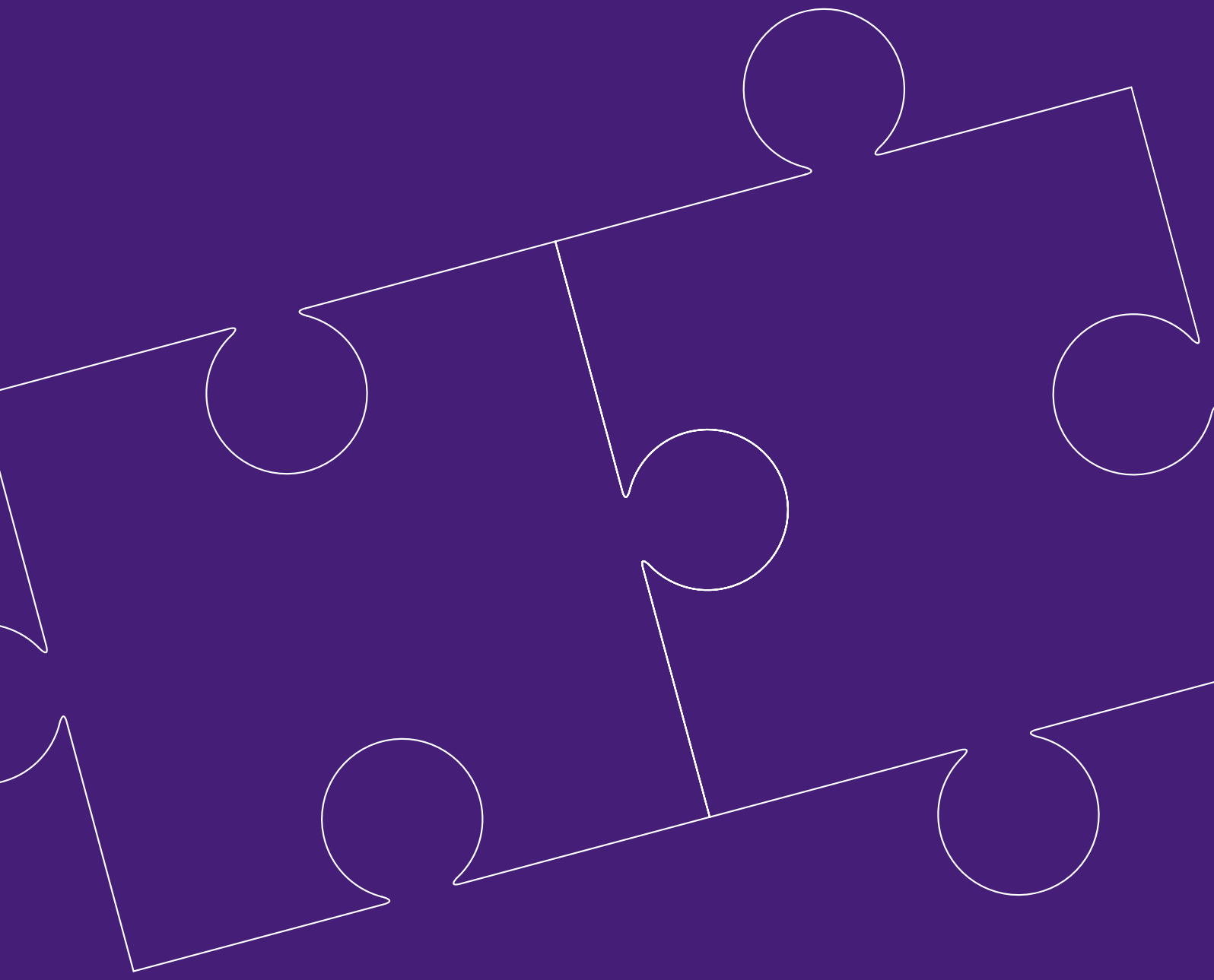
A Framework for Building Capacity to Improve Health



NSW HEALTH
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Health
Working as a Team
The Way Forward

NSW HEALTH DEPARTMENT

SHPN: (HP) 990226
ISBN: 0 7347 3124 8

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March 2001

CAPACITY BUILDING is...

An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.

Hawe et al: 1999

Foreword

NSW Health has one of the largest and best health systems in the world. The recently released *Health - Working as a Team: the way forward* commits NSW Health to further improvements in service delivery. While primarily focused on clinical care, these improvements also include an emphasis on preventing illness and promoting good health, health service providers working together, community participation, and a high level of leadership across the system.

One mechanism available to the health system to contribute to preventing illness and promoting health, is to incorporate effective health promotion programs into the routine work of services from across the whole health care continuum (prevention, diagnosis, treatment, rehabilitation and palliative care). Many parts of the system are already doing this.

This document, *A Framework for Building Capacity to Promote Health* provides a guide for enhancing the capability of the system to improve health. It is mainly focussed on building capacity within programs but it is paramount that when thinking about building capacity within programs, or within the community, that we are also focussed on building the capacity of the system to support change. Most importantly, the document emphasises five key action areas in capacity building: organisational change, workforce development, resource allocation, partnerships and leadership.

Using this framework will increase the likelihood that health promotion programs will be sustained and that people working on programs will have a greater capacity to address future health challenges, whatever those challenges may be.

This is useful information and I encourage health workers to adapt the framework to their setting or work environment with the understanding that in doing so, they will enhance the potential of the NSW Health system to maximise health investments and multiply health gains.

Michael Reid
Director General
NSW Health Department

Contents

Please note The term 'health promotion practitioner' or 'practitioner' is used within this document to refer to any person skilled in health promotion and working with others to increase their capacity to improve health. This means health promotion professionals, other health staff, staff from other organisations and community members.

Introduction

Building capacity to improve health is an important element of effective health promotion practice. It increases the range of people, organisations and communities who are able to address health problems, and in particular, problems that arise out of social inequity and social exclusion.

> *"Coupled with a new notion of shared responsibility, and the building of new coalitions with common goals and a common purpose, capacity-building is a key ingredient in redressing social exclusion, inequality and vulnerability in our community"* [1]
>
> Robert Fitzgerald,
> NSW Community Services Commissioner

Capacity building is an approach to development that builds independence[2]. It can be:

- a 'means to an end', where the purpose is for others to take on programs
- an 'end' in itself, where the intent is to enable others, from individuals through to government departments, to have greater capacity to work together to solve problems
- a process, where capacity building strategies are routinely incorporated as an important element of effective practice.

What emerges in discussion and debate about the purpose and process of capacity building is that different organisations have quite different ways of conceptualising capacity building[3].

A Framework for Building Capacity to Improve Health is a revised edition of an earlier document, *Capacity Building Framework*[4]. It's purpose is to guide the development of effective capacity building practice within health promotion. It has been developed in consultation with health promotion practitioners and other key stakeholders and it draws on capacity building work funded, or partly funded, by NSW Health. This includes:

- The Capacity Building Process and Outcomes Indicator Project which was conducted by Sydney University. The project report *Indicators to Help with Capacity Building in Health Promotion*[5] presents the research findings and the checklists developed to inform and monitor capacity building practice.
- The NSW Health Promoting Hospital Project which gathered a significant amount of information about health promoting health services and identified a range of issues for health service managers[6].
- Work located in the Northern Rivers Health Service Area and conducted by the University of Queensland which resulted in the development of an audit tool to monitor capacity building in community based projects[7,8].

The model presented below (Figure 1) reflects this pre-existing work, feedback from practitioners and the work of other researchers. It links the:

- key areas for strategy development (organisational development, workforce development, resource allocation, partnerships and leadership); to
- the three dimensions of capacity building identified by Hawe, King and Noort (infrastructure development, program sustainability and enhanced problem solving).

In addition, the model highlights the importance of the 'context' within which capacity building happens and reinforces the message that all capacity building is context rich: that strategies and approaches need to take account of context at all times.

The intent of this document is to further explain the above model and guide the development of capacity building strategies across the key action areas.

The first section of the document provides an overview of capacity building and the principles that underpin its practice, and introduces practitioners to some of the language of capacity building. The second section explains the components of the framework and lists suggested strategies for each area. The third section provides some suggestions for assessing and monitoring progress, and the final sections provide a list of useful resources to inform and support capacity building practice.

The *Framework* has grown out of information gained in developing *Indicators to Help with Capacity Building in Health Promotion*.[5] Questions are often asked about the links between the key action areas suggested within this document (organisational development, workforce development, resource allocation, and the elements of partnerships and leadership) and the checklists presented within the '*Indicators*' document.

