information and perspectives on LBD, HIA and WILDC issues and activities. Alumni may be offered HIA projects to undertake.
16. **Explore the development of LBD training programs** in the following programs: the Systems Approach, the Healthy Streets Program, the Health in Planning program, and training for staff in health equity for multi-cultural communities
17. CHETRE to initiate an **evaluation of the benefit and impact of the HIA and WILDC** training courses going forward through a longitudinal case study methodology to assess benefits for key stakeholders (trainees, trainee employers, target communities) and potential benefits for other stakeholders – regions and jurisdictions
18. **Explore stronger career outcomes for** participants who 'graduate' from any of the courses. This could include (1) recognition of completion of CHETRE modules as part of VET training options (e.g., Certificate IV in Population Health)[4] (2) partnership arrangements with institutes of higher education that provide advance standing to undergraduate (e.g., health promotion) or postgraduate (e.g., MPH) programs or (3) greater industry recognition of a CHETRE certificate.

[4] This in fact was meant to be the original purpose of training in locational disadvantage as envisaged by the early proponents and encapsulated in Ridoutt, L. and Santos, T. (2006)

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Appendix A: Description of Courses

Working in Locationally Disadvantaged Communities course

An initial pilot course was conducted in 2009, with a follow-up course in 2010. Other courses have been conducted in 2012, 2015 and 2019. All these courses included 6 days of lecture / workshop type training, help desk support, and site visits to relevant locations. The projects aimed to address important locational health and community issues. A few of the initial projects exist to this day. The more recent course in 2019 was stretched through to 2020 and 21 due to the COVID-19 pandemic.

The origins of the course lie in a grant given in 2002 by the Public Health Education and Research Program (PHERP), which sought to identify skill shortcomings in disadvantaged communities. Research was then conducted in three Area Health Services to detect these skills, and Ridoutt and Santos (2006) were able identify key competencies for performing locational disadvantage work. These then formed the basis for a three-module course. The three modules were:

1. Identify locationally disadvantaged communities (Module 1)
2. Assess geographical characteristics (compositional and contextual) that impact on locationally disadvantaged communities (Module 2)
3. Design, implement and evaluate interventions for locationally disadvantaged communities (Module 3)

The pilot program, for some reason unable to be established, deviated from the originally proposed modules, and instead focused on the following three:

1) Working with specific communities
2) Ability to support community participation
3) Developing and implementing community development strategies

Several different learning techniques were used in the initial and subsequent courses:

- ***technical learning*** (evaluation, project planning, needs assessment)
- ***conceptual learning*** (social determinants of health, patterns and causes of inequality)
- ***social learning*** (engaging the community, negotiation and collaboration)

The program process spreads the six training days over six months[5], help desk support over the phone or in person with CHETRE, site visits and financial support of between $500 and $2500. Once completed (a total of one year is allowed), a presentation by the participants on their projects ensues, and they are awarded with a certificate.

For the initial pilot course in 2009, expressions of interest were sought through SSWAHS from groups wishing to participate in the course. Groups were asked to propose a team project which was in a socially disadvantaged community, and which aimed to:

- Increase access to a specific health service or program that has shown health benefits
- Address one or more of the risk factors of chronic disease; or
- Improve opportunities for a healthy start to life.

[5] In the 2019-21 course, badly impacted by COVID 19, workshops 5 and 6 were held more than a year from the first 4.

Overall, the participants of the pilot course were comfortable with the learning-by-doing approach and, while some were not able to begin implementing their projects until very late in the process, each group was engaged in activity between the workshops which was related to their project, and which supported their learning within the sessions.

Another key takeaway from the course was that participants developed a sound understanding of, and commitment to, health equity. For some this was an understanding they brought to the course and further developed through the workshops.

Participation has varied, with each course having between 4 to 7 teams of 2 to 6 people. Attempts to implement changes based on feedback for each course were made to reflect the diverse needs of the participants.

Even so, over the years the course structure has changed only moderately although the processes of participant selection and preparation have been slowly modified to improve participant commitment and baseline understanding. This is demonstrated in Table 1.

Evaluation data was collected from the 2019-21 course through an end of course survey. Data from other WILDC courses do not exist. Respondents rated (based on their level of satisfaction) the course 6.1 out of 10, showing that they were moderately satisfied with the course overall. The average though masked a significant range of responses from 0 to 10, which shows very conflicting accounts of how respondents received the course.

