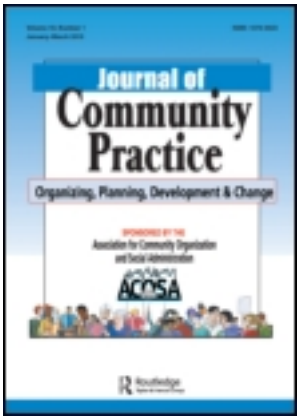

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Educating Students for Community-Based Partnerships

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ABSTRACT. Many courses for students in professional schools may expect or require a learning experience ''in the community.'' Simple placement in a community does not assure, however, that students will develop competencies from a community-based perspective, that is, competencies that enable professionals to: (1) enhance the capacity of community members to serve in partnership endeavors; (2) appreciate

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the role of participation by under-represented or under-served populations; and (3) develop skills for mobilizing community resources to address community-defined priorities. This article describes six domains–course goals, partners, exposure, product, classroom activities, disciplines–to characterize courses and other learning experiences, in order to assess the extent to which they promote community-based competencies. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.haworthpressinc.com>]*

KEYWORDS. Community-based teaching, community-based learning, service learning, collaboration, partnerships, community-based public health

Recognizing the increasing complexity of the determinants of health and well-being for individuals and populations, many prominent groups have argued for changes in the nature of the teaching and research that constitute the educational experiences for students pursuing health and human service careers. The Pew Commission on Health Professions has urged health schools to focus on education ''that understands and serves a broader set of community needs'' (O'Neill, 1993, p. 18). The Sun Valley Forum and the Association of Academic Medical Centers called for universities and health departments to ''foster and participate in true collaborative partnerships and share responsibility in the development and implementation of a community-driven agenda to improve the health of the people and the health of communities'' (Hogness, 1995, p. 169). In social services, the importance of collaboration and partnership has also stimulated interest in education on community building and practice (Morrison, Howard, Johnson, Navarro, Plachetka & Bell, 1997; Weil, 1996).

Reaching consensus, however, on the changes needed in education to bring communities to the center of the academic endeavor, whether in public health or other service professions, is fraught with difficulty. The purpose of this article is to describe the experience of the North Carolina Community-Based Public Health Initiative in addressing the issue of how to define and structure learning experiences in order to enhance the competencies of students to practice public health in ways that foster collaborative partnerships with communities. While many academic courses may expect or require a student experience ''in the community,'' it is important to define what is meant by a community

experience. The focus of this article is twofold. First, we define principles that underlie the term ''community-based,'' in contrast to other types of community experiences. Second, we describe criteria to characterize courses and other learning experiences, in order to assess the extent to which they are community-based.

BACKGROUND OF THE NORTH CAROLINA COMMUNITY-BASED PUBLIC HEALTH INITIATIVE

In 1992, the W. K. Kellogg Foundation launched the Community-Based Public Health Initiative (CBPHI) and supported consortia in seven states to enhance the capacity of partnerships among community-based organizations, health agencies, and schools of public health to address public health issues (Parker, Eng, Laraia et al., 1998; Margolis, Stevens, Baker et al., 1996). The North Carolina initiative is built upon a set of principles to focus teaching, practice and research in order to bring communities to the center of the public health endeavor. These principles emerged from an agreement among three community-based organizations, six health agencies, and two academic centers in North Carolina on conditions for joining a consortium to participate in this initiative. These conditions included, among others, the specification of particular community partners (instead of ''community'' as a setting), a commitment to community-identified issues and priority-setting, and a focus on improvements in service systems rather than addressing a categorical disease.

The first principle was that community-based public health enhances the capacity of communities to address issues of concern. Moving away from a service model that characterizes communities with needs and public health professionals as experts with the knowledge and expertise to address those needs, community-based public health strives to assure that community voices are, in the words of one community member, ''at the table.'' More specifically, this principle meant that communities would become partners in the performance of the core functions of public health–assessment, policy development, and assurance (Institute of Medicine, 1988).