While these links are still being explored it seems that

- Some checklists may reflect activity across a number of the key action areas.

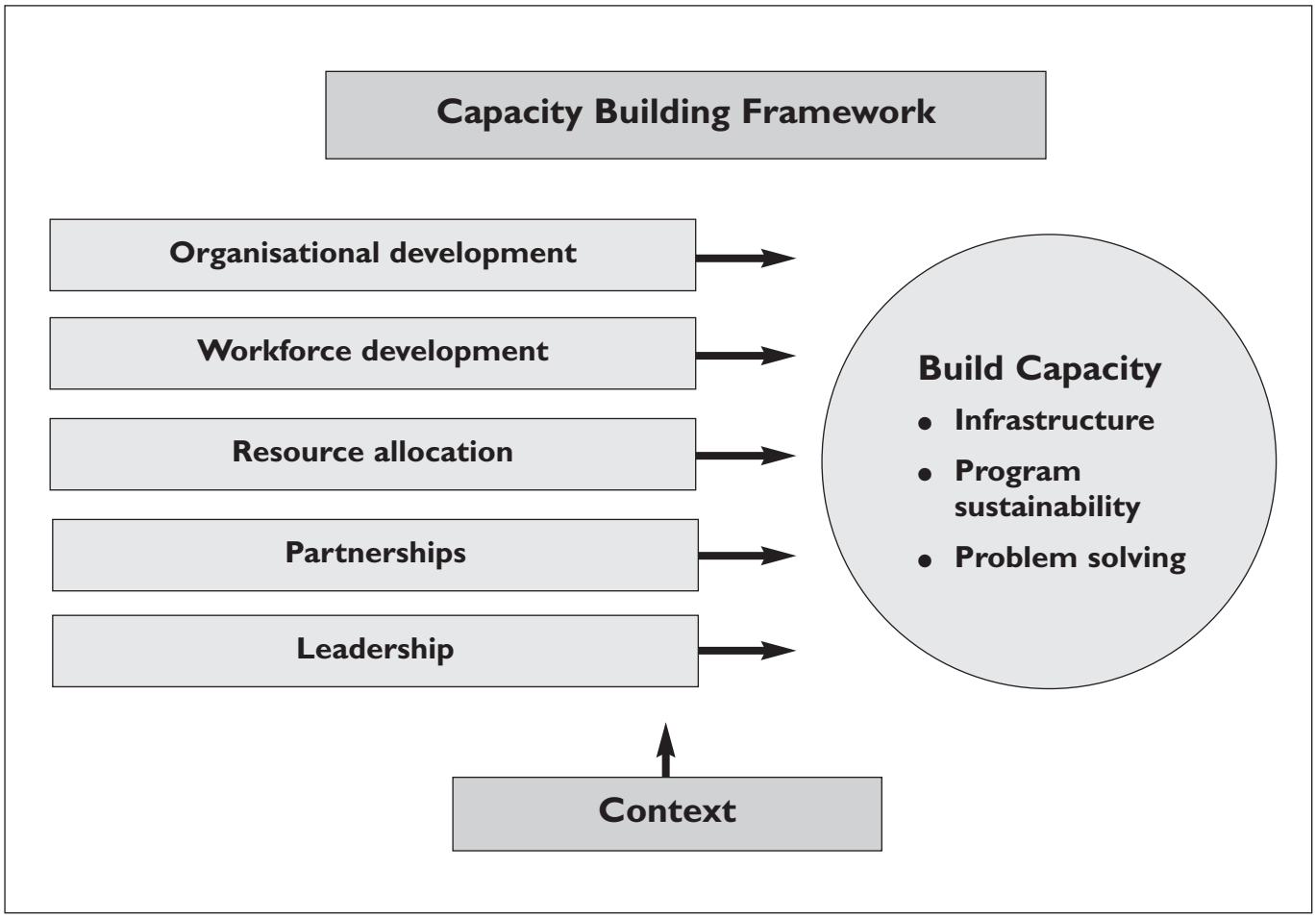
  For example, checklist number seven, 'Assessing the capacity of a particular organisation to tackle a health issue' could be used to guide and monitor a range of strategies from across all of the action areas.

- Others will primarily reflect one aspect of a particular strategy.

  For example, checklist number two, 'Assessing opportunities to promote incidental learning among other health workers', captures some of the structural and informal links that form part of an effective 'workforce development' strategy.

Our understanding of these links will be strengthened as more and more practitioners apply the *Framework* and the *Indicators* and the breadth and depth of research increases.

Figure 1 Capacity Building Framework



2 Understanding capacity building

What is capacity building?

Capacity building is sometimes described as the 'invisible work' of health promotion[10]. It is the 'behind the scenes' efforts by practitioners that increases the likelihood that effective health promotion programs will be sustained.

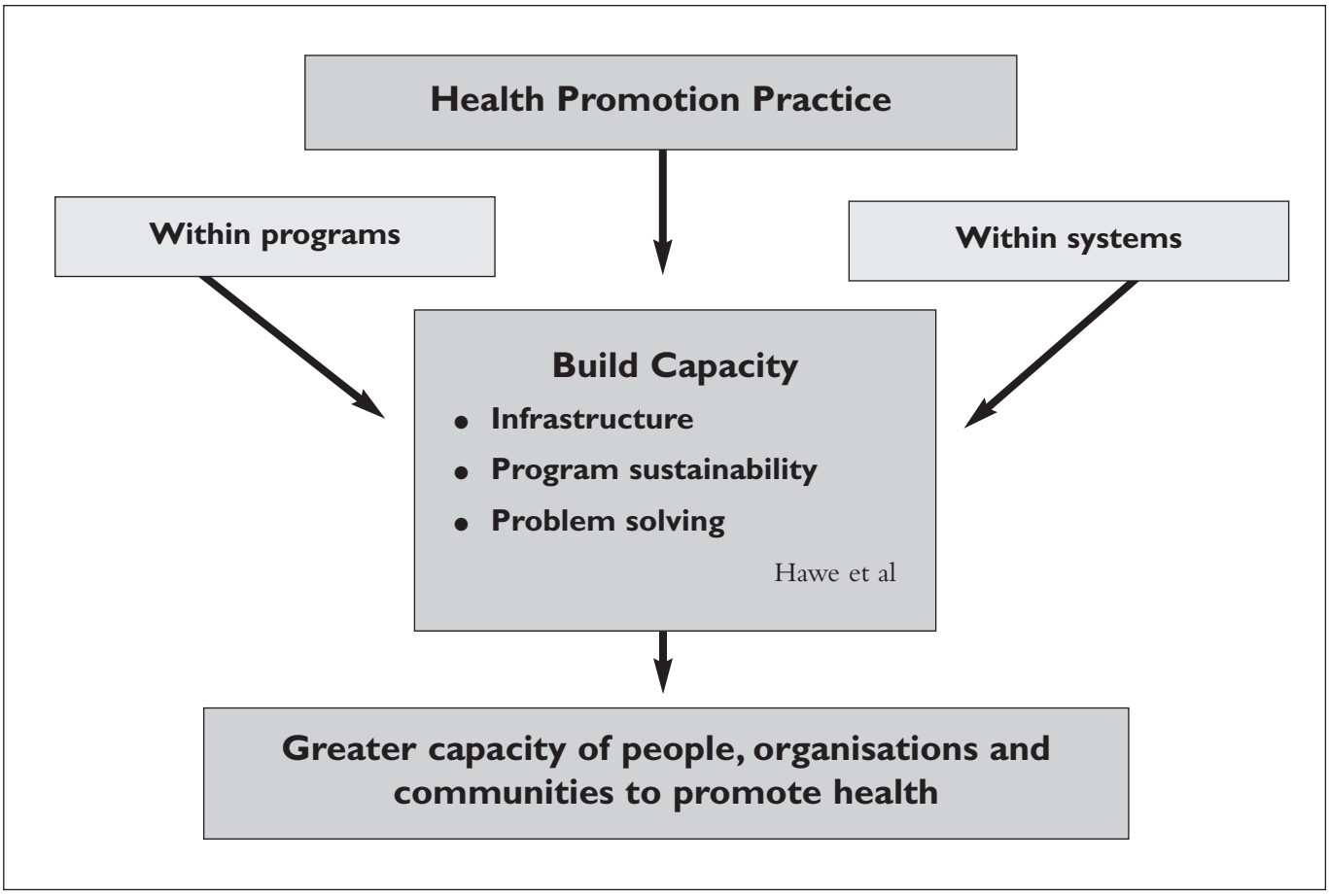
This can include activities as diverse as canvassing the opportunities for a program, lobbying for support, developing skills, supporting policy development, negotiating with management, guiding the establishment of partnerships, or contributing to organisational planning.

