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Strengthening health promotion and research in practice: the experiences of an Aboriginal Community Controlled Health Service

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for the degree of Doctor of Philosophy

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James Cook University

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Statement of the contribution of others

Nature of assistance	Contribution	Co-contributors
Intellectual support	Supervision	A/Professor Kerrianne Watt, Professor Jenni Judd, A/Professor Sue Devine. I met regularly with all members of my advisory team who provided research advice, direction on the publication strategy and critical review of the thesis.
	Statistical support	A/Professor Kerrianne Watt provided statistical support by helping me plan my analysis and checking my findings as required.
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	Recruitment of participants	Karla Canuto, Nina Nichols, Melinda Hammond, Hylda Wapau and Aletia Twist provided advice on recruitment strategies and encouraged staff participation.

Abstract

Introduction

Health promotion is recognised as an essential element of comprehensive primary health care. Primary health care organisations in Australia need to increase their capacity to deliver health promotion to reduce the growing burden of disease. Aboriginal Community Controlled Health Services (ACCHS) have been identified as ideal models for integrating clinical care, health promotion and community capacity building into primary health care services. Yet very little is known about how health promotion is practised, and what the enablers and barriers to health promotion practice are in an ACCHS.

Methods

The aim of this research was to explore how health promotion is practised and how it can be strengthened in an ACCHS. A mixed methods research design was used in this research, with a Participatory Action Research (PAR) approach. Using this approach, participants were actively involved in deciding the focus of knowledge generation, in collecting and analysing information and in taking action to address the priorities identified. Participants were staff at Apunipima Cape York Health Council, an ACCHS located in Cairns, Australia.

The thesis contains seven papers (three published, two in press, the remainder are under review). Paper one is a narrative literature review that identified the enablers and barriers to building health promotion capacity in health organisations. Paper two describes the steps the candidate undertook to establish and maintain a research partnership with an ACCHS. Papers three to seven report on the findings drawn from each of the five PAR cycles.

Multiple data collection methods were used and included cross-sectional surveys, semi-structured interviews and document analysis. A pre- and post-workforce survey (electronic) was conducted in cycle one and five. Qualitative and quantitative data were collected to explore how health promotion is practised in the organisation, attitudes to health promotion in a primary health care context, confidence to perform health promotion and staff's perceived enablers and barriers to health promotion work. The second PAR cycle focused on workforce development to build health promotion

evaluation capacity. Qualitative and quantitative data were collected via surveys (electronic) to assess staff confidence, satisfaction, and usefulness of the workshop series and mentoring support. The third PAR cycle explored how health promotion practice was captured and reported in the organisation. Semi-structured interviews were conducted with staff using a purposive sampling approach. Organisational documents such as operational, business and team plans, quality standards, reporting requirements and templates used by staff for reporting health promotion practice were reviewed. The combination of staff interviews and document analysis was used to triangulate the findings. The fourth PAR cycle explored how staff accessed skill development and expertise in health promotion to assist their work practice. Semi-structured interviews were conducted using a purposive sampling technique. The fifth PAR cycle repeated the baseline survey and in addition explored changes staff had noticed over the previous year.

Results

Staff in this ACCHS valued the role health promotion practice provides as part of comprehensive primary health care. Participants demonstrated a good understanding of and described practising health promotion at both individual and population levels. However, a number of areas were identified where health promotion practice could be strengthened. These areas focused on: workforce development in evaluating and sharing findings of health promotion projects; improving the way health promotion practice is captured and reported to decision-makers; and, understanding and formalising how staff access health promotion skill development and expertise.

As a result of this research, there were a number of changes to health promotion workforce and organisational practice. Changes included: an increase in skilled staff to complete health promotion project evaluations and document work for publication in peer-reviewed journals; updated project planning and evaluation templates; an increase in staff sharing their health promotion project outcomes with other staff, community members and peers at conferences; the development of strategic documents detailing activity aimed at individual and at population levels; and the development of new organisational performance indicators to capture the impact of health promotion practice. As a result of these changes, staff were significantly more confident in the organisation's ability to lead health promotion practice in 2016 compared to 2015.

Discussion

By identifying and understanding what influences health promotion practice, strategies can be put in place to strengthen practice. PAR provided practice-based evidence on how health promotion is practised and what influences this practice. By basing the researcher within the organisation and involving the workforce in identifying priorities to action, the researcher was able to understand the work context and current influences on practice, tailor strategies to the current enablers and address the gaps specific to this workplace. Through the research process, the scope of health promotion practice that was already occurring became more visible in the organisation.

The organisation was able to identify ways that health promotion practice could be strengthened through changes to workforce and organisational practice. The primary health care workforce needs to be skilled and knowledgeable in health promotion practice and needs the organisational support in place to effectively work at individual and population levels. Having the skills and capacity to share health promotion learnings with other staff, with community members, with other colleagues, and importantly, with decision-makers advances understanding of how health can be improved in disadvantaged populations such as those in Cape York.

The research also identified a number of external influences that affect the capacity of the organisation to practice health promotion. National and state leadership, investment in resources for health promotion practice, and the development of individual and population measures are needed to increase the capacity and capability of health promotion practice.

Conclusion

The research conducted within this ACCHS is the first study of its kind and provided practice-based learning and insights into how health promotion capacity can be strengthened in an ACCHS. The research aligns with current national policies that identify a need to increase health promotion and prevention approaches in primary health care. A number of recommendations for future research, policy and practice have been made that will increase health promotion practice in Indigenous primary health care settings.