A second principle of community-based public health was that the consortium would broaden the participation by vulnerable communities. Whereas the first principle advocates a key role for communities in decision-making, the second principle focuses on communities that

are traditionally under-represented in decision-making and, therefore, often under-served. For example, in this initiative, the four community partners were predominantly African-American, with incomes and other economic resources that placed these communities at higher risk than neighboring communities for poor health.

A third principle involved the development of skills among community residents in mobilizing resources to address community priorities. An important aspect of this attribute is the recognition that community members have multiple personal skills (for example, leadership and organizational skills) and belong to numerous formal and informal associations, such as service clubs and churches, that can be nurtured and brought to bear on issues of concern. Further, while agency financial and programmatic resources are often essential to address public health concerns, the assets of community members may make the difference between the success and failure of an initiative in a community (Saleebey, 1997; Kretzmann & McKnight, 1993).

In order to advance these principles, the CBPHI consortium fostered an approach to coalition-building, consistent with community building in social work practice, for which the outcome of improved community capacity would be as important as improved health (Weil, 1996). This approach included strategies to enhance the capacities of community partners to: (1) participate in and lead public health policy-making and implementation; (2) redefine health agency relationships with the communities they serve; and (3) develop greater community orientation in academic teaching and research (Parker, Eng, Laraia et al., 1998).

These strategies were implemented in four counties, whereby local health agencies, community-based organizations, and the School of Public Health and Area Health Education Center of the University of North Carolina were represented on four distinct coalitions. Each coalition served as the organizing force behind community-driven projects to address public health issues that would contribute to the goals and objectives identified by their communities. The community-based projects implemented by one or more of the four coalitions were: a neighborhood drug patrol (one coalition); recruitment and training of lay health advocates (three coalitions); youth health education and leadership training (three coalitions); a series of workshops or roundtables for minority business owners (one coalition): construction or renovation of community parks (three coalitions); and a chronic disease task

force focusing on diabetes (one coalition). How the lessons learned from these projects were disseminated to students of public health are described in the next section.

IMPLEMENTING AND ASSESSING COMMUNITY-BASED EDUCATION AT THE SCHOOL OF PUBLIC HEALTH OF THE UNIVERSITY OF NORTH CAROLINA

As articulated by the Institute of Medicine in *The Future of Public Health* (1988), the growing complexity of public health behooves educators to expand the traditional, narrow, discipline-based competencies to include ''understanding of how a particular discipline relates to the whole of public health, and an appreciation of the relationship of public health to social endeavor as a whole'' (IOM, p. 157). The Pew Health Professions Commission identified many competencies for health professionals for the year 2005 (O'Neil, 1993). Although the focus of the Commission was on clinical services, several competencies are applicable to public health and/or population-based practice. For example, the ability to ''understand the determinants of health and work with others in the community to integrate a range of activities that promote, protect, and improve the health of the community'' (O'Neil, 1983, p. 8) is a competency that speaks to the practice of public health and implies a community-based dimension. Understanding the need to emphasize ''primary and secondary preventive strategies for all people and help individuals, families, and communities maintain and promote health behaviors'' (O'Neil, 1993, p. 8), similarly suggests a community-based focus.

Based on these competencies suggested by the Pew Commission and the lessons learned from CBPHI, we have worked with our community and agency partners to develop the following competencies for students to learn from courses that can be characterized as community-based:

The Ability to Enhance the Capacity of Community Members to Serve as Partners in the Performance of Public Health Core Functions

This competency underscores the high value afforded to the concept of partnerships in community-based public health. While courses may

teach students ''about'' communities, a community-based course would enable students and faculty to leave skills with community members. Planning a health promotion program, running a community meeting, or recruiting community members to join an activity exemplify skills that will enable community members to continue to affect their communities, even after the student course or project has concluded.

The Capacity to Identify Under-Represented or Vulnerable Populations and to Enhance Their Participation in the Public Health Endeavor

This competency also builds upon the concept of partnership. Populations that are well-served by public and private agencies may be more accustomed to interacting with the university than are individuals from under-served communities. Encouraging community participation in assessments, program development, and evaluation by under-served populations will advance the abilities of students, faculty, and community members to act as partners.