Capacity building is defined as an approach to 'the development of sustainable skills, structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over'.[5]

The language of 'capacity building' and its related concepts are used in many fields. Bush notes that 'social determinants', 'prevention', 'community' and 'partnerships' are the substance of the language of capacity building across a wide range of organisations[11]. In addition, much work has been done which points to the importance of capacity to work in partnership[12,13], and the value of this in contributing to more effective health outcomes.

Capacity building occurs both within programs or more broadly within systems and leads to greater capacity of people, organisations and communities to promote health (Figure 2). This means that capacity building activity may be developed with individuals, groups, teams, organisations, inter-organisational coalitions, or communities.

Figure 2 Levels of Capacity Building



At any one time a practitioner may be building capacity at many levels within one health promotion program. For example, a practitioner may be working with:

- an individual, to develop particular health promotion planning skills
- a manager, to negotiate allocation of resources to support the program
- the project team, to develop their skills to manage and support the program, and identify opportunities to integrate the project into routine work practice
- people from other sectors, to cultivate project champions in health and other sectors, and identify potential project partners.

Each of these instances involve identifying and building on existing capacities to enhance independence in health promotion.

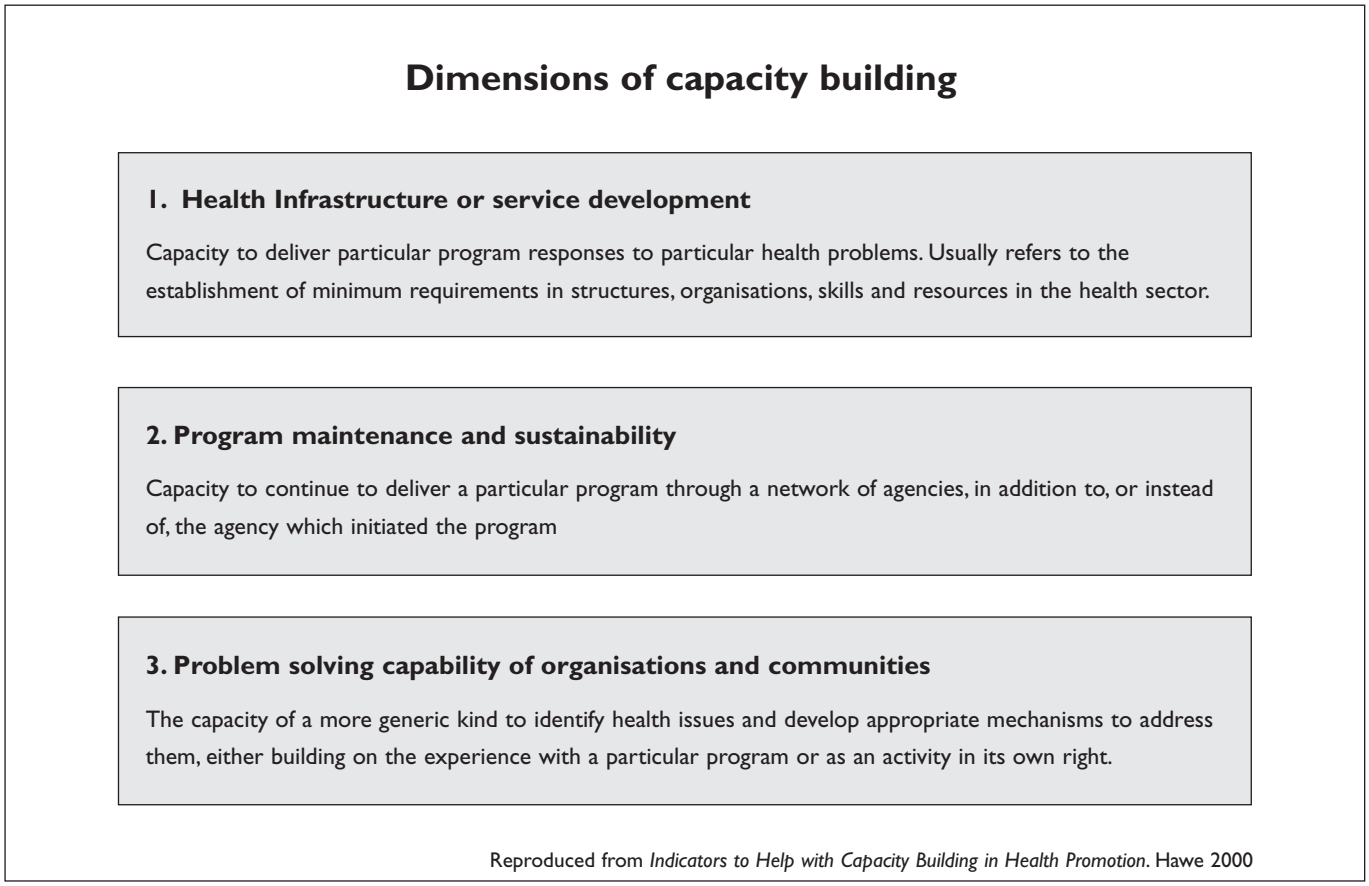
Hawe, King and Noort[5] have identified three distinctive dimensions to capacity building practice(Figure 3).

This work represents a major step forward for health promotion practitioners by clearly articulating the intent of capacity building efforts. Eade also highlights the importance of being clear about capacity building intent. She argues this assists in the development of relevant and focussed capacity building objectives and strategies.[2]

For example a practitioner may wish to engage an organisation in thinking about their contribution to health more broadly, and as a first step they may engage their interest by working with them on a program of mutual interest. In addition to program strategies, the practitioner may develop strategies that also contribute to the longer term goal. For example, they may develop planning processes within the program to engage senior managers in decision making about health or provide opportunities for incidental learning about health promotion concepts and processes.

The program itself may not be sustained. Not all programs need to be sustained. What is more important to sustain is the capacity for individuals, organisations and communities to mobilise themselves, when required, to initiate new action for new health challenges.

Figure 3 Capacity Building Dimensions



Reproduced from *Indicators to Help with Capacity Building in Health Promotion*. Hawe 2000

The following example illustrates how capacity to improve health can develop over time and how early work to build commitment and enhance skills may be reinforced and supported by later strategies and support.

Principles of capacity building practice

Whatever the capacity building strategy or approach, or whomever a practitioner may be working with (individuals, organisations or communities), a number of key principles always underpin effective capacity building practice:

Respect and value pre-existing capacities

Before beginning to build capacity within programs, practitioners need to identify pre-existing skills, structures, partnerships and resources and work with, and respect these.

Effective capacity building practice links local people with content and context expertise with health promotion practitioners with *technical and capacity building* expertise. It allows for an exchange of expertise between groups.

In addition, programs that are integrated into existing structures, and linked into existing positions and accountability processes, are more likely to be sustained.[14] While it may seem simpler to establish a separate vertical structure for management of a program, this often duplicates the workload of the people expected to be involved and may suggest a lack of confidence in existing structures or mechanisms. In the longer term this may undermine existing political and workplace relationships and contribute to a lack of support for a program.

One of the major criticisms of capacity building is that it is a 'top-down' approach that is often linked to a government's agendas for change. Fitzgerald makes the point that this can also be a strength.[15] He argues that when initiatives are supported and reinforced by 'systems' they are probably more likely to be sustainable.

Develop trust

The notion of trust is 'absolutely imperative to capacity building'[15]. Fitzgerald believes that capacity building is underpinned by trust and respect, and these qualities 'sit at the heart' of why so many otherwise good initiatives have failed. He argues that the lack of trust between partners, families, children, and government is at an all time low, and that this is born out of a failure of mutual respect or long term commitment to the genuine needs and aspirations of all stakeholders. According to McPeake[16] one of the key elements in developing trust is perseverance.

> "*We earned their trust not by anything else but probably by the fact that we kept going back and they kept talking to us*".