List of publications included in this thesis

Publications on which this thesis is based and contributions of authors

Chapter #, Paper #,	Publication, nature and extent of intellectual input from each author including the candidate
Chapter 1. Paper 1.	McFarlane K, Judd J, Devine S, Watt K. Reorientation of health services: enablers and barriers faced by organisations when increasing health promotion capacity. Health Promotion Journal of Australia. 2016; 27(2): 118-33. McFarlane was responsible for the concept and design of the study, conducted the search, extracted the data from the papers, synthesised and interpreted the findings and wrote the paper. Judd, Devine and Watt advised the search strategy and scope of the review and provided critical feedback to inform revisions to the paper.
Chapter 2. Paper 2.	McFarlane K, Devine S, Judd J, Canuto K, Watt K. Research with an Aboriginal Health Service: Building an effective partnership, step by step. Australian Indigenous Health Bulletin. 2016; 16(4). Retrieved [25/03/17] http://healthbulletin.org.au/articles/research-with-an-aboriginal-health-service-building-an-effective-partnership-step-by-step McFarlane was responsible for the concept and design of the paper, and wrote the paper. Devine, Judd, Canuto and Watt advised on the format of the paper and provided critical feedback to inform revisions to the paper.
Chapter 3. Paper 3.	McFarlane K, Devine S, Judd J, Nichols N, Watt K. Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service. Australian Journal of Primary Health. 2017; Online Early. Retrieved [25/03/17] http://dx.doi.org/10.1071/PY16033 McFarlane conceived and designed the study, developed the survey, performed the statistical analysis and qualitative analyses, interpreted the findings and wrote the paper. Devine, Judd and Watt contributed to the study design, survey development and provided critical feedback to inform revisions to the paper. Watt provided assistance with the statistical analysis and interpretation. Nichols provided critical feedback to inform revisions to the paper.

Chapter 4. Paper 4. Nichols N, McFarlane K, Gibson P, Millard F, Packer A, McDonald M. Skills, systems and supports: an Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity. Health Promotion Journal of Australia (in press).

McFarlane mentored Nichols in the study design and writing of the paper, developed the questionnaires, performed the statistical analysis and interpretation, wrote the first draft of the methods and results sections, and contributed to the drafting and revisions of all sections of the paper. Nichols conceived the design of the study, conducted the qualitative analysis, structured the paper, wrote and coordinated the manuscript. Gibson, Millard and Packer contributed to the design of the study. McDonald provided advice to the structure of the paper, interpretation of findings and provided critical feedback to inform revisions to the paper.

Chapter 5. Paper 5. McFarlane K, Devine S, Canuto K, Watt K, Judd J. Australian Indigenous primary health: Challenges in reporting health promotion outcomes. Health Promotion International. (under review).

McFarlane was responsible for the concept and design of the study, performed the document analysis, conducted the interviews and qualitative analyses and wrote the paper. Devine, Watt and Judd provided advice on the design of the study and analysis of findings. Devine, Canuto and Judd provided critical feedback to inform revisions to the paper.

Chapter 6. Paper 6. McFarlane K, Judd J, Wapau H, Nichols N, Watt K, Devine S. How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice. Rural and Remote Health (in press).

McFarlane was responsible for the concept and design of the study, conducted the interviews and qualitative analyses, and wrote the paper. Judd, Watt and Devine provided advice to the concept and study design, with Judd and Devine also providing critical feedback to inform revisions to the paper. Wapau and Nichols provided advice on the interpretation of the data and provided critical feedback to inform revisions to the paper.

Chapter 7. Paper 7.	McFarlane K, Judd J, Devine S, Nichols N, Watt K. Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service. Global Health Promotion. (under review). McFarlane was responsible for the concept and design of the study, developed the survey, performed the statistical analysis and qualitative analyses, interpreted the findings and wrote the paper. Judd, Devine and Watt contributed to the study design, survey development and provided critical feedback to inform revisions to the paper. In addition, Watt provided assistance with the statistical analysis and interpretation. Nichols provided advice on the interpretation of the findings and provided critical feedback to inform revisions to the paper.

List of publications which the candidate has co-authored during this period

Hanson D, Gunning C, Rose J, McFarlane K, Franklin RC. Working from the inside out: a case study of Mackay safe community. Health Education & Behavior. 2015; 42(1_suppl): 35S-45S. (Appendix P)

List of conferences which the candidate presented work from the thesis

The candidate presented work from this thesis at two national conferences. The abstracts and poster are attached in Appendix M, N, and O

Primary Health Care Research Symposium, Adelaide 29-31 July 2015

Population Health Congress, Hobart 6-9 September 2015

Table of contents

Acknowledgements iii

Statement of the contribution of others iv

Abstract vi

List of publications included in this thesis ix

List of publications which the candidate has co-authored during this period xii

List of conferences which the candidate presented work from the thesis xii

Table of contents xiii

List of tables xviii

List of figures xix

Abbreviations xx

Terms xx

Chapter 1. Introduction 1

1.1 Introduction 1

1.2 Background and motivation of the doctoral candidate 2

1.3 Aims and objectives 3

1.4 Context of the research 4

1.4.1 Health promotion policy and practice 4

1.4.2 Characteristics of the research setting 8

1.4.3 Research governance 10

1.5 Key definitions and principles 11

1.5.1 Defining health promotion 11

1.5.2 Health promotion in primary health care 12

1.5.3 Health promotion capacity building 13

1.6 Significance of the research 32

1.7 Thesis structure and organisation 32

1.8 Chapter summary 36

1.9 Chapter One references 37

Chapter 2. Methods 41

2.1 Overview of the chapter 41

2.2 Research approach 41

2.2.1 Study design 42

2.2.2 Ethical considerations 44

2.2.3 Research methodology 44

2.2.4 Data collection 45

2.2.5 Positioning of the researcher 50

2.2.6 Research credibility 51

2.2.7 Relevance of the research 52

2.3 Chapter Two references 53

2.4 Establishing and maintaining the research partnership 55

2.5 Paper two - Research with an Aboriginal Health Service: Building an effective partnership, step by step 55

2.6 Chapter summary 61

Chapter 3. Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service 62

3.1 Overview of the chapter 62

3.2 Paper three – Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service 63

3.3 Chapter summary 70

Chapter 4. Skills, systems and supports: An Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff 71

4.1 Overview of the chapter 71

4.2 Role of the PhD candidate 72

4.3 Paper four - Skills, systems and supports: an Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff 73

4.4 Chapter summary 85

Chapter 5. Australian Indigenous primary health: Challenges in reporting health promotion outcomes 86

