Professional development programs in health promotion: tools and processes to favor new practices

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Summary

Developing innovative interventions that are in sync with a health promotion paradigm often represents a challenge for professionals working in local public health organizations. Thus, it is critical to have both professional development programs that favor new practices and tools to examine these practices. In this case study, we analyze the health promotion approach used in a pilot intervention addressing children’s vulnerability that was developed and carried out by participants enrolled in a public health professional development program. More specifically, we use a modified version of Guichard and Ridde’s (Une grille d’analyse des actions pour lutter contre les inégalités sociales de santé. In Potvin, L., Moquet, M.-J. and Jones, C. M. (eds), Réduire les Inégalités Sociales en Santé. INPES, Saint-Denis Cedex, pp. 297–312, 2010) analytical grid to assess deductively the program participants’ use of health promotion practices in the analysis and planning, implementation, evaluation, sustainability and empowerment phases of the pilot intervention. We also seek evidence of practices involving (empowerment, participation, equity, holism, an ecological approach, intersectorality and sustainability) in the intervention. The results are mixed: our findings reveal evidence of the application of several dimensions of health promotion (equity, holism, an ecological approach, intersectorality and sustainability), but also a lack of integration of two key dimensions; that is, empowerment and participation, during various phases of the pilot intervention. These results show that the professional development program is associated with the adoption of a pilot intervention integrating multiple but not all dimensions of health promotion. We make recommendations to facilitate a more complete integration. This research also shows that the Guichard and Ridde grid proves to be a thorough instrument to document the practices of participants.

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INTRODUCTION

A new public health paradigm emerged in 1986 with the release of the Ottawa Charter for Health Promotion, signaling a critical evolution from traditional, individually focused health education to broader ecological, multi-level health promotion approaches targeting health and its determinants (O’Neill et al., 2012). This new paradigm created the need to develop and renew professional practices. Since then, numerous reflections and results have shown the difficulty for professionals moving from discourse to action (Wise and Nutbeam 2007; Ziglio et al., 2011). Professional development has been proposed as a lever for action to help public health practitioners develop and implement programs and interventions that correspond to this new paradigm (Ziglio et al., 2011; Tremblay et al., 2012).

In an effort to support the development of the practice of health promotion among professionals in the local Centres de Santé et de Services Sociaux (CSSS, Local Health and Social Services Centres), the Public Health Department of Montréal (PHDM) created the Health Promotion Laboratory (HPL). As a professional development program, the HPL has four objectives: build new ways to address local public health issues by means of health promotion interventions; develop a reflective practice; broaden professional competencies and initiate organizational changes that facilitate the adoption of new health promotion practices (Tremblay et al., 2013a). The program consists of one or two half-day monthly team sessions over a 2- to 3-year period. A program promoter from the PHDM and co-facilitators from the CSSS are tasked with running team activities. Professionals and managers from the CSSS take part in these team sessions based on their own interests in developing or improving professional practice. A key pedagogical strategy in the program requires participants to develop a pilot intervention compatible with the HPL health promotion concepts and methods, adapted to the learning needs of the team.

In this article, we analyze a four-pronged pilot intervention developed by HPL participants from one site. This pilot intervention addresses protection factors for children experiencing vulnerability: daycare access, breastfeeding, social support and neighborhood safety. The objective here is to examine the extent to which the HPL program participants apply a health promotion approach to the analysis and planning, implementation, evaluation, sustainability and empowerment phases of this intervention.

To achieve this objective, we apply a modified version of Guichard and Ridde’s (Guichard and Ridde, 2010) analytical grid to find evidence of integration of seven health promotion dimensions: empowerment, participation, holism, intersectorality, equity, sustainability and an ecological approach (Rootman, 2001). In so doing, we highlight intervention components that are in sync with a health promotion approach as well as areas where improvement is necessary. We also show the multiple benefits of such an application for program planners and evaluators. In addition, program participants may want to consider using the analytical grid for ongoing reflection of their practice.

THE HEALTH PROMOTION LABORATORY

Context

In 2004, the Québec government’s health system reform saw the creation of 95 CSSS. The goal of the CSSS is to bring health and social services closer to the population taking into account the local population needs and resources (Provost et al., 2011). These CSSS were tasked with a new mandate of integrating a population-based approach to services across the public health—palliative care continuum of services (Ministère de la Santé et des Services Sociaux, 2013). This did not go smoothly (Beaudet et al., 2011). For example, years after the reform, Richard et al. found that nurses’ practices were still mainly focused on disease prevention (Richard et al., 2010). The authors noted, for example, that nurses’ work activities rarely went beyond a traditional health education approach aimed at individual change, and their work usually was not grounded on concepts, such as empowerment, health determinants and socio-environmental dimensions of health (Richard et al., 2010). To fill this gap, the PHDM created the HPL program in 2010, with a general objective of developing or improving CSSS health professionals’ health promotion skills (Dufour et al., 2014).