Table 1 – Basic details on WILDC courses, 2009 to 2019

Course elements	Course Year				
	2009	2010	2012	2015	2019-21
Workshops	6 workshops	6 workshops	7 workshops	6 workshops	6 workshops
Participation	5 teams of 3 or 4 people	4 teams of 2 or 3 people	7 teams of 2 to 3 people	~5 teams	5 teams of 2 to 6 people
Support	Help desk support, site visits	Help desk support, site visits	Help desk support, site visits, $500-$2500 funding	Help desk support, site visits, $500-$2500 funding	Help desk support, site visits, $500-$2500 funding
Project	Yes	Yes	Yes	Yes	Yes
Duration	1 year	1 year	1 year	1 year	1 year

When asked about what they found most useful, respondents overwhelmingly reported collaboration with other groups and listening to guest speakers.

Another more conflicting question was that of the information being difficult to understand. While a majority answered the material was easy to understand, a sizeable portion of 37.5% answered that material was not always easy to understand. When asked to specify what they found difficult, answers included:

- public health models
- relevance and content
- program logic being too complex

The one respondent who answered negatively to the information being clear and relevant stated that:

> *"None of it made sense to me".*

The question asking what skills and knowledge you gained from the course included answers such as:

> *"I feel my understanding of the language of research has greatly improved"*
>
> *"... better understanding of research methods and how to collect data to build the evidence"*
>
> *"... better applying and integrating equity into planning projects"*

Respondents answered that they would overall incorporate the skills and knowledge gained from the course into their practice, with an average rating of 7 out of 10. The answers again ranged from 0 to 10.

The presenters were overall received very well by the participants with an average rating of 8.8. Answers ranged from 5 to 10.

Improvement was suggested in areas such as health outcomes, helping culturally and linguistically diverse communities (CALD), and adaptability to COVID. Respondents also felt they would like more information on First Nations people in all our work, evaluations, and relevant research material.

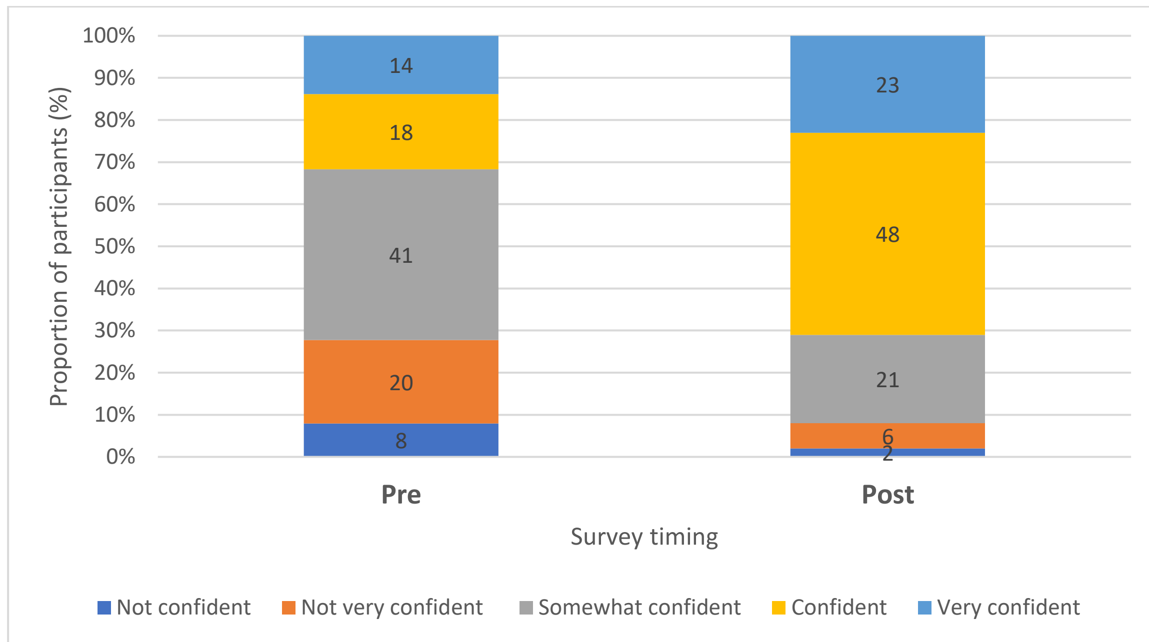
The Health Impact Assessment (HIA) course