5.1 Overview of the chapter 86

5.2 Paper five - Australian Indigenous primary health: Challenges in reporting health promotion outcomes 87

5.3 Chapter summary 103

Chapter 6. How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice 104

6.1 Overview of the chapter 104

6.2 Paper six - How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice 105

6.3 Chapter summary 121

Chapter 7. Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service 122

7.1 Overview of the chapter 122

7.2 Paper seven - Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service 123

7.3 Chapter summary 144

Chapter 8. Discussion and Conclusion 145

8.1 Overview of the chapter 145

8.2 Health promotion practice in ACCHS 146

8.3 Engagement with community 146

8.4 Developing skills and knowledge in health promotion 147

8.5 Leadership in health promotion 149

8.6 Changes in workforce and organisational practice 149

8.7 Strengths of the research 150

8.8 Limitations of the research 153

8.9 Challenges and lessons learned 155

8.10 Implications and recommendations 157

8.11 Conclusion 161

8.12 Chapter Eight references 164

Appendices 167

Appendix A: Human Research Ethics Committee approval 168

Appendix B: Memorandum of Understanding for the research collaboration Between James Cook University and Apunipima Cape York Health Council . 169

Appendix C: Information sheet 177

Appendix D: Consent form 179

Appendix E: Letters of support to publish in peer reviewed journals 180

Appendix F: Survey (pre-test) 185

Appendix G: Documents included for analysis 197

Appendix H: Interview questions: Capturing and reporting Health Promotion practice 200

Appendix I: Summary report provided to staff of the themes: Capturing and reporting Health Promotion practice 203

Appendix J: Interview questions: How staff access skill development and health promotion expertise 207

Appendix K: Summary report provided to staff of the themes: How staff access skill development and health promotion expertise 208

Appendix L: Survey (post-test) 214

Appendix M: Conference abstract submitted to the Population Health Congress, Hobart 6-9 September 2015 230

Appendix N: Conference abstract submitted to the Primary Health Care Research Symposium, Adelaide 29-31 July 2015...231

Appendix O: Poster presented at the Primary Health Care Research Symposium, 2015; and the Population Health Congress, 2015 232

Appendix P: Publication co-authored by candidate during the thesis 233

Appendix Q: Journal copyright permissions 244

List of tables

Table 1.1 National guiding documents' impact on health promotion 5

Table 1.2 Queensland guiding documents' impact health promotion 7

Table 2.1 Demographics of Apunipima staff 46

Table 2.2 Data collection process for the five PAR cycles 49

Table 4.1 Project timeline 77

Table 4.2 Overall usefulness of workshops and mentoring 80

Table 7.1 Staff confidence to perform health promotion competencies and their perceived confidence in the organisation to perform same competencies.............132

List of figures

Figure 1.1 Map of communities serviced by Apunipima 9

Figure 1.2 Health promotion framework 12

Figure 1.3 Capacity building framework 14

Figure 2.1 The PAR cycle 42

Figure 2.2 Participatory action research cycles 43

Figure 2.3 Mixed methods convergent design 45

Figure 5.1 Health promotion framework 91

Figure 5.2 Health promotion activities described in organisational documents. ... 93

Figure 7.1 Participatory action cycles 128

Abbreviations

Abbreviation	Name
ACCHS	Aboriginal Community Controlled Health Service
ACYHC	Apunipima Cape York Health Council
AGPAL	Australian General Practice Accreditation Limited
CQI	Continuous Quality Improvement
KPI	Key Performance Indicator
MOU	Memorandum of Understanding
NHMRC	National Health and Medical Research Council
nKPI	National Key Performance Indicator
OECD	Organisation for Economic Cooperation and Development
PAR	Participatory Action Research
RACGP	Royal Australian College of General Practitioners
s.d.	Standard deviation
SPSS	Statistical Package for the Social Sciences

Terms

Aboriginal Health Organisations

Aboriginal Health Organisations is used to refer to all First Nation health organisations. The term is used in this thesis to include all First Nation health organisations around the world.

Indigenous Primary Health Care Services/Settings

Indigenous Primary Health Care Services/Settings is respectfully used in this thesis to refer to Australian Aboriginal and Torres Strait Islander primary health care services/settings.

Chapter 1. Introduction

1.1 Introduction

Health promotion approaches are needed to reduce the growing burden of preventable diseases in Australia. Chronic diseases are the leading cause of ill health and death in Australia (1). By modifying lifestyle risk factors such as tobacco smoking, harmful alcohol use, physical inactivity, poor diet and obesity it is estimated that one-third of chronic disease could be prevented (1).

The burden of chronic disease is disproportionately higher in Aboriginal and Torres Strait Islander populations compared to non-Indigenous Australians (2). Indigenous primary health care organisations, also referred to as Aboriginal Community Controlled Health Services (ACCHS), are responding to the unique needs of this population to close the gap between the health disparities that exists. ACCHS have been identified as ideal models for integrating health promotion and clinical care into primary health care service delivery (3). However, there are a number of factors that can affect a health service's capacity to deliver health promotion approaches. How these factors are experienced in an ACCHS has not been documented.

The aim of this study was to explore how health promotion is practised and how it can be strengthened in an ACCHS. A mixed methods approach was used in this research, and a participatory action research approach was adopted. The researcher was based in the organisation for approximately 18 months. Being based in the organisation allowed the researcher to actively involve the workforce in deciding the focus of knowledge generation, in collecting and analysing information and in taking action to address the priorities identified. Participants were staff at Apunipima Cape York Health Council (Apunipima), an ACCHS located in Cairns, Australia. This research provides practice-based evidence of how health promotion can be strengthened in an ACCHS, and provides insight that is currently missing in the literature.

This chapter provides the background, context and key principles for the research and includes an outline of the structure of the thesis.

1.2 Background and motivation of the doctoral candidate

I have worked in a variety of health promotion roles for over 20 years. One of my most rewarding roles was working for Queensland Health as a project manager to build health promotion capacity in north Queensland. I was aware that health promotion practice commonly appeared in a majority of health staff's role descriptions, and I became interested in how this translates to practice. There are clear priorities in health service delivery and health promotion was often the activity prioritised after clinical care and treatment, if staff or organisational capacity allowed. In the capacity-building project, I focused on how health promotion could be strengthened using a systems framework of workforce development, organisational development, resources, leadership and partnerships (4). The focus was primarily on workforce development, with a number of strategies to support organisational change, develop leadership, foster and create new partnerships and identify how resources could be reallocated (staff and financial resources). This project began in 2006 and remained a priority until 2012.