The HPL requires that each CSSS allocate staff time to managers and professionals who volunteer to participate in the program. CSSS-HPL teams are composed of professionals drawn from various disciplines including physicians (generalists), nurses, community developers and social workers. Seven CSSS-HPL teams have been created since 2010. One program promoter from the PHDM is assigned to work with each HPL team. The program
Table 1: Description of the seven steps of the HPL’s program/operational approach and example of activities

<table>
<thead>
<tr>
<th>Steps (core program components)</th>
<th>Examples of activities</th>
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<tr>
<td>1. Identify a targeted issue and a team</td>
<td>Under this stage, the PHDM program promoters introduce the HPL to the management and the participants at a CSSS site. The management, who has agreed to participate, has chosen a team interested in the HPL and selected a theme or targeted issue to work on.</td>
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<td>2. Specify the operational approach</td>
<td>The PHDM program promoters and facilitators introduce participants to each of the steps in the operational approach. Participants learn about how the HPL came about; the issue they will work on as well as CSSS and PHDM support available to help them implement the lab. Each team fine-tunes the operational approach in accordance with their needs. Also, they usually strike a committee to plan and facilitate HPL meetings.</td>
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<tr>
<td>3. (a) Acquire basic concepts of public health and a space for reflection</td>
<td>At this step, the focus is on participants acquiring key concepts of public health and reflecting on how these concepts apply to their practice. The core training mechanism is collective reading and discussion of materials selected by PHDM program promoters or participants. This step also includes activities allowing participants to familiarize themselves with learned reflexivity.</td>
</tr>
<tr>
<td>(b) Transfer new knowledge and assure sustainability of the program</td>
<td>The objective of this step is to allow the team to discuss the program and transfer the knowledge that team members gain to other audiences. Among the other objectives is to gain further buy-in and support for the adoption and replication of the model among other staff in their divisions and more senior levels of decision-makers at the CSSS. In order to achieve these objectives, participants could learn how to write articles and make public presentations about their work on the HPL.</td>
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<tr>
<td>4. Study the problem (theme or targeted issue)</td>
<td>In this step, the team gains in-depth knowledge on the targeted issue assigned to them. In so doing, participants are taken to collect, analyze and interpret data to have a clearer picture of the targeted issue at hand. Activities range from theoretical discussions about key concepts related to the targeted issue, presentations by experts in the subject area to practical exposure to the needs of their clients through field visits in their territories.</td>
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<tr>
<td>5. Identify options for action</td>
<td>At this stage, the participants discuss potential health promotion interventions to target the issue and decide collectively what strategies and actions they ought to develop in relation to the issue they want to target to improve the health of their clients.</td>
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<tr>
<td>6. Develop partnerships</td>
<td>In this step, the team set up a partnership with community stakeholders to be involved in the health promotion intervention. Activities in this step may include weighing the advantages of collaborative action versus sectorialized action, identifying existing partners who are working in the territory and creating new networks.</td>
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<tr>
<td>7. Implement a new health promotion action or improve a current intervention</td>
<td>In this step, participants collectively plan the implementation of the intervention (or either improve a current intervention) addressing the targeted issue. To do so, the team may develop a logic model for the new intervention, develop intervention instruments, outline the material and human resources needed, set up an intersectoral coordination committee with partners and so on.</td>
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Source: Adapted from Richard et al., 2015.

promoters design the HPL’s program or operational approach. The operational approach guides team members from when the CSSS management selects an issue to work on, to the self-selection of participants who join the team, to the design and implementation of the pilot intervention (see Table 1 adapted from Richard et al., 2015).

Analytical approach: a multidimensional framework in health promotion evaluation

The 2001 World Health Organization (WHO)’s European Working Group on Health Promotion Evaluation suggested seven dimensions of health promotion: interventions should be empowering, participatory, holistic,
intersectoral, ecological, equitable and sustainable (Rootman, 2001). Empowering and participatory interventions require that communities and target populations be involved at all stages of the interventions. Being holistic entails taking into account the physical, social, spiritual and cultural dimensions of health. Being intersectoral involves collaboration and partnerships with a variety of stakeholders across traditional knowledge and professional divides. Being ecological requires the integration of multiple settings, levels of action and strategies. Being equitable means integrating the social determinants of health and seeking to foster social justice, not merely health outcomes. Finally sustainability refers to interventions that continue over long periods beyond the pilot stage (Rootman, 2001).