Building capacity for promoting health within a Western Sydney school community

- Following involvement in several health promotion initiatives, a community worker from a neighbourhood centre attended a health promotion training program provided by the Area Health Service.
- Working with a community nurse, and in response to concern from parents, the worker suggested a project to develop a canteen policy at the school, The principal negotiated with them to establish a breakfast project instead. A project team was established and gained a $4000 health promotion seeding grant. The process was supported by health promotion staff.
- Parents were assisted by the community worker and the community nurse to develop job descriptions for volunteers and guidelines for the breakfast program. A second round of funding was linked to development of a nutrition policy for the school. Health promotion staff continued to support change.
- Over time, the parent volunteers took responsibility for the day-to-day management of the breakfast program and the community worker continued to support them as needed.
- The community worker developed sophisticated planning skills and increased her understanding of the determinants of health. She assisted the school submit for and run a computer training program for parents (with child care provided). The school and the community worker continue to identify and support other health promoting initiatives.

Capacity building within a Northern Sydney Local Government Tobacco Sales to Minors Project

- Cultivation of project champions within local government to advocate for and support the program.
- Development of Memoranda of Understanding between individual Councils and the Health Service.
- Provision of training, information, and access to expertise in compliance monitoring and prosecutions to Council officers.
- Strategies to enhance Council commitment to the program such as a submission to the National, Local Government Awards.
- Allocation of Council resources to cover legal costs.
- Development of a regional local government structure for planning.
- Incorporation of responsibilities for the program into local government management plans, staff work plans and policy
- Monitoring and review processes established within individual Councils to enhance project effectiveness.
- Enhancement of understanding within Council of its ability to impact on health.
- Increased problem solving by Councils on the most appropriate tobacco and other strategies for their communities
- Establishment of a regional local government partnership to plan for and problem solve broader health issues

Be responsive to context

Context refers to the range of physical, economic, political, organisational and cultural environments within which a program sits. 'Context' is often thought about as the environmental constraints on a program that are generally not amenable to change. Programs never exist in isolation. Context can have a negative or positive impact on a program and is ever changing. Practitioners need to be aware of and be ready to respond to changes in context.

Bush[11] refers to work that was first proposed by Pawson and Tilley[17] and argues that researchers need to work out better ways to capture context within program evaluation. He states that the public health field is very good at measuring problems and strategies but an evaluation method that only focuses on the mechanisms for change, tells only half the story (Figure 4).

Figure 4 Pawson and Tilley model for evaluating capacity building

Avoid pre-packaged ideas and strategies

Capacity building is an *approach* to development not a set of pre-determined activities. There is no single way to build capacity. Although experience tells us there is a need to work across the key action areas, practitioners approach each situation separately to identify pre-existing capacities and develop strategies particular to a program or organisation, in its time and place.

> *Capacity builders need the ability to observe accurately, to interpret their observations intelligently and impersonally and then to deliver the appropriate intervention at the appropriate time.*[18]

It is also important to remember that the relationship between the program management group and the capacity builder will change as decision making and program management skills evolve. The relationship may move from being a 'hands on' development relationship to a 'hands off' consultative or facilitative relationship. Practitioners need to be mindful of, and ready to change their roles and responsibilities as capacity is increased.

For example, a newly established project team will have different capacity building needs to one that has been established for some time and is competent and ready to contribute to problem solving on broader health issues.

Develop well planned and integrated strategies

To be most effective, capacity building needs to work at a number of levels (eg. with individuals, groups or across organisations) and use a combination of strategies from the action areas of organisational development, workforce development, resource allocation, partnerships and leadership. The following example presents a range of interactive strategies developed within a Local Government project.

Kaplan[18] discusses the importance of integrated strategies as a key element in the development of effective capacity building organisations in Africa. Those organisations that had had most success were consistently found to be those who had first clearly identify their corporate goals, then developed workforce strategies to meet these goals, and finally re-allocated resources against their organisational priorities and goals.

Why focus on building capacity?

There are a number of important reasons for the health system to focus on capacity building. These include:

- **Multiplying health gains**
  A focus on capacity building will increase the likelihood that other people and organisations within health and other sectors will also be able to promote health. This will multiply health gains many times over.
- **Visibility**
  A focus on capacity building increases the recognition given to the diverse efforts of practitioners working with others to take on and sustain programs. It gives a 'name' to a large portion of work carried out by practitioners in developing effective programs.
- **Accountability**
  One of the difficulties of working 'invisibly' is that practitioners are not readily accountable for this part of their work. Similarly, managers have lacked clear guidelines for assessing the quality of work purporting to build capacity for health promotion.
- **Responsive systems**
  Capacity building involves a focus on the processes that support change within and between organisations. It leads to systems which value critical problem solving and leadership across organisations. Responsive systems are more likely to work in partnership to address health challenges. This is in contrast to a 'silo' approach where organisations may be working on similar problems in isolation from each other.
- **Address inequity**
  There is increasing evidence that poorer health is linked to the conditions that arise out of inequity and social exclusion. Capacity building is promoted across government as a mechanism for addressing inequity and building stronger communities through increasing community and civic participation.
- **Unifying theme**
  The language of capacity building is not owned by any one sector and therefore provides a unifying theme under which government departments and other organisations can work together to address inequities.
- **Reorientation of health services**
  This is one of the main strategies advanced in the Ottawa Charter for Health Promotion. The message is that along with treating ill health, health services need also to take greater responsibility for improving the health of the communities they serve.

3 Strategies for building capacity

Health promotion practitioners are typically skilled program planners. Developing strategies to build capacity is no different to developing strategies in any well planned program. They are developed to meet particular capacity building goals and objectives and the choice of strategies is influenced by:

- the particular context within which the program will apply
- pre-existing capacities to support change
- a practitioner's role in achieving change
- a practitioner's sphere of influence to effect change.

Practitioners need to be clear at the outset about their intent in building capacity. Is it to develop an infrastructure to design and deliver a program? Is it to ensure program sustainability? Is it to enhance problem solving capacities? Clarifying the intent makes it more likely practitioners will develop achievable capacity building goals, objectives, and relevant strategies.

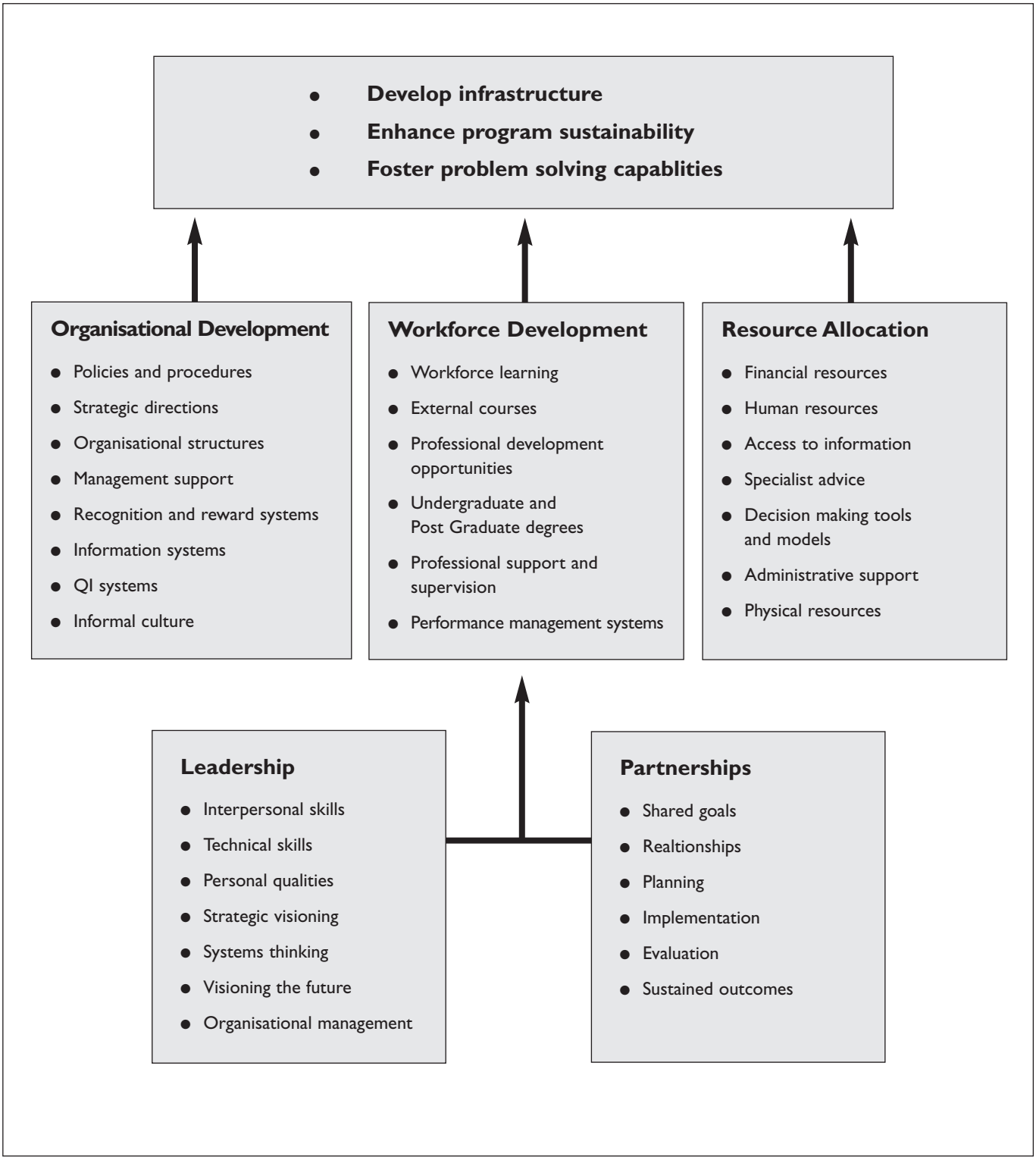
To be successful, it is recommended that the strategies span the three key action areas of organisational development, workforce development, and resource allocation. It is also recommended that the strategies work at a number of different levels, such as with service providers, their managers and program partners.