Many achievements occurred as a direct result of this project: over 250 staff (internal and external partners) completed a five-day short course in health promotion; over 25 Aboriginal and Torres Strait Islander health staff completed the Graduate Diploma in Indigenous Health Promotion through the University of Sydney; and organisational changes were reflected in strategic and local planning documents stating the importance of the role of health promotion in health service delivery. Over the same time period, significant recognition of the health promotion profession was achieved with the addition of Health Promotion Officers being included in the Queensland Health, Health Practitioner Award. Inclusion in the Health Practitioner Award brought benefits such as a parity in wages and conditions with other health professions, clearer pathways for career entry and advancement, and inclusion of a professional development allocation to support continued learning in the field (5). Queensland was the first state in Australia to recognise health promotion positions as equal to other allied health professional roles.

However, with a change in state government in 2012 to a Liberal National Party majority government, and a mandate to 'cut non-frontline staff in the public service'(6), the health promotion workforce in Queensland was decimated. Almost all state health promotion positions were cut and financial resources to non-government organisations

delivering health promotion and prevention programs were considerably reduced. Health promotion staff who remained were stand-alone positions in each health service. All positions were abolished in the regional public health units and the state wide Preventive Health Branch. The Preventive Health Branch redesigned its focus and a reduced number of health promotion positions were created, with previous staff required apply. The positions that remained in the state now focused solely on campaigns and individual risk factors. Health promotion was undervalued and this was reflected in the reduced capacity and change of operations for those remaining health promotion positions. For health staff involved in health promotion activities a clear message was sent. Health promotion was a discredited, non-essential activity and not frontline service delivery.

I was Director of the health promotion service in north Queensland at the time. The whole service was made redundant (approximately 30 positions). I was devastated for my passionate health promotion colleagues, for the loss of health promotion focus in Queensland and for the future health impact this would have on the north Queensland communities we served.

It was at this time that my thoughts of doing a PhD began to really take shape. Prevention is the only solution for a sustainable health system, and a supported and skilled health promotion workforce resourced to tackle this is required. While this is currently not the case in Queensland, I wanted to move forward to contribute and document how health promotion capacity can be strengthened from those still working in the field. With support from past health promotion colleagues and peers my research proposal began to form. I was fortunate to link with colleagues at Apunipima, who showed immediate interest in my research idea, and provided me with practical direction and feedback to guide the research focus in a way that would be useful to their organisation's needs.

1.3 Aims and objectives

The aim of this research was to investigate and explore how health promotion is practised in an ACCHS, namely Apunipima. A participatory action research process was applied to add to and strengthen the organisation's health promotion and research practice.

The objectives of the research were to:

- identify current practices, enablers and barriers for health promotion in an ACCHS;
- document the health promotion approach within an ACCHS; and
- Use participatory action research as a tool for strengthening health promotion and research practice within this ACCHS.

1.4 Context of the research

1.4.1 Health promotion policy and practice

There have been a number of policy changes in Australia over recent years that have impacted on the attention to and practice of health promotion. National strategic documents state the increased need for health promotion and illness prevention approaches. Table 1.1, adapted from Jolley and colleagues (7), outlines current national strategies and their stated impact on health promotion and prevention practice.

Table 1.1 National guiding documents' impact on health promotion

Document	Context	Intended impact on health promotion
Australia: The Healthiest Country by 2020 – National Preventative Health Strategy, 2009 (8)	Prepared by the National Preventative Health Taskforce, sets targets on overweight and obesity, smoking and risky alcohol use	To inform, enable and support people to make healthy choices; and to reform primary health care with a greater focus on prevention
Building a 21st Century Primary Health Care system: Australia's First National Primary Health Care Strategy, 2010 (9)	Written on the understanding that the Commonwealth is to take full responsibility for PHC as per the National Health and Hospitals Network Agreement.	Increased focus on prevention
National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (10)	Prepared by the Australian Government in partnership with Aboriginal and Torres Strait Islander peak bodies to provide guidance to Aboriginal Community Controlled Health Organisations, mainstream health services, state and territory governments	Increased focus on addressing social inequities and determinants of health. Focus on protective factors to prevent ill health
National Strategic Framework for Chronic Conditions 2017-2025 Draft 2 (11)	Written for decision and policy makers at national, state and local levels as an overarching policy for the prevention and management of chronic conditions. *(The final version has not been released at the time of thesis submission)*	Increased focus on prevention from individual to population level approaches to reduce lifestyle risk factors that contribute to chronic conditions

At the same time, national political changes have also reduced the leadership capacity in health promotion and prevention approaches. The Australian National Preventative Health Agency was closed in June 2014 (12). This agency was responsible for policy leadership and establishing partnerships with Commonwealth, State and Territory governments, health promotion organisations and primary health care providers. The agency was tasked with: guiding healthy public policy; scaling up evidence-informed health promotion strategies; developing knowledge management systems to share evidence-informed practice; improving national surveillance systems for prevention and health promotion; building capacity in health promotion; and creating a strong national identity as a leader in prevention approaches. In 2013, the year prior to its closure, the agency published the national policy document - Australia: The Healthiest Country by 2020 (8). Without the closure of the agency, the government has dissolved its commitment to reform primary health care to have a greater focus on prevention. The removal of this agency resulted in $374 million reduction of funding on prevention and health promotion to the states (13). From 2008 to 2014, Australia's spending on public health activities, which includes health promotion activities, has reduced from 2.2 per cent to 1.4 per cent of total health expenditure (1).

Table 1.2 details the current Queensland guiding health documents. Between 2012 and 2016, there was an absence of Queensland government strategic direction documents for health. Exceptions are Making Tracks which details the closing the gap commitments the Queensland government committed to in 2007 and the Cape York food and nutrition strategy (14,15). The Cape York food and nutrition strategy was finalised in June 2012 and acknowledges that while the strategy was led by Queensland Health, the workforce, namely the public health nutritionists, can no longer commit to the strategies detailed as the workforce in north Queensland was abolished in September that year (15).