Evaluation tools, which encompass the integration of the seven dimensions of health promotion, are scarce (Rootman et al., 2001a). Typically health promotion evaluation literature addresses one or two health promotion dimensions, leaving other dimensions unexplored. Examples of dimensions explicitly addressed in earlier work are empowerment and participation (Green and Kreuter, 1999; Laverack and Labonté, 2000; Brandstetter et al., 2014); ecological approach (Richard et al., 2002, 2011; Green and Kreuter 2005), sustainability (Bilodeau et al., 2005; Blanchet and Boggs, 2012) and equity (Potvin et al., 2007).

Guichard and Ridde’s grid is unique because it was designed by combining different health promotion tools used in the Netherlands, elsewhere in Europe and in Canada (Guichard and Ridde, 2010). Their grid, integrating these three tools, is comprehensive in that it allows an analysis of interventions subsuming all seven dimensions of health promotion identified by Rootman et al. (Rootman et al., 2001a). Guichard and Ridde’s grid is a reflective tool designed to help practitioners in health promotion understand the extent to which their interventions have the potential to reduce social inequalities in health; what works? why? and how?

Guichard and Ridde’s grid is divided into phases: analysis and planning, implementation, evaluation, sustainability and empowerment. Each phase is composed of a series of questions numbering 51 items. The phases and seven dimensions of the interventions are complementary to each other. Phases refer to the processes typically associated with health promotion interventions. Dimensions refer to cardinal principles of health promotion that ought to permeate all phases of the intervention (Rootman et al., 2001a). The final two dimensions of Guichard and Ridde’s grid (sustainability, empowerment) are also found in Rootman et al.’s seven dimensions. Equally, the remaining five dimensions of Rootman et al. (holism, intersectorality, equity, sustainability and ecological approach) are found transversally in the first three phases of Guichard and Ridde’s grid.

In this study, the authors modified and administered Guichard and Ridde’s grid with the following purposes: (i) to determine the integration of a health promotion approach in the HPL pilot intervention and (ii) to provide insights on the HPL program, particularly with regard to its operational approach.

We modified the Guichard and Ridde’s grid (hereafter called, HPL-AG) as follows: (i) revising the language of each item to reflect the focus of the analysis (health promotion rather than reduction of health inequalities); (ii) adding items in three of the five phases of the grid (analysis and planning, implementation and empowerment) in order to reflect the sub-projects carried out within the pilot intervention; (iii) identifying the health promotion dimensions (participation, holism, intersectorality, equity and ecological approach) found transversally in each phase and (iv) developing a five-level response scale (poor, fair, good, excellent and not applicable) for each item of the grid. We pre-tested the modified HPL-AG with one of the PHDM program promoters in order to check for meaning, comprehension and language accessibility. The HPL-AG has 88 items and sub-items to allow for full analysis of all the projects designed and carried out by HPL program participants. Table 2 summarizes the original grid as well as the modifications made for this study, which focuses on team C’s projects. Other teams’ projects are dealt with in upcoming studies (Guichard and Ridde’s grid is available in French at http://www.inpes.sante.fr/ressources-methodologiques/iss.asp).

**METHODS**

The analysis of the four-pronged pilot intervention presented here was undertaken in the context of a larger project, the Analysis of the Health Promotion Laboratory, The ALPS Project. ALPS is a multi-case evaluative study of seven cases that uses quantitative and qualitative methods to evaluate the implementation, processes and outcomes of the HPL (Richard et al., 2014). The ALPS case study design allows an in-depth description and analysis of the processes and outcomes of the HPL program and the context in which it was situated (Yin, 2003; Stake, 2006). In this article, we use qualitative analysis to examine team C’s intervention. This team was chosen because of its being the first of the seven cases that sought to complete the entire seven steps of the HPL program. In addition, during the HPL program, team C fully implemented two of the four projects it designed during the HPL. No other HPL team used this modality. The team
### Table 2: Summary modified HPL-AG