Skills for Mobilizing Community Resources to Address Community-Defined Priorities

There are two principle components to mobilization–collaboration and identification of community assets. Community-based courses would help students develop strategies to bring varied interests together. Skills in promoting collaboration among groups of diverse backgrounds and building coalitions are fundamental to community-based public health. Another component would focus specifically on resources. The conventional view of program planning has been to identify ''needs'' or ''deficits'' in communities and then try to find the resources, usually financial, to fill those needs (Saleebey, 1997; Kretzmann & McKnight, 1993). One of the important contributions of community-based public health has been to begin to integrate the concept of community assets and strengths into the practice of public health (Parks & Straker, 1996; Ammerman & Parks, 1998). Community-based teaching would develop an appreciation of the assets that communities themselves can bring to bear on issues.

After student competencies that reflect community-based principles were defined, the second step was to design learning activities that

would appropriately and effectively develop the desired knowledge and skills. Historically, education for health and other service professionals has involved a range of activities from conventional didactic presentations, to structured and supervised clinical encounters, to placements in agencies that are responsible for assessing and assuring the health of populations. Field study, both in public agencies and in community settings, is a key component of many masters programs (Community-Campus Partnerships for Health, 1997; Council on Social Work Education, 1994; Center for Public Health Practice, 1993; Sorensen & Bialek, 1991). Similarly, many students are required to perform internships, which enable them to commit blocks of time to a particular setting outside of the school. Volunteerism represents yet another type of experiential education. Many students are drawn to public health, for example, because of the value they place on community approaches to public issues, so it is not uncommon for public health students to volunteer their time in formal organizations with long-standing agendas for social action or informal associations that come together to address short-term problems or concerns.

To assess which courses and learning experiences have the potential to develop the competencies needed for the community-based practice of public health, we have developed a matrix that consists of six domains: goals, partner, exposure, product, classroom, and disciplines. These grew out of discussions among community partners and faculty participants about their shared and differing expectations for students who undertake community classes and projects. As a starting point for characterizing courses and other educational activities of the School of Public Health, we have applied a 6 point scale to each of these dimensions, ranging from 0 (no community content) to 5 (community-driven content). What follows is an elaboration of these domains as shown in Table 1.

Goals

This domain assesses whether a given course explicitly addresses competencies necessary for community-based practice. Although skills such as data analysis, policy analysis, or environmental assessment may be important for addressing community issues and are crucial for a well-educated public health professional, community-based courses would articulate the principles outlined above.

TABLE 1. A Continuum of ‘‘Community-Based” Learning Experiences

	1	2	3	4	5
Course Goals	Community-based competencies are mentioned in course goals or objectives	Strategies to develop community-based competencies are described	Strategies to develop community-based competencies are strongly emphasized	The development of community-based competencies are a central component of the course	Primary goals of the course are to develop community-based competencies
Partner	Primary Care Treatment Facility, e.g., hospital	Primary Care Prevention Center, e.g., community health center	Agency working with community members	Community group in coordination with an institution	A grassroots group, serving vulnerable populations
Exposure	In the “community” one time to observe	In the community partial time, e.g., a section of the class	Frequent visits to the community	Ongoing regularly scheduled visits to the community	In the community full time in order to enhance partnerships
Product	A single presentation to community members	A student initiated report to be used by a community organization or institution	A report, tool or educational material to be used by the community, developed with some community input	A report, tool or educational material developed with substantial community input	A community-initiated product with sustainable value, reflecting an understanding of local assets, created in partnership with students
Classroom	Focus of class is community-based issues and work, but no time spent with community members	Course occasionally brings people of the community into classroom to participate	Course regularly brings people of the community into classroom to participate	Faculty and community members together develop and plan a course that includes regular community participation	Faculty and community members in partnership to teach an interactive class, integrating students from several departments
Disciplines	One faculty teaching community issues from the perspective of a single discipline	One faculty member teaching a multi-disciplinary approach focused on community-based health	Joint teaching by faculty from at least two disciplines	Faculty from different disciplines structure a course with content from different disciplines	Faculty from different disciplines structure a course that goes beyond the parallel use of different disciplines to engage in multi-disciplinary inquiry

Partner

The partner reflects the responsible and participating group or agency outside of the University. An agency providing primary health care could be a community site for community-based teaching. Although primary care most narrowly refers to personal medical care that provides first contact with the health system, with comprehensiveness and coordination, more broadly it encompasses attentiveness to community-driven needs and desires. Therefore, a primary care treatment facility in a hospital would be community-based if it could demonstrate a role for community members in the setting of priorities.