In addition, strategies may need to be developed to enhance the leadership and partnerships available to a program. In particular, a practitioner will need to identify:

- the level of leadership and range of leadership qualities already in existence within an organisation and among team members
- the quality and range of partnerships that are in existence or can potentially be developed to support a program.

The following pages provide a short description of each of the components of the capacity building framework and suggests strategies for building capacity within each of them.

Capacity building framework key action areas



Organisational development

The practitioner who understands principles of organisational change and who has tools and skills for analysing and facilitating such change will be more successful than his or her counterpart who does not possess such knowledge[22].

Organisational development refers to processes that ensure that the structures, systems, policies, procedures and practices of an organisation reflect its purpose, role, values and objectives and ensure that change is managed effectively.[6] An organisation that is more likely to take up new ways of working in order to respond to changes in strategic directions is one that is often described as a learning organisation.

Senge suggests that *learning organisations are places where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together.*[23]

Building the capacity of an organisation to improve health is a complex task. No single theory is sufficient for explaining how and why organisations change. Health promotion draws on theories such as Systems theory,[24] Organisational Change theory,[22] and Domain theory[25] to inform understanding about organisational development.

Auer and Rippon propose a hierarchy of issues that need to be considered in progressing change.[26] They proceed in the following order:

1. **Environmental context** (what are the external factors impacting on the organisations ability to contribute to the program)
2. **Goals** (what you want to achieve, with and for whom)
3. **Roles** (whose job is what to enable you to achieve your goals)
4. **Organisational structures, systems and procedures** (the way people are supported to fulfil their roles)
5. **Relationships** (peoples ability to get along and respect each other)

Some other factors influencing the choice of organisational development strategies include:

- Change often progresses in **stages**: awareness, adoption, implementation and institutionalisation of change.[25]
- The level of change can be from incremental, which may only involve fine tuning, through to transformational change which may involve a major restructure.
- Different strategies will require different **styles of leading** to support integration of the program into the organisation: collaborative, consultative, directive, and coercive.[25]
- Organisations are often divided informally and formally across **domains**:[24] **Policy** (strategic and policy directions), **Management** (achievement of economic and organisational targets) and **Service** (professional and service groupings). Each domain is dominated by different interests and ethics. Managing processes between domains may require conflict resolution whilst managing processes within domains may require consensus building.

Examples of organisational development strategies	
Elements	**Strategies**
Policies and strategic plans	• Identify and enhance opportunities to incorporate health promotion action and population health approaches into core business of the service or organisation. • Develop policies that ensure an appropriate proportion of funds are allocated to support health promotion action.
Organisational management structures	• Establish health promotion positions within executive structures. • Incorporate health promotion action into performance agreements and job descriptions at all levels of the service / organisation. • Monitor work practices to ensure appropriate time is allocated to health promotion action.
Management support and commitment	• Develop systems to support service and organisational commitment to health promotion. • Develop mainstream line management positions and accountabilities for health promotion within the organisation. • Involve senior managers in steering committees for health promotion projects.
Recognition and reward systems	• Acknowledge achievements, develop formal feedback and acknowledgment systems for those undertaking health promotion work. Integrate health promotion award systems into mainstream health service award schemes.
Information systems – monitoring and evaluation	• Develop systems that accurately identify the amount and type of health promotion action undertaken by staff. • Develop / utilise appropriate evaluation strategies. • Incorporate health promotion into staff appraisal processes.
Quality Improvement systems	• Use available best practice tools for health promotion work (eg. Program Management Guidelines, Competency Based Standards for health promotion action, Quality Management Service and EQUIP standards, *Indicators to Help with Capacity Building in Health Promotion*).
Informal organisational culture	• Seek to encourage attitudes which support health promotion action.

Workforce development

Workforce development refers to a process initiated within organisations and communities, in response to the identified strategic priorities of the system, to help ensure that the people working within these systems have the abilities and commitment to contribute to organisational and community goals. Workforce refers to both the paid and unpaid workforce within organisations and communities.

Workforce learning can be achieved in three ways:[5]

1. **incidental learning** where the learning appears to be by 'accident' and people are not aware that they are learning. For example, in casual conversations or when a person is engaged in activities such as attending the launch of a health promotion program or product.
2. **informal learning** where the learner is aware of being engaged in the learning process. There are three types of informal learning activities:
    - Proactivity, such as encouraging people to take on new responsibilities
    - Creativity, such as encouraging people to break out of old patterns of thinking
    - Reflectivity, which is learning from reframing a problem or issue and looking at new solutions which may be superior to the ones initially tried by the learner.
3. **formal learning** strategies where the learner or their workplace has identified learning or training needs and develops strategies to meet these. For example mentoring schemes, training programs or post graduate university courses.

Workforce development strategies represent an important component of building the capacity of an organisation or community. However when developed in isolation from other capacity building strategies, they are unlikely to bring about effective and sustainable changes in work practices.

Examples of how strategies might be linked are:

- Engage managers in decision making about health promotion priorities and integration of health promotion targets into organisational planning documents
- Engage managers in monitoring and evaluating the health promotion practice of their staff by making managers accountable for seeding grant budgets and targets
- Ensure any training is competency based[27] and link training with work place performance review and projects supervised by the worker's line manager
- Target two or more levels of a service or organisation. For example, the professional development of primary health nurses could be linked with programs for Nursing Unit Managers and Directors of Community Health to ensure that the skills and knowledge acquired by the workers is supported and applied within the workplace
- Take advantage of existing or emerging opportunities. For example, acquiring project funds for priority health issues or campaigns provides opportunity for workers to apply health promotion skills and knowledge to contemporary issues.

Examples of workforce development strategies	
Elements	**Strategies**
On the job learning including incidental and informal learning opportunities	● Provide a range of opportunities for people across the health system to learn about health promotion, including: ● Health promotion committees ● Health promotion seeding grants project ● Scholarships, traineeships or mentoring programs ● Secondments and job rotations ● Planning guides to support self directed learning ● Participant implementation and management of projects ● Information sharing initiatives
Course development	● Incorporate competency based standards into courses for health professionals.
Professional development opportunities / continuing	● Disseminate information about, and support graduate and post graduate studies relevant to health promotion
Education/undergraduate and post graduate studies	● Where appropriate support incorporation of health promotion into graduate and post graduate degrees. ● Develop skills-based courses including: ● Core skills courses ● Conferences ● Workshops ● Seminars ● 'In service' programs on specific health issues
Professional support and supervision systems	● Establish formal supervision or support arrangements for health promotion work. This may be provided individually or in groups and provided internally or externally. ● Establish peer support systems, buddy systems or networks for people working on similar issues. ● Provide access to specialist advice and support through networks and consultancies.
Performance management systems	● Incorporate health promotion work into regular performance appraisal or performance management systems. ● Develop specific performance management guidelines to be used by team leaders or coordinators in other parts of the health system for health promotion work conducted by their workers. ● Utilise *Indicators to Help with Capacity Building in Health Promotion* as a tool to assist in performance review

Resource allocation

Resource allocation is an economic process, not just a planning one. Economics is primarily concerned with the efficiency of resource allocation.[28] It requires **technical** efficiency to minimise the use of available **resources** (which could be used elsewhere), and allocative efficiency to ensure the mix of goods and resources yields the greatest benefit to society.