<table>
<thead>
<tr>
<th>Phases of the intervention</th>
<th>Guichard and Ridde’s grid</th>
<th>HPL-AG modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered by</td>
<td>Professionals and mentors/facilitators, and evaluators involved in the intervention</td>
<td>External researchers/evaluators</td>
</tr>
<tr>
<td>Language of focus of intervention</td>
<td>Social inequalities in health</td>
<td>Health promotion: Examined all projects designed and carried out by team C as per the seven dimensions by Rootman et al. (Rootman et al., 2001a): empowerment, participation, holism, intersectorality, equity, sustainability and an ecological approach.</td>
</tr>
<tr>
<td>Analysis and planning</td>
<td>(1) Sources of information used in selecting the intervention (empirical, scientific and theoretical), focus given to social and behavioral determinants of health, identification of the subgroups affected by the issue and determinants affecting these different subgroups of the population. (2) Involvement of partners, experts and target groups. (3) Influence of the literature on the intervention chosen. (4) Objectives of the intervention addressing the social determinants of health, target different levels of action, reduce social inequities in health and conform to the analysis of the issue.</td>
<td>In this phase, we added various sub-items for each of the four projects in areas, such as description and analysis of the problem, involvement of partners, spin-offs of projects and development of educational tools.</td>
</tr>
<tr>
<td>Implementation</td>
<td>(1) Incentives and work methods encouraging participation and seeking input from partners. (2) Definition of tasks, responsibilities and identification of intervention coordinators/directors. (3) Leadership sharing among all actors involved. (4) Adaptation and accessibility of intervention to target groups and stigmatization.</td>
<td>In this phase, we added various sub-items in areas, such as incentives to involve partners, work methods, obstacles faced in implementing the projects, leadership sharing with target groups and appropriateness of tools to reach the target groups.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>(1) Evaluation plan in place from the planning phase and beyond the pilot stage. (2) Participation of different actors in all stages of the evaluation. (3) Evaluation plan envisions possible negative effects of the intervention on the different subgroups and the effects over the long term.</td>
<td>This phase was not completed because this team did not undertake a formal evaluation of its projects concurrent with the HPL. Consequently, an analysis of items in this phase was not possible.</td>
</tr>
<tr>
<td>Sustainability</td>
<td>(1) Integration of activities leading to the sustainability of the intervention starting from the planning stages and going beyond the pilot stage. (2) Investment of human and financial resources dedicated to the intervention. (3) Organizational risks (staff, logistics) in place to support the intervention.</td>
<td>No changes were made to items in this phase.</td>
</tr>
<tr>
<td>Empowerment</td>
<td>(1) Activities embedded throughout the different phases of the intervention to develop participants’ self-esteem, reinforce technical capacity. (2) Enhancement of the critical consciousness of the target groups involved.</td>
<td>We added sub-items in order to capture activities leading to participation and empowerment of partners and pertaining to intersectoral work.</td>
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</table>
The group was composed of eight members from the Children and Family Services’ Division of the CSSS who agreed to enroll in the HPL voluntarily. These professionals offer one-on-one counseling on nutrition, vaccination, education, children’s behavior and family life. They work with mothers and their families who have children less than 5 years old. By enrolling in the HPL, these professionals agreed to reflect on their practice and to develop a pilot health promotion intervention as stipulated in the HPL’s operational approach (Table 1).

Data collection
We collected data from three sources. First, we examined documents, such as meeting minutes, the program promoter’s logbooks, educational tools used in meetings and materials developed by the team (e.g., articles, promotional brochures). We used these data to complete the first version of the HPL-AG. Second, informed by the results of the application of the HPL-AG, we used this grid as an interview tool, to conduct one in-depth interview (administered in two encounters) with the PHDM program promoter to clarify and complement the HPL-AG findings. Third, we conducted one focus group with team members. At this session, we presented a summary of the results by each phase of the HPL-AG and the participants validated and corroborated findings. The program promoter and group interviews were digitally recorded with the participants’ consent. Our project obtained ethical approval from both the Montreal Health and Social Services Agency and the Université de Montréal’s ethics committees.

Data analysis
Given that health promotion dimensions are integrated transversally at each HPL-AG phase, we used the HPL-AG items as deductive, predetermined codes to analyze the intervention (Saldaña, 2013). We coded the team’s data in two steps: (i) S.T. used ‘holistic coding’ to manually code the data by numbering each data paragraph to the corresponding HPL-AG item (Saldaña, 2013). After the data coding was completed, S.T. summarized and entered the item data into the HPL-AG electronic version. Next, L.R. validated the initial coding by manually examining the HPL-AG items individually, and S.T. recoded jointly agreed upon items. (ii) After consulting an author of the original grid concerning the usefulness of a five-level scale (poor, fair, good, excellent and non-applicable), we developed a codebook presenting the scale value parameters. Then S.T. assigned individual values to each item of HPL-AG’s responses, which were validated by L.R. (see Supplementary material, Appendix A). The analysts mutually resolved disagreements throughout the coding phases. Disagreements, such as discrepancies on values assigned to items, were minor. Particular items related to Projects 3 and 4—of each of the phases were determined to be non-applicable on the basis of data not yet being available. We collected, coded and analyzed the data in French. We translated the citations used in the ‘Results’ section.