Slightly further along the continuum would be agencies for which the primary mission is to meet the primary and preventive needs of a community. Examples include local public health departments and community health centers. The next step on the continuum involves community agencies whose primary roles would be outside of health, but whose activities ordinarily involve a fair degree of partnership with community members. For example, course activity that works with Head Start or Housing Authority Residents' Councils would address the public health aspects of those programs. At the end of the partners continuum would be grass roots organizations. In the North Carolina CBPHI initiative, for example, the community partner in Wake County was Strengthening the Black Family, Inc. Formed in 1980 for the single purpose of sponsoring an annual conference on issues of concern to African-American families, this organization, through its volunteer board and staff, now oversees a Teens Against AIDS program, a community computer access program, and the Southeast Raleigh Center for Community Health and Development, established to house the CBPH initiative activities.

Courses or field work that involved a primary care facility would receive a score of 1 on partnership. Courses engaged with community-based organizations, such as Strengthening the Black Family, Inc., serving vulnerable and/or under-represented communities, would receive a 5.

Exposure

The exposure dimension refers to the amount of time spent in the community. At a minimum, a community-based (or more accurately at this end of the continuum, a community-focused) course would require a visit outside of the classroom. While classes may involve teaching and other forms of participation by community members in university classrooms, the community-based experience would encourage students to venture out from the University. Currently, it is possible for some public health students to complete their masters training without leaving the classroom. Students in five of the eight departments of the School of Public Health are expected to undertake an internship or practicum outside of the University, but these placements do not necessarily require time spent with a community.

Courses that involve a visit to a community site would receive a score of 1. Courses that encompass an ongoing placement at a commu-

nity site with a community-based organization would receive a score of 5. The *ongoing* placement reflects the idea that the ability to develop and enhance partnerships is most likely to come from the commitment of substantial time.

Product

The third dimension of this matrix is the expected product. The creation of a product that is useful to community members is essential to community-based teaching. At one end of the spectrum this would involve a single presentation to community representatives about the issue or question under study. At the other end of this spectrum would be a community-initiated product created in partnership with students. For example, recently a community-based organization raised the issue of school busing as a barrier to the receipt of school health services for children. Since magnet schools had been created in the neighborhood in order to attract a more diverse student population, most of the children in the community in question attended elementary schools in other parts of the county. A team of students enrolled in a program planning course applied these skills as they developed a framework for community members to use in addressing this issue to begin to influence school health policy. Another student fulfilled an internship requirement by working with the four CBPHI coalitions to plan and produce a video documentary of the project. In sum, a product that is motivated by community insights, uses community assets, and enhances the capacity of the community would contribute to the acquisition of community-based competencies.

Classroom

The fifth dimension reflects the position that community-based teaching would be most effective when community members are co-instructors. A course receiving a score of 1 would be community-based solely because of its focus, but not include any classroom interaction with community members. The next level would occasionally involve community members as guest lecturers invited by the responsible faculty member. CBPHI initiatives in Baltimore, Oakland, and North Carolina have developed this type of ''community'' faculty. At the other end of the continuum, faculty and community members, in partnership, would jointly plan and teach an interactive class, integrat-

ing students from several different departments and backgrounds. For example, we have developed a course entitled ''Community Voices,'' which brings together students from public health, medicine, nursing, pharmacy, dentistry, and social work; faculty from several disciplines; and community members to address ways to promote community university collaboration and to develop listening skills, in particular, to facilitate work in communities. While there has been some degree of joint planning with community members who regularly participate in the presentations, this course would be accorded a score of 4.