The HIA process aims to assess plans, projects and policies before they are executed. Thus, it is used to foresee possible health impacts in projects by determining positive and negative impacts and assessing severity and impact on health equity. HIA has several steps, moving from pre-screening to assessment and eventually to evaluation and follow-up. The six step HIA is as follows:

1) Screening
2) Scoping
3) Identification
4) Assessment
5) Decision Making & Recommendations
6) Evaluation & Follow-up

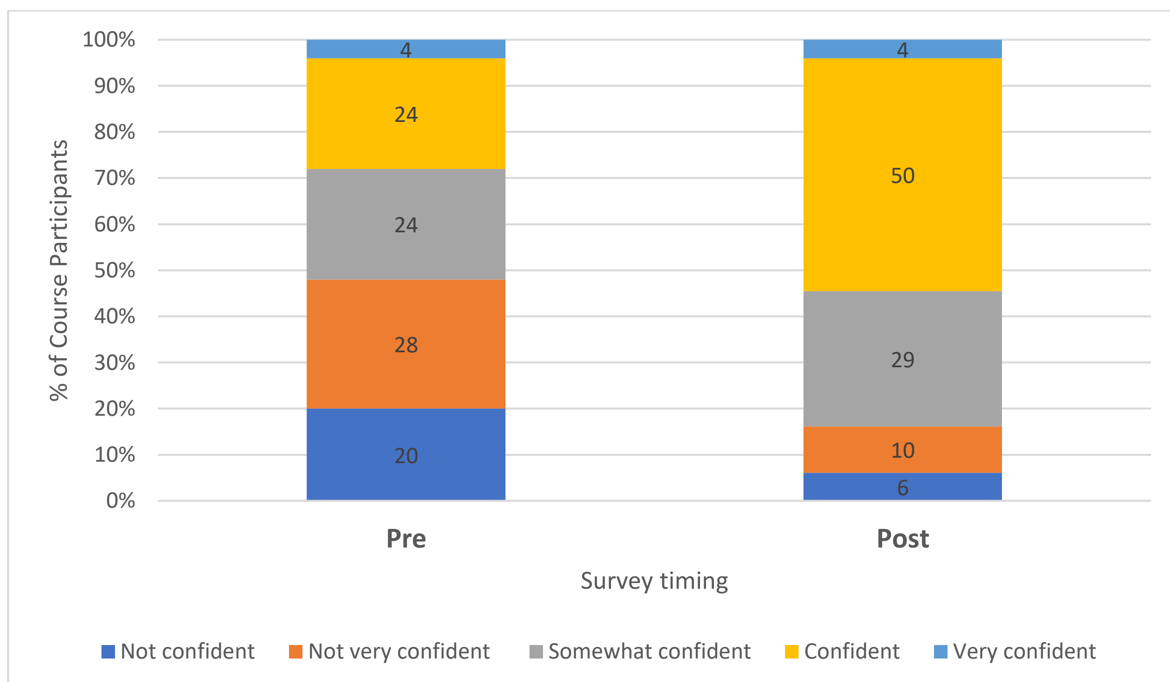
HIA courses were conducted in 2012, 2014, 2016 and 2018. Surveys before and after training in the 2015 and 2018 courses were undertaken to evaluate the efficacy of the program. The results from these surveys (combining the two courses) are noted below.

Figure 2: Distribution of participants by level of confidence pre- and post-course to understand what is meant by HIA (n = 51 [pre-course] and n = 48 [post course])