RESULTS
Team C members completed the HPL in ~280 h, with 56 half-day sessions over the course of 35 months (January 2011–December 2013). Before joining the HPL program, the team’s practices had mostly centered on one-on-one clinical post-natal monitoring of babies’ health after mothers were released from hospital and follow-up of babies’ weight gain and development. As part of the HPL program, this work was expanded to encompass four preventive and multi-layered factors that have an impact on children: daycare access, breastfeeding, social support and neighborhood safety. The team designed four projects that address the respective factors, with the goal of improving the health of children of vulnerable families in the CSSS territory. Projects 1 and 2 were designed and carried out during the HPL. Projects 3 and 4 were designed during the HPL; but given the length it took the team to complete the seven-step HPL operational approach, these two projects were implemented post-HPL.
Project 1 consisted in setting up collaboration agreements with not-for-profit daycare facilities in order to reserve some places for children from marginalized families. Project 2 focused on establishing a network with local partners (e.g., breastfeeding support organizations, private clinics, hospitals) to promote breastfeeding. Another component of this project involved administering a follow-up telephone call to mothers 3 weeks after the delivery of their newborns to support and monitor their breastfeeding practices. Project 3 focused on establishing the foundation of an initiative to provide social support to isolated immigrant mothers and Project 4 began the groundwork with a network of agencies to foster neighborhood safety, especially for families experiencing vulnerability. Because the majority of the implementation tasks for Projects 3 and 4 were carried out post-HPL, only partial data are reported in this study (see Supplementary material, Appendix A).

In the sections that follow, we summarize team C’s projects by means of the HPL-AG phases. In doing so, we highlight which health promotion dimensions appeared to be integrated in each phase. While we present each phase as a distinct component, in reality, the phases overlap, especially as team C designed and implemented projects sometimes sequentially, and sometimes simultaneously.

Analysis and planning phase
The HPL-AG’s analysis and planning phase has 26 items addressing multiple questions on the intervention, ranging from the literature used to understand the problem to the participation of the target group (community members). This phase is crucial to setting the foundations of a health promotion approach for the full intervention and involves making informed decisions about the nature and scope of the intervention (Bartholomew et al., 2011; Guichard and Ridde, 2010). Integrating multiple dimensions of health promotion in this phase sets a path for the remaining phases of the intervention (Rootman et al., 2001a). In analyzing and planning the four projects, team C used mainly the scientific literature, complemented by gray literature, to understand the protective factors that had an impact on children experiencing vulnerability.

From a holistic perspective, this literature (Institut de la statistique du Québec, 2011; Miszkurka et al., 2010) helped the participants understand the social determinants underlying these factors, including healthy child development, social support networks, income and social support and unemployment. Findings also reveal that the participants identified specific subgroups, affected by each of the protection or risk factors, for example, families with children from 0 to 5 years old, in particular, those from immigrant backgrounds who were new to the country and experienced marginalization, had insufficient knowledge of the host country language(s) and lived in poverty. Looking at intersectorality, the participants worked with partners from different sectors, such as publically funded childcare centers, non-governmental organizations, hospitals and private clinics, as well as with academic experts, for example, on the issue of depression among immigrant women. The purpose of their intersectoral work was to gain a richer understanding of all protection factors pertinent to the four projects.

Examing equity (Potvin et al., 2007), the team members addressed social inequalities by tailoring the four projects, which implicitly addressed the social determinants of health. For one participant, working with vulnerable populations is part of addressing social inequalities:

I think there is inequality, if one/we . . . if an immigrant who has just arrived doesn’t have access to public services as such; they’re not accustomed; they don’t speak the language, they are not . . . ; they don’t know how to dress or find reasonably-priced clothes for their children, they don’t have access to food banks, all of that to me means social inequality. Ref. 21.8: FG-03-26-14.

Considering an ecological perspective (Richard et al., 2010), the four projects aimed at targeting various levels of action: organizations or agencies supporting mothers and families with small children; the community at large or networks of agencies improving safety in the neighborhood; mothers with children from 0 to 5 years old and mothers’ friends and families. One participant stated:

But the work is not just about breastfeeding.