Disciplines

In order to demonstrate the value placed on partnerships and the need for multiple perspectives to address public health issues, courses should expose students to more than a single discipline. Ideally, such a course would be team-taught by faculty members with different types of training and attended by students from multiple disciplines.

APPLYING THE COMMUNITY-BASED MATRIX TO COURSES

For illustrative purposes we describe the application of this community-based matrix to two courses. The first example, ''Rural Health and Community Action,'' ostensibly a course reflecting community-based principles and practices, received a score of 14 out of a possible 30 points. The ''course goals'' included the development of community-based competencies, but for the most part the course focused on rural health in contrast to the community action component so the score was 3. The course involved interaction with rural health agencies, but not community groups, so the ''site'' score is 3. The class required no time spent outside of the School of Public Health in rural settings, so the ''exposure'' score was 0. Students produce papers reflecting a rural health issue, but since community members were not necessarily involved in the definition of the product, the score was 3. Community members and rural professionals were invited into the class so the ''classroom'' score was 3. Finally, since the class is taught by a single professor, based on that individual's own training, the ''discipline'' score was 2.

The second example, ''Public Health Program Planning and Evaluation,'' required students to work in groups of 2 to 4 in order to define a public health problem and develop a program plan to address it. For this illustration, one student project called upon students to develop community-based competencies, but not as the primary goal of the course. The score for the ''goals'' would be 4. Since the students worked with agencies engaged with community members, the ''partner'' score was 3. Students spent part of their preparation in the community setting, so the ''exposure'' score was 2. The ''product'' score was 2 because the students defined the issue and produced a final report, without a required or expected community role. The ''classroom'' dimension received a score of 2 because community members were occasionally called upon to offer their expertise in the teaching of the course, in contrast simply to providing information about the issue in question. The ''discipline'' score was 5 because the course was team-taught by four faculty from at least three different disciplines, and involved students from as many as 8 departments. The total score was 18.

During the assessment process, it became apparent that more intensive analysis would be necessary to assign valid and reliable scores. For example, course descriptions, designed for informational and perhaps marketing purposes, did not always reflect the substance of courses at the level required for this analysis. Ongoing work will involve interviews and interaction with faculty members and students about the degree to which courses manifest these dimensions of ''community-basedness.''

DISCUSSION

As faculty in academic professional programs, we have come to recognize that community partnerships are fundamental to the practice of public health, social work, and other human services. As members of communities and lay organizations, we have heightened our expectations for academic professional training to transfer skills that enhance partnerships with communities. Through implementing our Community-Based Public Health initiative, we have articulated three underlying principles of community-based work and defined three competencies that are important for students (as well as members of the service professions) to learn to develop partnerships. These competencies–understanding the importance of community capacity build-

ing, appreciating the role of participation by vulnerable populations, and developing skills for mobilizing community resources–give rise to more creative ways of thinking about curricula and criteria for accrediting professional degree programs.

To assess courses and other learning experiences guiding students in developing their capacities for community-based work, we have delineated six domains, each representing a continuum from minimal to maximal community-based focus. This tool may help to clarify for students, community preceptors, and faculty advisors what community-based academic training should accomplish. For example, learning contracts signed by three parties could define respective expectations, roles, products, and time commitments. Furthermore, such a tool can be used to compare and contrast service learning courses across academic units within a professional school and even across universities, given that the terms ''community'' and ''community-based'' have gained such currency. The application of this six-dimension matrix to self-identified ''community'' courses in our School of Public Health, for example, demonstrated lower than anticipated scores overall, thus highlighting the need for systematic curriculum planning and implementation that prospectively recognizes the multiple dimensions of community-based course offerings and field practica.

Faculty and community partners working with the CBPHI are continuing to refine these dimensions, as well as to assess curricula based on them. With the National Center for the Advancement of Community-Based Public Health, we are examining if and how the accreditation of other professional academic institutions includes community-based practice criteria. As the demands for the development of partnerships among academicians, agency professionals, and communities continue to grow, it is incumbent upon professional schools to exercise leadership in: (1) defining and identifying the skills needed to educate graduates who are competent partners in communities, and (2) developing the methods required to enhance those skills.

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