'Resources' includes those things needed to support a program. This includes people, physical space, administrative support, planning tools, and financial support. It can also include commitment of 'in kind' allocations from inter-organisational groups or partners.

Some of the questions that may be considered in deciding whether resources will be made available to support a program are:

- Will the program create an on-going demand for resources beyond the current allocation, and if so, does this fit with the organisation's goals?
- If the organisation invests in this program, what will it de-invest in to free up resources?
- Will the returns on this investment be short, medium or long term?
- Who will benefit from this investment?
- Is there strong organisational commitment to the program?
- Are the program goals and objectives realistic and achievable?
- Is evaluation clearly defined?
- Is it realistic to expect staff to pick up this program?
- What mechanisms and structures can be put in place to integrate the program into routine work practice?

The availability and sustainability of resources is often a crucial point in whether a program will be developed or maintained. In research by South Eastern Sydney Area Health Service to evaluate their Seeding Grant program, researchers were consistently told that a major reason for seeking a seeding grant was to access financial resources. In addition, the driver for some early Area Health Service capacity building approaches was a scarcity of resources. For example, one of the reasons the Wentworth Area Health Promotion Service sought to engage the broader health system in health promotion, was to increase the allocation of mainstream health service resources towards health promotion.

Deeble[27] describes a range of techniques that may assist in resource allocation decision making. These are: cost-benefit analysis; cost-effectiveness analysis; cost-utility analysis; burden of disease and capacity to benefit; program budgeting marginal analysis (PBMA); purchaser-provider contracting; and health benefit grouping/ disease based economic modelling.

A workshop auspiced by the National Public Health Partnership identified there needed to be a national approach to exploring how best to use these tools, how public health could influence broader strategic decision making on resource allocation and the need for better understanding across the public health field on economic decision-making principles and methods.

Examples of strategies to enhance resource allocation	
Elements	**Strategies**
Financial resources	• Lobbying for an appropriate proportion of service or organisation's budget to be allocated to health promotion action. • Obtaining short and long term funding for special projects. • Develop a seeding grant program. • Actively disseminate information about funding opportunities from health and other sectors (eg RTA – Bikesafe) to other organisations so that they might become engaged and interested in health promotion.
Human resources development	• Establishment of 'core' health promotion positions to support program • Lobbying for a fixed percentage of worker's time to be devoted to health promotion action. • Developing opportunities for others outside the health system to do health promotion. • Build a base of advocates for health promotion within health and other sectors and in particular, at senior management levels
Information	• Ensuring availability and use of information (eg. health status, risk factors, national goals and targets, literature reviews, information about effective practice) to support health promotion action. • Negotiate for health promotion material and access to data bases be available through health service and other libraries and share this information with program partners.
Specialist advice	• Ensuring access to expertise when required (eg research and evaluation, planning, media and marketing, workforce development). • Provide 'no-cost' or 'low-cost' access to health promotion skills development courses for potential program partners in the community and other sectors.
Decision making tools and models	• Utilise best practice models, guidelines and/or standards for health promotion action (eg Competency Based Standards, Program Management Guidelines, Quality Management Service standards, Program Budgeting Marginal Analysis (PBMA) tools).
Administrative and physical resources	• Ensuring the availability of clerical or administrative support, equipment, office and meeting spaces.

Leadership

Leadership is a function of training, experience and personality. Within a capacity building approach practitioners are seeking to foster the characteristics of leadership within programs and across organisations, by developing and building leadership qualities in themselves and others.

Leaders are people who are systems thinkers and future orientated. They are ready to critically analyse their work and are people who[30]:

- Search out opportunities to change and grow, and experiment with leadership;
- Enable others to act by giving power away, providing choice, developing competence, assigning critical tasks, and offering visible support
- Set example by behaving in ways that are consistent with shared values
- Engage, mobilise, inspire and team with other to make thing happen
- 'Encourage the Heart' by recognising individual contributions to the success of every project and celebrating team accomplishments regularly.

Leaders recognise the need for 'adaptive work' to precede change and are able to 'stage-manage tension' and 'create a holding environment' until those they are working with realise what needs to change[31]. Senge[22] has described leaders in learning organisations as:

- **Designers**
  Little credit goes to the designer, and their work is often behind the scenes and invisible. *' The consequences that appear today are the result of work done in the past'*. Leaders see how the parts fit together to perform as a whole and recognise the connections between programs, systems and the broader environment.
- **Stewards**
  Leaders have a sense of the larger purpose of their program and are willing to craft the program in response to the needs and views of others so that the purpose and vision of the program are owned more broadly.
- **Teachers**
  Leaders foster learning for everyone and remain committed to the truth. They have a capacity to see current reality and do not persist in seeing everything as 'fine' simply to avoid uneasiness.

One aspect of leadership that is familiar to many health promotion practitioners is the notion of 'managing up'. This involves the development of strategies to engage managers in decision making processes about health promotion, and to recognise sources of authority (our own as well as others) and to work with these.

Rather than identifying leadership as a position of authority or a person with certain personality traits, Senge[22] believes it is more meaningful to identify leadership as an art. Leadership needs to be apparent at every level of a program, not merely at the top.

Health promotion practitioners use their personal qualities as leaders as resources that are applied in various settings to build leadership in others.

Examples of strategies to build leadership[30,32]	
Elements	**Strategies**
Personal growth and learning	• Identify and work with mentors • Utilise opportunities to develop and test new skills eg. step forward to participate in and chair committees • Foster a leadership learning team • Seek and respond to feedback about your leadership skills
Visioning the future	• Have your own personal vision • Understand health promotion needs and issues • Identify emerging trends • Balance the tension between a focus on results and current realities • Continuously test assumptions
Systems and strategic thinking	• Develop planning skills in yourself and others • Be aware of the complexity of relationships within health and between the health system and other sectors. • Contribute effectively to the organisations strategic plan • Reflexivity – see yourself within the bigger picture • Strategically manage resources
Creative collaboration	• Promote an environment of creativity, innovation, performance reflection and lateral solutions. • Form and use partnerships • Build visions through consultation and collaboration • Use opportunities to integrate strategies between health and other sectors
Communication skills	• Demonstrate actions that motivate and inspire others • Communicate information effectively and articulate outcomes in ways that are meaningful to others • Value diversity • Provide opportunities for reflection and analysis
Political and social change strategies	• Be aware of the broader political and social context • Become familiar with the policies and processes that will impact on your work • Use policy development processes to influence change • Be prepared to articulate health promotion priorities
Team learning	• Tap the potential for many minds to be more intelligent than one mind, foster dialogue and discussion • Be conscious of other team members – develop 'operational trust' and operate as colleagues • Foster 'learning team' approaches in other teams • Make time to practice team learning • Celebrate team accomplishments regularly

Partnerships

The development of effective partnerships to address health problems is important because many of the determinants of health are outside the realm of health services.

The establishment of the National Public Health Partnership[33] (NPHP) is testament to Commonwealth and State commitment to the importance of partnership approaches. Work for the NPHP has identified that there are two main types of partnerships:

1. Strategic partnerships in which systems engage with systems
2. Local or community partnerships that focus on people.

The opportunity to work collaboratively with other organisations (or sectors) is often missed when organisations do not have the capacity to initiate and sustain involvement. Building capacity requires action from within organisations as well as between them. Health workers who know how to motivate their own organisation have a powerful means for effecting change.

Enabling behaviours by organisations include:

- A clear written and stated focus on partnerships, that they are important, and that this is the normal means by which outcomes are achieved in public health
- Modelling of the desired behaviours by leaders within the organisation so that working in partnership becomes part of the culture.

The terms applied to partnerships are varied and seem to be interchangeable. Bush[8] describes the various types as:

- **Joint ventures**
  The association of people, natural or corporate, who agree by contract to engage in some common undertaking for joint profit by combining their respective resources
- **Collaboration**
  Shared planning and/or delivery of work across different organisations, involving different professional traditions and skills
- **Alliances**
  Collaboration between two or more parties to pursue agreed goals
- **Intersectoral collaboration**
  Activities by part or parts of the health sector which involve a direct relationship or partnership with another sector and which involve joint planning or action on a health related issue, and actions taken outside of the health sector, generally with the health sector, with the explicit intention of improving individual and community health
- **Coalitions**
  Alliances among different sectors, organisations or constituencies for a common purpose
- **Partnerships**
  Capitalise on each organisations unique strengths, to work together to achieve shared or related goals that neither could achieve as well by working alone.