Table 1.2 Queensland guiding documents' impact health promotion

Document	**Context**	**Intended impact on health promotion**
Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 (14)	Policy and accountability framework that details the Queensland government intentions to improve health outcomes in Aboriginal and Torres Strait Islander populations	Focus on early years, addressing risk factors, improving cultural competence of the workforce and supporting community decision-making in health service delivery
My health, Queensland's future: Advancing health 2026 (16)	Written to guide Queensland government investment in health	Focus on promoting wellbeing by improving health behaviours, preventing illness and injury and addressing the social determinants of health
The health of Queenslanders 2016: Report of the Chief Health Officer Queensland (17)	The report has three objectives: • To provide an assessment on the health status of Queenslanders • To be a reference document for health practitioners in Queensland • To inform strategic policy and planning within Queensland Health	Health assessment of the populations risk and protective behaviours
Cape York food and nutrition strategy 2012-2017 (15)	Guide for the Cape York nutrition workforce and other key stakeholders	Increased focus on prevention strategies
Queensland health sexual health strategy 2016-2021 (18)	Detailed strategy which sits under the *My health, Queensland's future: Advancing health 2026* to guide government, non-government and community sector services	Increase awareness, education and early detection in sexual health

In 2012, the Queensland Government made significant cuts to health promotion and prevention expenditure, and in 2013/14 the South Australian Government followed suit (12). In Queensland, the majority of the health promotion workforce was removed and funding ceased or was considerably reduced to non-government organisations working on health promotion and prevention projects.

Primary health care organisations have always been important providers of health promotion approaches. In particular, ACCHS are identified as ideal models of comprehensive primary health care, integrating clinical care, health promotion and community capacity building (3). With reduced resources and leadership at a state and national level, it is more important than ever to understand the needs of ACCHS to deliver health promotion approaches given their focus is on a priority population.

1.4.2 Characteristics of the research setting

Apunipima provides comprehensive primary health care to 11 Cape York communities (See Figure 1.1). All communities are considered remote or very remote, have basic infrastructure and access to minimal services (19). The health needs in these communities are greater than in regional or urban Australian communities (20).

Figure 1.1 Map of communities serviced by Apunipima (21)

Apunipima employs approximately 150 staff. Staff include a mixture of community-based (20%) and Cairns-based fly-in, fly-out service providers (40%) (22). The workforce includes Aboriginal and Torres Strait Islander health workers and health practitioners, audiologists, diabetes nurse educators, dieticians, general practitioners, nutritionists, health promotion officers, social and emotional well-being and corporate support staff. Over half the workforce identify as Aboriginal or Torres Strait Islander and the majority of the workforce are female.

The main office for Apunipima is located in Cairns and provides space for all staff. Apunipima also has a primary health clinic at Mossman Gorge and small offices located in Coen, Cooktown and Mapoon (23). Aside from the Mossman Gorge clinic,

primary health care is delivered from the Queensland Health primary health centres located in the remote communities.

Staff who provide services in the communities such as clinicians, health promotion staff and health workers travel Monday to Thursday to approximately two or three communities that are close in geographical location. On Friday the majority of Apunipima staff are in the Cairns office undertaking administrative tasks which include attending staff meetings, submitting timesheets and organising future travel to the Cape York communities. No clinical services are provided at the Cairns office. It is purely the administrative hub for the organisation.

Apunipima was established in 1994 initially as a health advocacy organisation. In 2006, Apunipima transitioned to providing primary health care in Cape York and is now the largest community-controlled health organisation in Queensland (23). Apunipima receives a range of funding, predominantly from state and federal governments.

1.4.3 Research governance

Apunipima has been involved in research partnerships with tertiary institutions since 1999. There were a number of processes and existing structures which guided the approval, governance and support for this research project.

The Apunipima Clinical Research Council approved the research project in May 2014. Later that year, Apunipima established a Research Governance Committee to provide direction regarding the research priorities for the organisation. The purpose of this committee is to approve and ensure research is conducted respectfully, appropriately, is mutually beneficial to participants, and progresses Apunipima's strategic objectives. Throughout this research project, the Research Governance Committee reviewed and supported all papers, with the exception of the literature review, prior to their submission for publication (Appendix E).

A memorandum of understanding (MOU) documented the responsibilities of the doctoral candidate and Apunipima. Content of the MOU covered: conduct, intellectual property and publications, ethics and data management, risk and liability, term and termination processes, as well as a dispute process. A project schedule was included in

the MOU. This covered the objectives of the research, timeframe, budget, and project deliverables (refer to Appendix B).

An Apunipima-based reference group was established to support the research project. Members included the research coordinator, team managers and a community-based staff member, all with a strong interest in strengthening health promotion practice in the organisation. The reference group met, on average, every six weeks for the doctoral candidate to provide updates on the research progress, troubleshoot any issues and discuss data collection processes and feedback. The doctoral candidate was based in the organisation for approximately 18 months and the reference group members were their first point of call.

1.5 Key definitions and principles

1.5.1 Defining health promotion

Health promotion approaches enable people to increase control over their health and its determinants, and thereby improve their health (24). Health promotion recognises that an individual's health is determined not only by their behaviours and risk factors, but also by their circumstances and the environments in which they live. The Ottawa Charter for health promotion defines five action areas to focus efforts on both the individual and the social environment in which people live, work and play. These actions are: build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services (24).

The health promotion framework, adapted from Talbot and Verrinder (25), illustrates the types of strategies and activities used in health promotion practice (see Figure 1.2). Strategies used in health promotion include those that are able to be implemented one-on-one with an individual, group-based, and those with a community and population focus. Health promotion is multi-strategic, and effective approaches involve working across the framework.