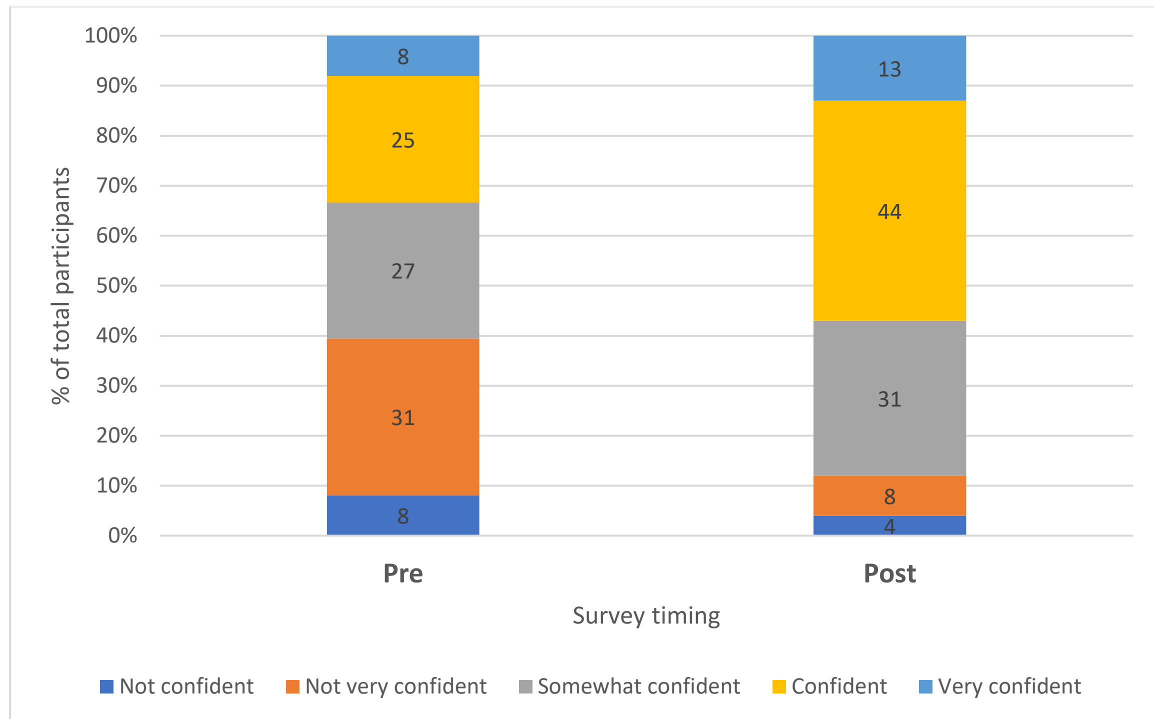
The proportion of participants with 'Confidence Levels' of 'Confident' or 'Very confident' changed pre- to post-course from 32% to 71% understand what is meant by HIA.

Figure 3: Distribution of participants by level of confidence pre- and post-course to identify some of the issues in HIA (n = 51 [pre-course] and n = 48 [post course])



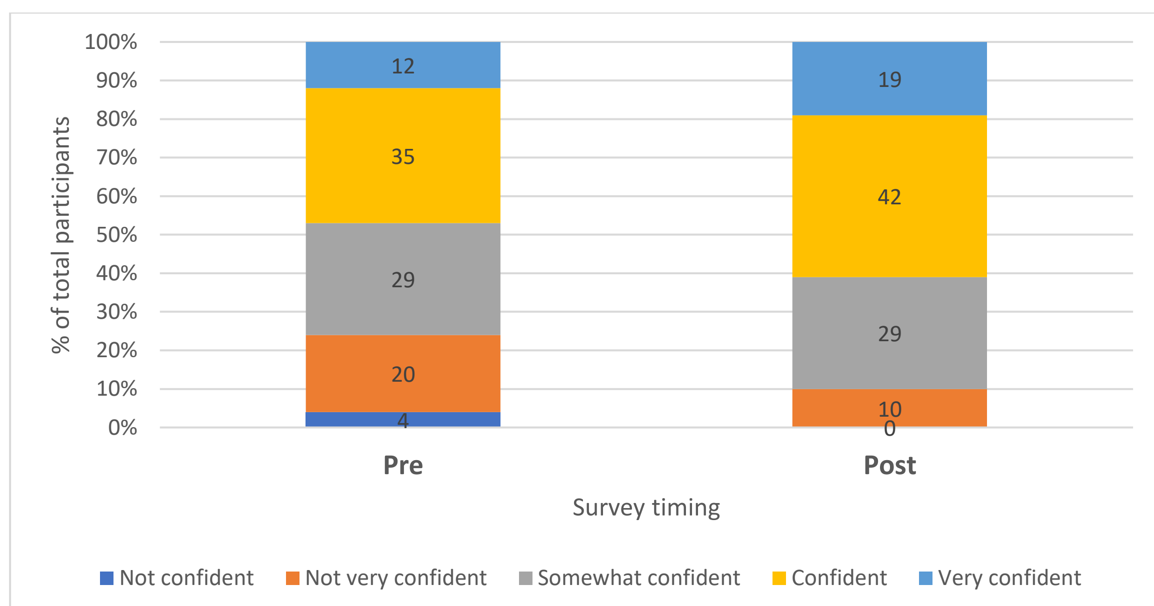
The proportion of participants with 'Confidence Levels' of 'Confident' or 'Very confident' changed pre- to post-course from 28% to 54% being able to identify some of the issues in HIA.