Examples of strategies to build partnerships[12]

Elements	Strategies
Shared goals	● Identify appropriate partners / services that have program goals, objectives, resources and people necessary to implement initiatives. ● Identify the need to work together and create opportunities to identify shared and similar goals.
Relationships	● Identify / enhance lines of communication between organisations. ● Create cooperative working environments through regular meetings. ● Develop shared agreements such as memoranda of understanding that define the formality of the relationship. ● Document agreements, expectations and commitments of all partners and tasks. ● Review and monitor the effectiveness and the benefits and gains of the partnership through regular feedback. ● Invest time to build and maintain levels of trust within the partnership ● Be mindful of changes in the partnership relationships as the partnership matures and be prepared to change functions and roles in response to emerging independence.
Planning and implementation	● Identify resources required to develop, negotiate, implement, evaluate and sustain the planned action. ● Involve all parties directly in planning to ensure the program remains relevant to all partners. ● Encourage reflective and critical thinking to influence program development. ● Develop an agreed way of working, dealing with conflict and disagreement, supplying feedback about program results and outcomes ● Set aside time to review and renegotiate the planned action.
Evaluation	● Ensure measurable project outcomes are meaningful to all partners involved. ● Develop evaluation methods that reflect the funds allocated and likely outcomes.
Sustained outcomes	● Ensure partners have a good understanding of each others organisational values and goals and a sustainable network is established. ● Regularly identify and re-evaluate the level of operation of the partnership and respect and value emerging autonomy of the partnership. ● Consider appropriate ongoing contact for future actions.

4 Monitoring and evaluating practice

Mechanisms to successfully evaluate and monitor capacity building efforts are still being explored. A key tool to support evaluation are the checklists developed by Hawe, King and Noort which are described and presented within the project report, *Indicators to Help with Capacity Building in Health Promotion*[5]. Table 1 presents a summary of the checklists and their application.

A research project to support dissemination into practice of the checklists and gather stories of practice is currently being undertaken by NSW Health. Progress information about the use of the indicators and common questions from the field will be available on a NSW Health, Health Promotion 'Capacity Building' web page www.health.nsw. gov.au.

Table 1 Capacity Building Indicator Checklists

Scenario	Applications
1. Assessing the strength of a coalition	Use this to assess how well an inter organisational coalition is functioning or to set objectives or tasks in relation to coalition planning.
2. Assessing opportunities to promote incidental learning among other health workers	Use this for situations where the aim is to promote invisible skills transfer (ie not pertaining to formal training programs). For gaining health promotion skills unknowingly or 'by accident'
3. Assessing opportunities to promote informal learning among other health workers	Use this for situations where the aim is to promote invisible skills transfer (ie not pertaining to formal training programs). To encourage others to be more engaged in 'on the job' health promotion skills development.
4. Assessing if a program is likely to be sustained	Use at the conclusion of a program to assess the presence of program, organisational and community level factors known to be associated with program uptake and maintenance.
5. Assessing the learning environment of a team or project	Use to assess whether or not the structure and function of a group is optimal for innovation or learning. It is assumed that a dysfunctional unit is unlikely to take on new roles successfully.
6. Assessing capacity for organisational learning	Same as above but for organisations.
7. Assessing the capacity of a particular organisation to tackle a health issue	Arranges critical factors that may be assessed separately or in combination. Includes an assessment of partnership capacity and program delivery capacity.
8. Assessing the quality of program planning	Assesses one component of checklist 7 in more detail.
9. Assessing community capacity to address community issues	Sorted into predisposing, enabling and reinforcing factors.

Work by Robert Bush and Allyson Mutch, from the University of Queensland involved the development of a Community Capacity Health Development Index (Figure 5). This material is being produced as a manual and the authors propose that the index could be used in a wide range of research and planning situations. This tool is still in draft form and the authors should be contacted for more information. The audit tool maps four domains: network partnerships; knowledge transfer; problem solving; and infrastructure.

Figure 5 Health Development Index by Robert Bush

Structure of the Community Capacity Health Development Index			
Domain 1	**Domain 2**	**Domain 3**	**Domain 4**
Network Partnerships	Knowledge Transfer	Problem Solving	Infrastructure
Levels of Capacity	Levels of Capacity	Levels of Capacity	Levels of Sustainability
1. There is capacity to identify the organisations and groups to implement sustain a program	1. There is capacity to develop a program that meets local needs	1. There is capacity in the network to work together to solve problems	1. Policy investments
2. There is capacity to deliver the program through a network of organisations and groups	2. There is the capacity to transfer knowledge in order to implement/ sustain the program within a network	2. There is the capacity to identify and overcome problems/barriers, to implementing/sustaining within your own organisation	2. Financial investments
3. There is a sustainable network established to maintain and resource the program through a network of partnerships	3. There is the capacity to integrate a program into the mainstream practices of the network partners	3. There is the capacity to sustain flexible problem solving over time across the network	3. Human investments
			4. Social investments

The Health Promoting Hospitals Project developed a capacity building matrix (Table 2) to assist in mapping responses from health service managers about health promotion and their understanding of health promoting organisations. The matrix was also used as a format for the gathering of information in the Health Promoting Hospitals Awards.

The format appeared to be useful in assisting the judges in assessing the quality of award submissions. The matrix links the three dimensions of capacity building: infrastructure, program sustainability and problem solving; and the components of the capacity building framework: organisational development (structure), workforce development (skills) and resources.

Some practitioners may find this a useful tool for thinking about and mapping out the breadth of their work within a particular program. It can be used to map strategies or as a way to monitor outcomes. In reality, it is highly unlikely that any two people would fill out the table in quite the same way! In addition, practitioners will find their strategies can fit into a number of boxes equally well – depending on how you think about the strategy. None of this is particularly neat! Its not really important where the individual strategies fit, its more important to begin trying to capture capacity building information and exploring strategies to continuously enhance capacity, and especially to enhance problem solving capacity. Table 3 provides a worked example of how the matrix might be used.

Table 2 Matrix used to map managers responses within the HPH research and as a reporting format for the Health Promoting Hospitals Award Scheme submissions.

Framework	Dimensions		
	Infrastructure	**Program sustainability**	**Problem solving**
Organisational structures			
Skills			
Resources			

Table 3 An example of an audit of capacity building strategies and/or outcomes within a school

	Infrastructure	Sustainability	Problem Solving
Organisational development	● School supports development of health promotion initiatives ● Health service policy ensures health workers are working with schools using whole of school approach ● Health Promotion reflected in school policy documents ● Good links between the school and its community, and the health sector.	● Planning for a particular health promoting program is integrated into school planning processes ● The program reinforces and supports Key Learning Areas ● Clearly identified lines of communication and reporting for the program within the school system	● School community members involved in the program are contributing to identifying and addressing health issues in the community that impact on the school community, in partnership with other sectors ● Parent participants in the program report on the program at P&C and other school decision making forums
Workforce Development	● Teachers and others working within the school community have access to health promotion expertise ● HP tools utilised to support effective hp practice	● Health workers and teachers are skilled in working with whole of school approach and this is integrated into staff performance review ● Health workers contribute to planning for, and support teacher workforce development program based on school health priorities ● Skills required to implement and sustain the program are developed	● Parents and teachers involved in the program reflect on and enhance skills in working in partnership and problem solving ● Students /staff/ parents actively contribute to health program development, evaluation and reporting
Resource Allocation	● School ensures mandatory health education provided to students	● Resources allocated to support integration of the health program into regular work practices (eg. admin, practical support) ● Resources allocated to health promotion contribute to achievement of existing educational goals	● School allocates resources (usually worker time) to support the school in contributing to problem solving with the community and other sectors

5 Useful resources

- Argyris, C and Schon, D. *Organisational Learning II Theory, Method, and Practice* Adison Wesley, USA, 1996 - organisational development - how to measure organisational learning, page 174 scoring a conversation page 98 a map of perseverance of counterproductive actions; leadership - 256-258 how managers can use their artistic sense and 7 points to make a process of strategy encompass realisation and intent; partnerships- how defensive covers must be broken down within organisations and between organisations, research on how to increase the likelihood of partnerships.