Because our target audience, in fact, is the baby. But surrounding the baby is the family, so one always needs to work around this. Ref. 13-28: FG-03-26-14.

Implementation phase
The HPL-AG implementation phase has 19 items, ranging from inquiring about multiple actor participation and intersectorality incentives to leadership sharing to clarifying the roles of team members and addressing issues of accessibility and sources of stigmatization. Notwithstanding that phases are non-linear (Guichard and Ridde, 2010), the implementation phase is crucial to operationalizing decisions made in the analysis and planning phase. This phase entails putting into practice the mechanisms, measures, strategies, logistics and tasks necessary to ensure that the intervention is carried out as planned (Green and Kreuter, 2005; Guichard and Ridde, 2010). In this phase, the participants worked with partners across various sectors to ensure that all four factors were addressed.
They sought to rebuild, consolidate and establish new partnerships with sister agencies in the territory, such as breastfeeding support organizations. Collaborations with them were among the main raison d’être of the HPL program. Team members also consulted extensively with experts on the socioeconomic status of children under five in the territory. One participant explained how they worked with partners:

It means sitting down together and looking together at what who does what, . . . That’s also the goal, to create links with the various stakeholders . . . we wanted to better support our mothers, but there was also a matter of harmonization [of services]. Ref. 8-11: FG-03-26-14.

In line with research on team effectiveness and the importance of goal clarity and alignment (Peralta et al., 2015), the team ensured that the roles of all involved were clear (i.e. ‘who’ does ‘what’). This included having distinctly defined roles and responsibilities for the coordinators for each of the four projects as well as tasks for each team member.

Taking stock of the key role of shared leadership (Carson et al., 2007; Konu and Viitanen, 2008), the participants shared the leadership with partners. For example, during the implementation of project 2 activities, one partner of the breastfeeding network took the lead to coordinate and host the network meetings. Team members encouraged leadership with the CSSS, providing some financial support for this partner’s work with the network. Other incentives for partner participation included training for network members at meetings.

In regard to accessibility, the projects addressed physical access because the installations frequented by these groups were already accessible. With respect to stigmatization or discrimination issues, participants recognized that communication barriers existed between them and the mothers and families who did not speak English or French.

Evaluation
The HPL-AG has 10 items in the evaluation phase, ranging from an evaluation plan being in place at the outset of the program to participation of the target group to consideration of the long term effects (negative or positive) of the intervention. Evaluation is a key component of health promotion planning (Rootman et al., 2001a); however, according to data, team C did not have a formal evaluation of the projects implemented as an objective during the HPL. One participant stated:

No, we have no intention of doing that. Ref. 18-3: FG-03-26-14.

Sustainability phase
The HPL-AG has four items in this phase, ranging from sustainability issues addressed at the outset of the intervention to the stabilization of resources dedicated to the projects over the long term. Sustainability of the intervention requires that continuation of the initiative be considered from the analysis and planning phase and routinized as well as institutionalized beyond the pilot stage (Pluye et al., 2004). In this study, the participants developed a sustainability plan for the projects towards the end of the HPL program. This plan involved routinization of the intervention by devoting, post-HPL, 1 h of discussion at every staff meeting of the Children and Family Services’ Division, so that everyone could reflect on the projects. One participant stated,

We are now going to have our team meeting from 9 am–12 pm because we’re adding an hour of lab [HPL] time from 11 am–12 pm. As for the girls who were at the clinic, all of that was canceled so everyone can participate. Ref. 19-23: FG-03-26-14.

In addition, the division assigned responsibility to two team members per project to ensure continuity of the activities beyond the pilot stage.

Empowerment phase
The HPL-AG has 11 items in the empowerment phase, ranging from embedding activities leading to empowering the target groups to developing critical thinking of partners. Empowerment is linked to meaningful participation of all actors involved in the intervention throughout the different phases of the projects (Rootman et al., 2001a; Guichard and Ridde, 2010). According to the participants, the four projects aimed to improve the coordination of services among partners who already had enough ‘power’ and capacity to act among themselves. For one participant,

It’s not an issue of empowerment. It is an issue of sharing. Ref. 20-21: FG-03-26-14.