Figure 4: Distribution of participants by level of confidence pre- and post-course to understand linkages between HIA and policy / planning (n = 50 [pre-course] and n = 48 [post course])



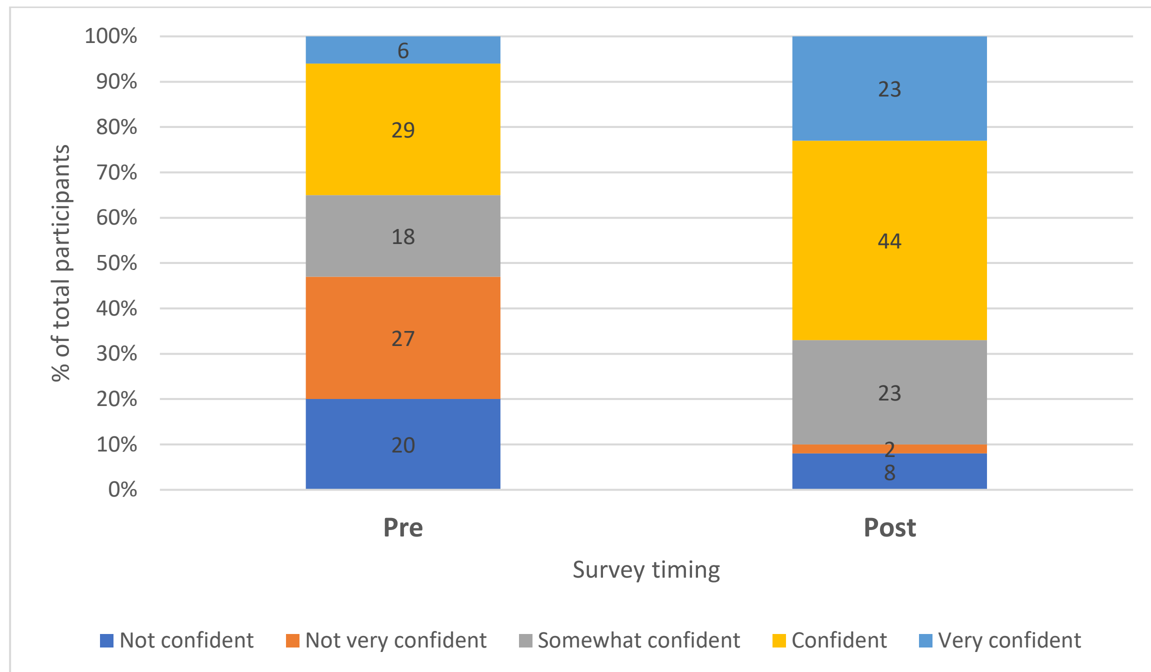
The proportion of participants with 'Confidence Levels' of 'Confident' or 'Very confident' to be able to understand linkages between HIA and policy / planning changed pre- to post-course from 33% to 57%.

Figure 5: Distribution of participants by level of confidence pre- and post-course that HIA can be used to improve policy / planning (n = 51 [pre-course] and n = 48 [post course])



The proportion of participants with 'Confidence Levels' of 'Confident' or 'Very confident' that HIA can be used to improve policy / planning changed pre- to post-course from 47% to 61%.

Figure 6: Distribution of participants by level of confidence pre- and post-course that they understand the steps involved in HIA (n = 51 [pre-course] and n = 48 [post course])



The proportion of participants with 'Confidence Levels' of 'Confident' or 'Very confident' that they understand the steps involved in completing a HIA changed pre- to post-course from 35% to 67%.

When respondents were asked about what worked well in the course, common answers included the interactive format, the stepwise approach, and the variety of the content. The guest lecturers were also enthusiastically received.

> *"Interactivity. Guest speakers. Refers to real case studies. HIAs"*

> *"Loved the guest speakers. Really broad understanding/exposure to HIA Case study was great, very lucky to have the SWSLHD and Local council speak to us after we had done it."*

There were less responses to the question asking what did not work well, some participants felt that more direction would have been useful or felt that more practical activities would have been of benefit. Overall, the responses are quite subjective.

> *"Clarity on assignments- quite broad and difficult to find a proposal in the 3 days.*

> *"I liked the group work, but thought there could have been more practical walk through of each step as a whole group."*

When asked if the HIA training had met expectations, answers to this open-ended question varied greatly, with a majority feeling like their expectations had been met.