- Bush, R. and Mutch, M *Capacity Building for Harm Reduction at the District Level: Conceptual Development and the Dimensions of Practice*, paper presented at the Fourth Symposium on Community Action and Research and the Prevention of Alcohol and Other Drug Problems. Kettil Brunn Society Thematic Meeting, New Zealand, February 1998 - lists four fundamental shifts necessary for capacity building and four features of a sustainable health system.

- *Compendium of Healthcare Policies*- endorses best practice guidelines and benchmarking, internet site http://www.achse.org.au/nsw/policy/group3.htm, a guide for organisational development/partnerships is *Measuring Up: A Primer for Benchmarking in the Australian Public Service*- Department of Finance, 1996 internet site www.finance.gov.au/pubs/pig/benchmk/benchm.htm explains the key concepts, lists 10 factors for greater success De Bono, E *The Use of Lateral Thinking*, Jonathan Cape, England, 1967 - lateral thinking is a process used in capacity building, chance processes lead to major discoveries and advances and generate new ideas - Chapter 7. It follows from this analysis that an increase in meetings/interactions between different people/organisations is likely to increase their capacity and their ability to promote health.

- *Capacity Building Website* NSW Health has developed a site to bring together key NSW Health publications on capacity building, other useful capacity building information, stories of practice, frequently asked questions, and links to useful sites. The site may be accessed through the NSW Health site www.health.nsw.gov.au

- *Community Capacity Building and Asset Mapping Model* internet site www.cha.ab.ca/commdev/capmodl.htm Has been developed by the Community Development Office of the Capital Heath Region in Edmonton, Alberta. This model has 6 key steps and the site is useful for resources and organisational development.

- De Bono, E *Handbook for the Positive Revolution*, Penguin, England, 1991 -organisational development is about people and perception, and creating circles of concern, circles of community, quality, projects and concern pages 90-97, page 119 sources of power; workforce development -page 112-115 a simple technique for constructive thinking, six thinking hats

- De Bono, E. *Atlas of Management Thinking*, Penguin, Great Britain, 1981 - resources/ leadership - information and symbols for innovative creative thinking

- Deeble, John. *Resource Allocation in Public Health: An Economic Approach*. A background report on planning and resource allocation methods of potential interest to public health has been produced under the auspices of the National Public Health Partnership (NPHP). The report is available on the NPHP website http://hna.ffh.vic.gov.au/nphp/resalloc/index.htm

- Eade, Deborah. *Capacity Building. An Approach to People-Centred Development*. Oxfam 1997. Talks about capacity building from the perspective of an international aid organisation but much of the discuss about what is capacity building is extremely relevant to work within the health system. Highlights that capacity building is an approach to development, that will have a positive, or negative impact depending on the political, economic and social context within which activity occurs. Presents

7 models within which Oxfam programs fit. These demonstrate that capacity building projects do not exist as separate entities but exist within broader systems.

- Edwards, M. and Ewen, A. *360 Degree Feedback, The Powerful New Model for Employee Assessment and Performance Improvement*, ANACOM, 1949 - workforce development and organisational development, this book has been re-printed in 1996

- Fitzgerald, C and Kirby, L. *Developing Leaders Research and Applications in Psychological Type and Leadership Development, Integrating Reality and Vision, Mind and Heart*, Davies-Black, California, 1997 - leadership - how it can be developed using the Myers-Briggs Type Indicator

- Karpin, David S. Industry Taskforce on Leadership and Management Skills, AGPS, Canberra ACT, (1995) *Enterprising Nation: Renewing Australia's Managers to meet the challenge of the Asia-Pacific Century: Executive Summary*, - organisational development - identifies gaps to be bridged for small to medium enterprises to meet world best practice, partnerships - suggests study tours; leadership/ workforce development - identifies skills lacking in Australian managers, contrasts old and new management paradigms with an 11 item checklist, describes emerging senior management profile, recommends Williamson Foundation Leadership Program, recommends development of core generic management competencies

- Kaplan, Alan *Community Development Resource Association, South Africa*. This organisation, and in particular Alan Kaplan, its director, come highly recommended by Deborah Eade. In her view he is the one person who really challenges her thinking on capacity building. Although their material is written for NGO's and other organisations in developing countries – their thoughts and ideas on capacity building have broad applicability. They have a commitment to sharing information and all their articles are available on their website http://www.cdra.org.za. Capacity Building. Myth or Reality is at http://www.cdra.org.za/ar9495.htm

- Pawson, Ray. and Tilley, Nick. *Realistic Evaluation Sage*, London. 1998

- An accessible, practical text on evaluation written with humour and humility. The source text for the 'context + mechanism = outcome' model. A useful reference since capacity building is so context dependant. Builds from 'a history of evaluation in 28.5 pages' which challenges the foundational assumptions of the main evaluation theories, and cumulates in a rigorous model of how programs interact with their environment.

- Quality Management Services. *National Community Health Accreditation and Standards Project, A Manual of Standards for Community Health* Australian Government Printing Service, Canberra 1985 - organisational development and resources standards - 4,5,6,8,9,10,11; partnerships - standard 4; workforce development - standards 7, 11

- Raphael, D. *How to Carry Out a Community Quality of Life Manual* information about this approach is available at the internet site www.utoronto.ca/qol

- Reid, E. *Keynote Address, Symposium: Power and Partnerships for Health Promotion Leadership*, Vic Health, Melbourne, August 1996 - partnerships - necessary conditions for them; leadership - tactical approaches, five radical changes required for transformative health promotion; sustainablity - brief outline of Bruce Parnell's (of Mc Farland Burnett Centre for Medical Research) methodology for measuring capacity building approach●

- Ruslin, R. *Human Resource Management in Libraries Theory and Practice* Neal Schuman, New York, 1991 - leadership - Chapter 3, checklists that could be generalised for leadership skills, 34 key issues for consideration in subordinate evaluation; workforce development - prerequisites for performance evaluation, list of effective evaluation techniques

- Sacher and Associates, *Performance Measures Applied, A Practical Manual to Measure Performance in Australian Companies*, Sacher and Associates, Australia, 1994 - workforce development by performance management

- Senge, Peter. *The Fifth Discipline. The art and practice of the learning organisation*. Lots of thought provoking ideas on leadership and the five aspects of learning organisations (systems thinking, personal mastery, mental models, building shared vision, and team learning).

6 Challenges for the future

There are a number of challenges in progressing a capacity building approach. This includes:

- **Language**

The language of capacity building is seen by some as jargonistic, paternalistic and 'top-down'. It is also a language that is readily understood by leaders across the health system. It may provide a mechanism for engaging in debates about community capacity and the importance of prevention and addressing inequities in health. The challenges are to continue questioning the language and principles that underpin effective practice, and increase understanding of each others definitions and approaches to capacity building.

- **Silo effect**

A major unifying theme in government interest in capacity building is the need to get better at working together to enhance capacity within communities. It is understood that the 'silo effect', where departments work in isolation from each other, leads to duplication of effort and reduced ability to impact on communities. Capacity building has the potential to offer a solution to this problem.

- **Policy into practice**

The gathering of stories of practice, identifying future indicator development and identifying the links between the Framework and the Indicators documents are all challenges for the capacity building field. NSW Health has developed a funded Dissemination Grants project to support dissemination of the indicators research and gather stories of practice. The grants project is actively supporting practitioners in their research and will identify if there are areas of capacity building practice that are not being captured with the checklists. NSW Health is also establishing a data base of practitioners using the Indicators and the Framework to increase understanding about how the tools are being used in practice.

- **Evidence of pathways from capacity building to health outcomes.**

Evidence of how capacity building contributes to health outcome needs further exploration. In addition, application of the Capacity Building Framework and the Indicators to designated public health priority issues (eg. tobacco, physical activity, nutrition and injury prevention) needs to be progressed. The NSW Safe Communities project has recently tendered for an evaluation of the project and this will include the use of the Indicator checklists as one of their sets of evaluation tools. NSW Health will continue to explore the potential for using the Indicators more broadly across the public health field.

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Acknowledgements

The National Public Health Partnership. (1999)
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25/3/2000

Representatives from these organisations have supported the revision of the framework.

- CEIDA
- Central Sydney Drug and Alcohol Services
- Northern Sydney Health
- NSW Health: Health Promotion Strategies Unit
- South Western Sydney Area Health Service
- South Eastern Sydney Area Health Service
- Southern Area Health Service
- Sydney University
- Western Sydney Area Health Service
- Wentworth Area Health Service

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