In regard to the empowerment of mothers and family members, they were consulted at some point during the intervention, but they were not involved in planning and implementing the four projects. One participant stated:

I find that it’s the best way that is to involve the mothers in the process. This is often discussed at our table, with our group of infants where we try . . . but if you knew about our population, you would understand, that would be more difficult, they’re immigrants who aren’t familiar with institutions, they’re not used to working like that in a democratic way, they need to be led to all of that, it is
In conclusion, the results reveal the integration of several dimensions of health promotion during the different phases of the pilot intervention (equity, holism, ecological approach, intersectorality and sustainability). The results also illustrate a lack of integration of a couple of dimensions in the intervention (empowerment and participation).

Summary of results from the five-level scale
Table 3 presents the HPL-AG percentages of the scale value given to the four projects during each phase of the intervention. Rankings of excellent or good indicate integration of the health promotion dimensions, and rankings of poor or fair indicate a lack of integration of particular dimensions.

Projects 1 and 2 are the only ones for which most data on implementation were available; nevertheless, Table 3 indicates a lack of integration of the empowerment dimension, but suggests full integration of the sustainability dimension.

Using the HPL-AG
We used the HPL-AG grid to assess the pilot intervention after it was completed. As discussed earlier, we presented a summary of the findings to team C members in the focus group, as documented in the HPL-AG by phase. Given that the participants were not familiar with the grid, a few of them challenged the relevance of some questions. For example, the question focusing on the different levels of actions targeted by the intervention did not appear relevant to these participants. As researchers, we had to clarify our language and meaning. In contrast, the question addressing social inequalities drew a different reaction, seeming to trigger all participants to reflect on the isolation experienced by marginalized communities, which they had discussed during the HPL. Reviewing their projects phase by phase appeared useful for the participants. The PHDM program promoter also commented on the grid, indicating that it was too long and that many questions seemed repetitive. All participants, however, became engaged in discussing what they had achieved during the HPL and what more they could be doing after completion the HPL.

DISCUSSION
Developing innovative interventions that are in sync with a health promotion paradigm often represents a challenge for professionals. Thus, it is crucial to have tools and processes that favor new practices. Our adaptation and application of Guichard and Ridde’s analytical grid has proven useful in two ways: (i) to assess the integration of a health promotion approach throughout the different phases of the HPL pilot intervention; and (ii) to shed some light on what the results reveal about the HPL program and highlight some recommendations about the HPL’s operational approach.

Applicability of the HPL-AG in assessing the health promotion intervention: using the HPL-AG, we found that the team participation in the HPL program yielded actions and projects that are compatible with a health promotion approach owing to its integration of several dimensions of health promotion (equity, holism, ecological approach, intersectorality and sustainability) (Rootman et al., 2001a). This integration may be interpreted as an indicator of new and improved health professionals’ practice. On the other hand, our findings revealed a lack of an explicit integration of the dimensions of empowerment and participation, especially with respect to the target group, which represents an opportunity for further improvement of practice. The HPL-AG’s comprehensiveness encompassing multiple dimensions of health promotion was useful in allowing in-depth examination on each phase of the intervention. We also noticed that the grid prompted reflection during individual and group interviews with the participants. The grid’s comprehensiveness, however, could also be a limitation in that it would best be administered through in-person interviews in order to maximize the understanding of the problematic in question (Guichard and Ridde, 2010). For organizations, this requires commitment to train staff on how to use the grid or to hire external consultants to accompany them in the process. Nevertheless, its benefits—developing interventions

Table 3: Percentages across the four projects from the five-level scale

<table>
<thead>
<tr>
<th>All four projects</th>
<th>Poor (%)</th>
<th>Fair (%)</th>
<th>Good (%)</th>
<th>Excellent (%)</th>
<th>N/A (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis and planning</td>
<td>12.50</td>
<td>1.92</td>
<td>18.27</td>
<td>56.73</td>
<td>10.58</td>
</tr>
<tr>
<td>Implementation</td>
<td>13.16</td>
<td>10.53</td>
<td>19.74</td>
<td>19.74</td>
<td>36.84</td>
</tr>
<tr>
<td>Evaluation</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Sustainability</td>
<td>0.00</td>
<td>0.00</td>
<td>75.00</td>
<td>25.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Empowerment</td>
<td>27.27</td>
<td>2.27</td>
<td>11.36</td>
<td>0.00</td>
<td>59.09</td>
</tr>
</tbody>
</table>
and implementing interventions that are compatible with a new public health paradigm—overweight its limitations.