> *"Yes, it outlined the HIA process in depth and CHETRE provided hands on support to the project".*

A few expressed neutrality in the matter, with one respondent stating,

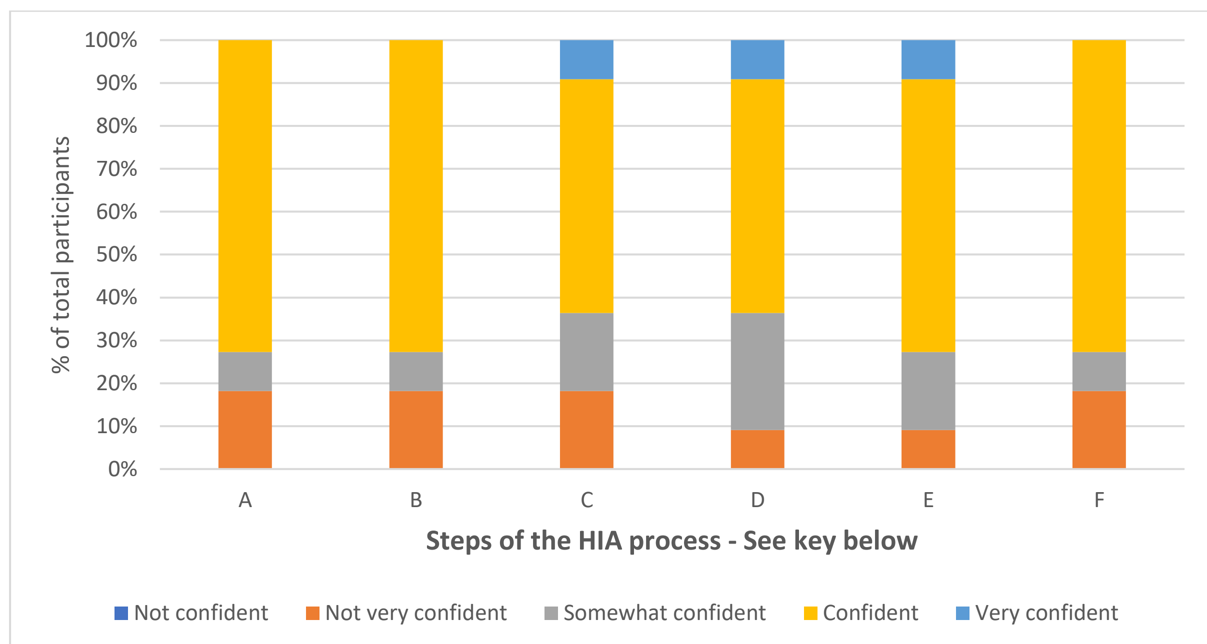
> *"Expectations partially met, Limited by the level of engagement of council as to how far we progress through the HIA process between each of the training days."*

Although, a couple of respondents felt their expectations hadn't been met,

> *"No. I feel that the training over complicated how to conduct a HIA. The templates made it harder to determine what to do as well. I think the training would be better delivered on an individual basis with each HIA team. Also, I don't feel that the presenters adequately explained the content. The slides had lots of information that wasn't expanded upon or clarified."*

There were some additional post-course questions asked of the 2018 HIA course participants including for the data in Figure 7. For most steps 70+% of participants are confident or very confident in being able to perform the steps. In two of the steps though - 'Identification' and 'Assessment' – the level of confidence is slightly lower at just over 60%.

Figure 7: Level of confidence in 2018 participant post-course understanding of different steps of the HIA (n = 11)



Key:

A	Screening
B	Scoping
C	Identification
D	Assessment
E	Decision Making and Recommendations
F	Monitoring and Evaluation

Appendix B: Data collection details

Audit of past efforts

An attempt will be made to develop a more detailed understanding and description of the past training efforts in the HIA and WILDC areas through:

(1) Management audit type interviews with CHETRE officers involved with the delivery of relevant training (some of these may not be at CHETRE anymore but still reachable within the LHD). These interviews will explore in more detail the actual training process adopted and seek greater insight into the use of support resource materials, training guides and mentor processes.

(2) Thorough review of the documentation specifically associated with the CHETRE training will be undertaken; that is, reports published as 'grey' literature held by CHETRE such as course/facilitator reports, and participant notes and reports on specific courses. The details sought included budget, assessment of participant achievement against learning outcomes, some feedback from participants about their level of satisfaction with course delivery, and a report on the course outcomes.