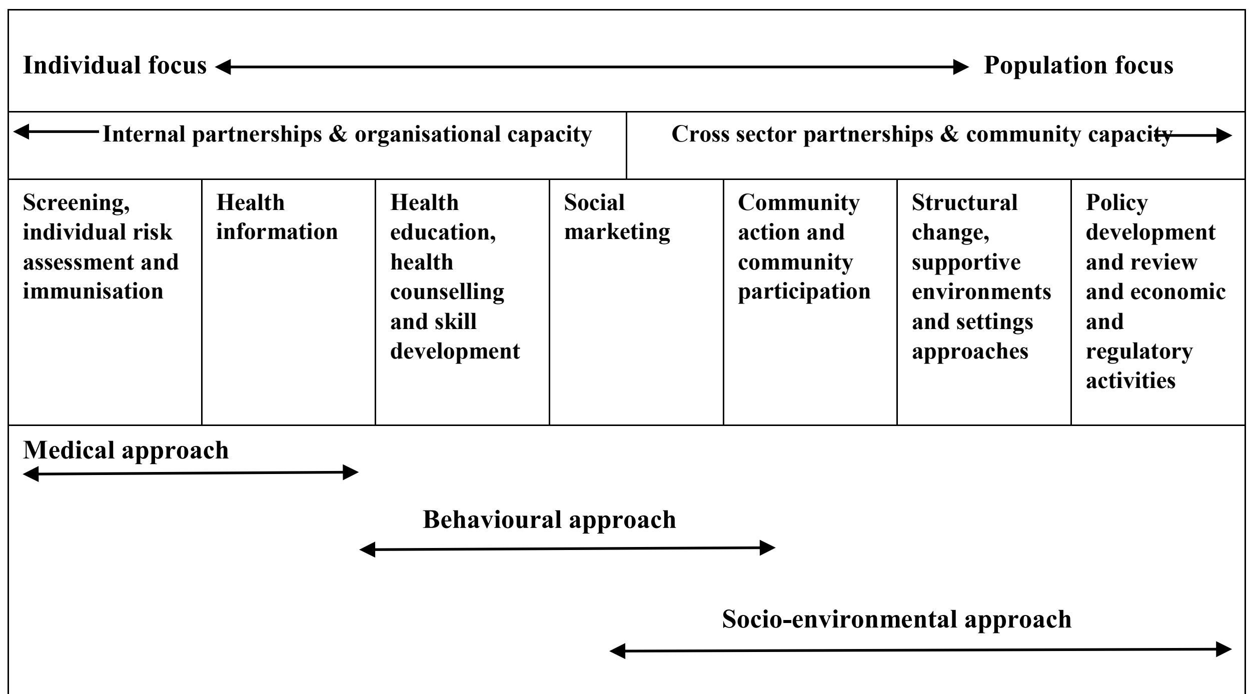

Figure 1.2 Health promotion framework (19)

1.5.2 Health promotion in primary health care

Primary health care involves early detection of risk factors and the promotion of protective behaviours, treatment and management of health (26). Health promotion approaches are an important part of comprehensive primary health care. Health promotion approaches complement the efforts in disease management and empower individuals to increase control over their health. As originally stated in the Alma Ata Declaration, primary health care involves the community in controlling and preventing health problems (27).

In Australia, Aboriginal Community Controlled Health Organisations emerged in the early 1970s as primary health care organisations, to improve access and provide culturally appropriate health care for Aboriginal and Torres Strait Islander people (28). These primary health care services are community-controlled and promote self-determination, consistent with health promotion theory that health can be improved only by empowering individuals, families and communities (24).

Aboriginal and Torres Strait Islander people suffer a greater burden of ill health than their non-Indigenous counterparts (2). There are higher rates of smoking, risky alcohol consumption, overweight/obesity, in Indigenous Australians compared to non-

Indigenous Australians, and lower rates of physical activity (1). Lifestyle-related risk factors are modifiable through health promotion and prevention approaches. At least 80 per cent of all heart disease, stroke and type 2 diabetes and over 40 per cent of cancer could be prevented through improvements in diet, increased physical activity levels and a reduction in tobacco smoking (29). To address the higher rates of ill health experienced in Aboriginal and Torres Strait Islander populations (1), health promotion approaches are particularly important for primary health care service delivery in Aboriginal and Torres Strait Islander communities.

Successful health promotion approaches with Indigenous populations have a number of common features. They adopt a participatory approach with the target audience to work together to plan, deliver and evaluate the health program (30-32). The health promotion approaches focus on more than just the health issue or behaviour and consider the social determinants of health (33). They consider the social, cultural, environmental and political influences on health and engage other organisations to address these influences (32,34).

As health promotion is multi-strategic, many staff in the primary health care organisation contribute to health promotion approaches. In reference to the health promotion framework (Figure 1.2) (25), general practitioners and allied health staff are more likely to be involved in individual strategies such as assessing risk factors, for example smoking status and immunisation. Community-based staff, such as health workers and community nutritionists are more likely to be involved in group based health education and skill development. Leaders in the primary health care organisation are more likely to be involved in advocating for structural, policy and regulatory change. Health promotion staff work across the whole framework, often being active in the areas of the framework where there is a gap in activity, and provide support to efforts that are already occurring in other areas of the framework to ensure a multi-strategic approach is taken.

1.5.3 Health promotion capacity building

Health promoting health services is a World Health Organisation approach that emerged in the 1990s (35). The approach identified that to improve population health, health services need to develop specific structures, cultures, decisions, and processes to

support health promotion work; and in doing so effectively, they would not compromise the delivery of treatment services. More specifically the health promotion capacity building framework (Figure 1.3) identifies what the specific structures and processes need to focus on (4).