The HPL-AG and the HPL \textit{operational approach}:

This is the first ALPS study to report on the HPL’s pilot interventions developed by the team. Other studies published so far have reported on the implementation of the HPL, the HPL’s logic analysis, the HPL reflexivity and competency development among the HPL program participants \citep{Richard2015, Tremblay2013a, Tremblay2013b}. Examining the full pilot intervention, we found that the HPL \textit{operational approach} directs participants to analyze the socioeconomic and environmental context in which the interventions take place as well as the need to work intersectorality. The HPL \textit{operational approach}, however, is silent with respect to participation and empowerment of community members. In addition, it does not make a requirement to evaluate the interventions explicit \citep[see Table 1]{tiers}. With respect to the evaluation phase, the literature notes that a clear evaluation plan involving participation of all actors at all stages of the intervention is required \citep{Potvin2008, Guichard2010, Bartholomew2011}. The HPL’s operational approach outlines the development of a logic model for the intervention, which could have contributed to assessing the evaluability of the projects developed by the participants \citep{Dwyer2003}. However, participants were adjusting to learning new ways of working and developing new projects \citep{Potvin2012}, which might explain not having evaluation as a priority during the HPL. In addition, integrating evaluation into the organizational culture requires investment of time and resources, which many organizations have not or cannot reach yet \citep{Mayne2009}. In this regard, the HPL-AG provides a good basis for reflection on the need of health promotion interventions to integrate evaluation in all phases of the intervention.

With regard to the empowerment phase, Rootman \textit{et al.} \citep{Rootman2001} have suggested that ‘...the primary criterion for determining whether a particular initiative should be considered to be health promoting, ought to be the extent to which it involves the process of enabling or empowering individuals or communities’ \citep[p. 14]{Rootman2001}. Authors note that empowerment entails community actors having a sense of collective efficacy, political efficacy and critical thinking \citep{Wallerstein2006, Laverack2000}. It involves public health institutions or agencies considering themselves one of the partners in the intervention \citep{Nguyen2003}, and using a combination of bottom up and top down approaches in designing and carrying out the interventions \citep{Bloch2014}. In addition, it is necessary to let community members take time to develop leadership in the project without being constrained by a budgetary predetermined timeframe \citep{Sardu2011}. In reality, however, program design as well as internal and external factors facilitate or hinder the integration of participation and empowerment in interventions. The HPL-AG comprehensives, however, provide the bases for reflection on integrating these dimensions from the outset of the intervention. We suggest that the HPL program promoters include a reflection on these key components in a future iteration of their approach.

\textbf{Authors’ reflexivity}

We used the HPL-AG’s items and dimensions as predetermined codes \citep{Saldaña2013} in order to harmonize our analysis with the research goals for the study \citep{Saldaña2013}. Given our peripheral (external researchers/evaluators’) role in this study, this approach provided a structured method for coding and analyzing the HPL’s pilot intervention. Further research, however, could provide insights into other aspects of the HPL program; for example, in helping to understand what went on behind the scenes for HPL program participants and power relations between health professionals and women and families. Undertaking research to capture these dynamics ought to be considered.

\textbf{Limitations}

First, this article focuses on a single case study. Second, no baseline data were available on the participants’ knowledge of health promotion concepts prior to starting the HPL program. The results presented in this article are based on available data. It is therefore impossible to precisely determine what aspects of their knowledge or work are attributable to the HPL and what aspects may have existed before the HPL. Third, the scheduling of the validation session with the participants was done 3 months after the HPL had been completed or 35 months from the beginning of the HPL. As a result, the participants had to rely on recalling what had happened 1–3 years before. To overcome these limitations, we provided additional information to the participants, citing documents, dates and statements from their written materials, which worked well in helping the participants provide input on the findings presented.

\textbf{CONCLUSION}

We have demonstrated in this article that the HPL-AG was a useful tool to examine the extent to which the HPL program participants have applied a health promotion approach in their pilot intervention. We found that the
intervention is compatible with a health promotion approach, owing to its integration of several dimensions of health promotion (equity, holism, ecological approach, intersectorality and sustainability). This integration may well be interpreted as an indicator of new and improved health professionals’ practice. However, we also found a lack of an explicit integration of the dimensions of empowerment and participation, especially with respect to the target group, and a lack of a formal evaluation phase, all of which represent an opportunity for further improvement of practice. To address this gap, we proposed that these dimensions and evaluation phase be explicitly included in the HPL’s operational approach and across all phases of health promotion interventions. Furthermore, we suggest that Guichard and Ridde’s grid is a useful tool to plan and assess health promotion interventions that are multidimensional and that professionals in the HPL program may want to consider using it for ongoing critical reflection of their practice (Guichard and Ridde, 2010).

SUPPLEMENTARY MATERIAL
Supplementary material is available at Health Promotion International online.

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