Given that a review of LBD HIA training up until 2015 has already been undertaken, and a review of LBD WILDC training was undertaken in 2018, only training provided beyond these dates will be reviewed in this evaluation work. Certainly, the findings of those two reports will be acknowledged and utilised, but only focusing in detail on training and consequent community interventions beyond those dates will limit the period of training to be considered.

Literature review

A broad review of the literature associated LBD, HIA and WILDC in relation to capacity building will be undertaken to examine the contexts in which they are used, limitations to their use and relative effectiveness for adult learners.

Literature will be sought through interrogation of the following database sources:

- Academic Search Premier
- Medline
- Science Direct
- ProQuest
- Google Scholar

Other possible sources of literature to explore would be the abstracts of specialised human resources (for health) journals and websites of vocational education and training specialists (e.g., NCVER). Searches will be limited to publications from 2015 onwards to capture only the most recent data. The key search terms will include combinations of the terms in the table 2.

Table 2: Possible key search terms for the literature search

Broad search terms	Specific search terms relevant to LBD	Search terms relevant to outcomes
Vocational training	Learning by doing	Learning outcomes
On the job training	Active learning	Performance indicators
Capacity building	Experiential learning	Performance improvement
Health	Project-based learning	Evaluation

The search process will be limited to English language publications and overseas studies will only be from developed countries with comparable health systems (e.g., OECD countries).

All documents will be reviewed initially and assessed for inclusion and subsequent analysis.

For those documents to be used to provide evidence of effectiveness of outcomes, an assessment on the quality of those studies will be completed using the Mixed Methods Assessment Tool (MMAT)[6].

Consultations

Training Participant Interviews

There were several types of participants in the capacity building interventions. The HIA LBD interventions have apparently targeted in order of prevalence:

- Health service staff (primarily population health)
- NGO staff (presumably health sector)
- Non health sector staff (including councils, housing), and
- Community members.

The WILDC LBD interventions have seemingly targeted (in order of prevalence):

- NGO staff
- SWSLHD staff
- Other government agency staff.

It is proposed to interview a maximum of 8 past 'graduates' of LBD (four from each course area) with a cross section of these different course participant types. In the end a total of 13 course participants were interviewed, 7 HIA trainees, and 6 WILDC trainees. The consultants were reliant on CHETRE to help with this process, including issuing invitations to participate in the study.

Consultations were undertaken using a structured interview schedule (see Evaluation Plan) agreed with the Steering Committee. Consultations were mostly conducted remotely by phone or Zoom conference. As a quality improvement project and given no indication of the interview population as vulnerable, it is not foreseen that ethics approval will be a requirement. However, the consultants will of course abide by ethical principles regarding subjects.

The interview schedules explored such questions as:

- How did the LBD impact job performance, career direction?

[6] Pluye P (2013) Critical appraisal tools for assessing the methodological quality of qualitative, quantitative and mixed methods studies included in systematic mixed studies reviews [Letter]. *Journal of Evaluation in Clinical Practice* 19(4):122.

- How effective and efficient was the training? Were there constraints to learning?
- Was LBD better than other approaches?
- Whether or not it influenced a decision, or were there any unintended outcomes?
- What other content areas would be amenable to an LBD approach?

Stakeholder Interviews

Stakeholders for the LBD initiative included:

- Designers of the HIA and WILDC initiative
- Managers of the program and individual courses
- Course trainers/facilitators
- Managers of services (LHD, NGO, Council, etc.) that had staff trained through the LBD
- Community leaders

A total of 4 managers of trainees were interviewed, and 5 trainers or course developers.

Consultations were undertaken using a structured interview schedule (see Evaluation Plan). Consultations were mostly conducted remotely by phone or Zoom conference. The focus of the interviews was on:

- How effective and efficient was the training? Were there constraints to learning?
- What is needed to better support effective LBD training?
- Was LBD better than other approaches?
- Did learning influence a decision on service delivery?
- Were there any unintended outcomes of the training?
- What other content areas would be amenable to an LBD approach?

If possible, the stakeholder interviews will explore whether HIA and WILD programs delivered products and outcomes because of the training. For instance, did WILD capacity building training lead to projects or sustained activity in communities? Were HIA practices continued to be used in councils, other departments, the health system in years following the training?