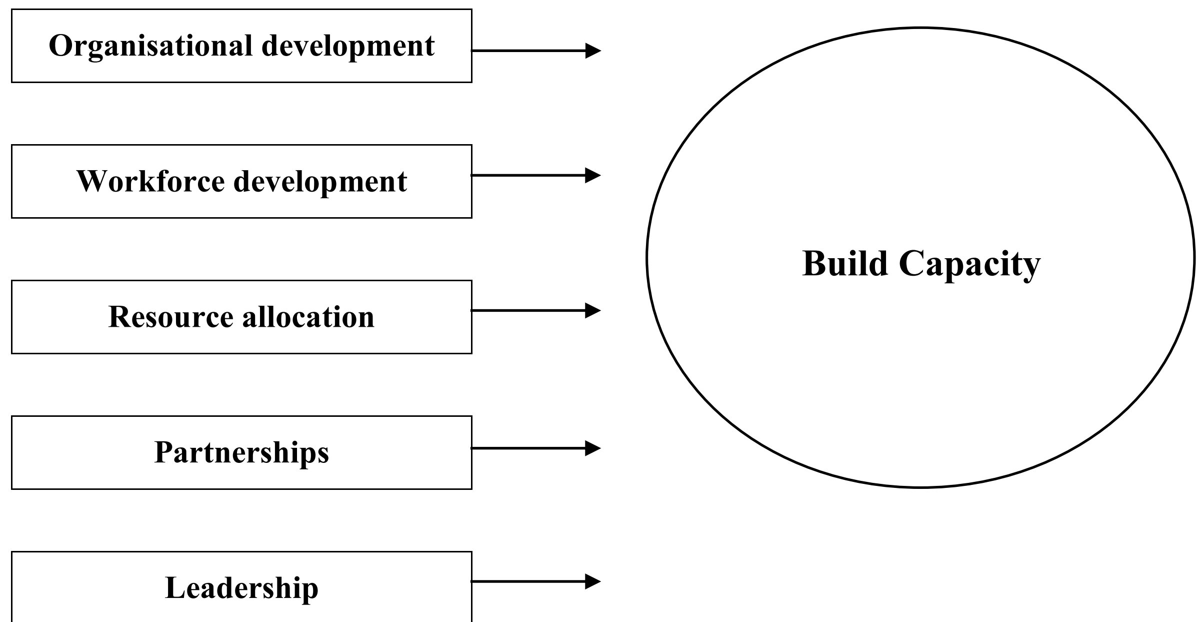

Figure 1.3 Capacity building framework (4)

The health promotion capacity building framework identifies a structure for organisations to strengthen their health promotion practice (4). Organisational development includes the structures and processes of the organisation. Strategies may target policies and procedures, quality assurance and management support. Workforce development strategies focus on the knowledge, skills and practice of the staff in the organisation. Resource allocation includes financial and human resources dedicated to health promotion practice. Partnerships can be with internal and external stakeholders to combine resources and expertise to address health priorities. Leadership may include the organisation's vision or strategic documents, expertise of staff, and ability to negotiate and champion health promotion practice.

A narrative literature review was conducted to identify the common enablers and barriers faced by health organisations when increasing their health promotion capacity. A secondary aim of the literature review was to explore the experiences of health organisations when increasing their health promotion capacity, in particular Aboriginal and Torres Strait Islander organisations. This literature review has been published and is inserted on the following pages.

Paper One McFarlane K, Judd J, Devine S, Watt K. **Reorientation of health services: enablers and barriers faced by organisations when increasing health promotion capacity**, Health Promotion Journal of Australia. 2016; 27(2): 118-33

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Reorientation of health services: enablers and barriers faced by organisations when increasing health promotion capacity

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Abstract

Issue addressed: Primary healthcare settings are important providers of health promotion approaches. However, organisational challenges can affect their capacity to deliver these approaches. This review identified the common enablers and barriers health organisations faced and it aimed to explore the experiences health organisations, in particular Aboriginal organisations, had when increasing their health promotion capacity.

Methods: A systematic search of peer-reviewed literature was conducted. Articles published between 1990 2014 that focused on a health care settings approach and discussed factors that facilitated or hindered an organisation's ability to increase health promotion capacity were included.

Results: Twenty-five articles met the inclusion criteria. Qualitative (*n* – 18) and quantitative (*n* – 7) study designs were included. Only one article described the experiences of an Aboriginal health organisation. Enablers included: management support, skilled staff, provision of external support to the organisation, committed staffing and financial resources, leadership and the availability of external partners to work with. Barriers included: lack of management support, lack of dedicated health promotion staff, staff lacking skills or confidence, competing priorities and a lack of time and resources allocated to health promotion activities.

Conclusions: While the literature highlighted the importance of health promotion work, barriers can limit the delivery of health promotion approaches within primary healthcare organisations. A gap in the literature exists about how Aboriginal health organisations face these challenges.

So what? Primary healthcare organisations wanting to increase their health promotion capacity can pre-empt the common barriers and strengthen identified enablers through the shared learnings outlined in this review.

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Introduction

Health promotion plays an important role in maintaining and improving the overall health of the population. Health promotion is defined as 'the process of enabling people to increase control over their health and its determinants, and thereby improve their health'[1]. Approaches that are multi-strategic and guided by the Ottawa Charter for Health Promotion[1] have been effective in improving healthy lifestyle behaviours and in reducing the risk of developing non-communicable diseases.[2] By specifically improving diet, physical activity levels and eliminating tobacco smoking it is estimated at least 80 per cent of all heart disease, stroke and type 2 diabetes and over 40 per cent of cancer would be prevented.[2]

An individual's health is determined not only by their behaviours but also by their circumstances and environment.[3] Health promotion approaches focus on strengthening the skills and capabilities of individuals, groups and the broader population as well as influencing the social, environmental and economic determinants of health.[1] To address the environmental, social and economic determinants, health promotion approaches are implemented across several organisational settings both within and outside of the health sector. Health services are recognised by the World Health Organization as a key setting for health promotion and include hospitals, primary health care, community health and public health organisations.[4]

Primary healthcare organisations are important providers of health promotion approaches. They are the first point of contact for individuals, families and the community with the healthcare system.[5] Four out of five Australians will see a primary healthcare professional at least once a year.[6] The links between health promotion and

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primary health care were defined in the Declaration of Alma-Ata.[7] Primary health care is a key setting for the promotion of healthy behaviours, identification of risk factors for ill health and the treatment of illness.[8]

In Australia, the health status and life expectancy of Aboriginal and Torres Strait Islander peoples is much lower than that of the general population.[9] The higher mortality rates for preventable chronic diseases is well documented.[10] In response to this health inequity, Aboriginal community controlled health services (ACCHS) emerged in the early 1970s to improve access and provide culturally appropriate health care.[11] ACCHS are primary healthcare organisations that provide holistic, comprehensive and culturally appropriate health care, planned and managed by boards elected from the local Aboriginal community.[11] The philosophy of community control is consistent with health promotion theory, which states that the health status of Aboriginal people can only be improved by local Aboriginal people controlling healthcare delivery in their community.[11]

Both mainstream primary healthcare services and ACCHS face many known challenges in the delivery of health promotion. Short-term funding cycles, lack of commitment to long-term evaluations, inconsistencies in practices, and the contested meanings of health promotion by decision makers continue to hinder the effective implementation of health promotion approaches.[4,12] Additionally, managing both treatment and health promotion roles can be challenging for primary healthcare providers. The broader health promotion role may be neglected if an individualistic approach that focuses solely on the immediate treatment needs of the client is taken. This individualistic approach to health care and emphasis on health education alone may influence decision makers within the health service to prioritise short-term targets of health care at the expense of long-term targets that support improved health outcomes.[12]

With the emergence of health-promoting healthcare settings in the 1990s, health promotion practitioners have focused on building health promotion capacity through infrastructure that includes staff, skills, resources and workplace structures to address health problems more effectively.[13] Others have focused on building capacity to sustain the effects of health promotion programs and build problem-solving capacity through partnerships at an individual, community and organisation level to better address health problems.[14,15] Work done by Hawe and colleagues,[16] NSW Health Department,[17] and later supported by Judd and Keleher,[18] identified specific organisational structures and processes that can strengthen health promotion capacity within an organisation. Organisations need workforce capability, organisational support through resource allocation and collaborative approaches, and structures to utilise opportunities and skill sets to deliver effective health promotion approaches.[16] Systems thinking linked with change processes have been used at organisational levels to identify system supports and influencing mechanisms such as policies, inter-relationships, resources and organisational values.[19] The health promotion capacity building framework identifies five key components required to build capacity: organisational development, workforce development, resource allocation, leadership and partnerships.[17] The framework acknowledges the interdependency between the components and has guided health promotion capacity building work, particularly in Australia, since the early 2000s.[20]

The health promotion capacity building framework[17] identified areas that can be strengthened to embed health promotion within an organisation. However, when reorientating health services it is important to understand the challenges of implementing change into practice. This review aimed to identify the common enablers and barriers these organisations face and to explore the experiences health organisations, in particular Aboriginal and Torres Strait Islander organisations, had when increasing their health promotion capacity.

Methods

A systematic search of peer-reviewed articles was conducted using electronic databases including APAIS, APAFT, CINAHL, Current Contents Connect, Medline, ProQuest Central, PsycARTICLES, PsycINFO, Scopus, Social Sciences Citation Index, the Cochrane library, Google Scholar and the Australian Indigenous Health*Infonet*. Further articles were sourced from hand searching of reference lists from articles identified through the database search.

Search terms (MeSH and text words) were defined by the outcome of interest 'health promotion'; the change effect which included terms such as 'capacity building', 'organisational innovation', 'organisational change' and 'organisational development'; and the health organisational setting using terms such as 'primary health care', 'public health administration' and 'community health services'. Given the particular interest in exploring health promotion in Indigenous healthcare settings, 'Indigenous' and 'Aboriginal and Torres Strait Islander' search terms were also used. However, no relevant articles were found. The Australian Indigenous Health*Infonet* database was then searched and one relevant article was found.

Only articles published in English between 1990 and March 2014 were included. The rationale for the start year was that health promoting health settings were first discussed in the early 1990s. The dates of publication for articles in the full text review ranged from 1992 to 2014. To ensure articles described enablers and/or barriers for building organisational health promotion capacity within a health organisation were found, articles were only included if they focused on a health care–settings approach and discussed the factors that facilitated or hindered an organisation's ability to increase their health promotion capacity. Both qualitative and quantitative studies were included to obtain a broader understanding of this area.

Articles were excluded if: (i) health promotion capacity was aimed at collectively increasing a coalition's or group of partner

organisations ability to undertake a combined health promotion approach; or (ii) the content was general in nature and an organisation's experiences were not used as examples of how health promotion capacity was affected.

Titles and abstracts were independently reviewed for topic relevance. Four hundred and sixty-five articles were found. After the removal of duplicates ($n = 340$) a total of 125 articles were then reviewed for relevance. Following a full-text review, 100 articles were excluded, leaving 25 relevant articles to be included in the review. Figure 1 summarises the article selection process.

Results

Twenty-five articles met the inclusion criteria. These articles described health promotion capacity building initiatives in Australia, Canada, United States of America, Africa, China, United Kingdom, Sweden and the Solomon Islands, with the majority of papers from Australia ($n = 8$) and Canada ($n = 8$). The organisational settings included primary health care, community health, hospitals and public health organisations. Table 1 summarises the studies discussed in this review.

There were three main ways the articles identified the enablers and barriers to increasing health promotion capacity. First, health organisations implemented specific capacity building interventions, such as workforce training and leadership development, and assessed the enablers and barriers when implementing these interventions. Second, health organisations implemented a new program in their organisation and included in their evaluation the impact of organisational enablers or barriers. Lastly, articles reported on what the health promotion workforce perceived were the enablers and barriers to health promotion practice. Across all studies common themes were identified.

Enablers for increasing health promotion capacity within health care organisations

To increase organisational health promotion capacity, management support,[18,20–33] a skilled and knowledgeable workforce,[34–38] external specialist assistance,[18,24,32,34,35] resource allocation,[20,22,27,31] leadership[26,27,29,31,33,39,40] and access to external partners to work on health promotion approaches[21,25–27] were the most commonly reported enablers. Management support was reported in two ways: first, the line manager's influence on work practice; and second, the influence of the organisation's ethos and practice. Key features of these enablers are outlined in Table 2.

Barriers to increasing health promotion capacity within healthcare organisations

The most common reported barriers for an organisation aiming to increase health promotion capacity were: lack of management support;[20,26,37,38] lack of dedicated health promotion staff;[25,26,40,44]

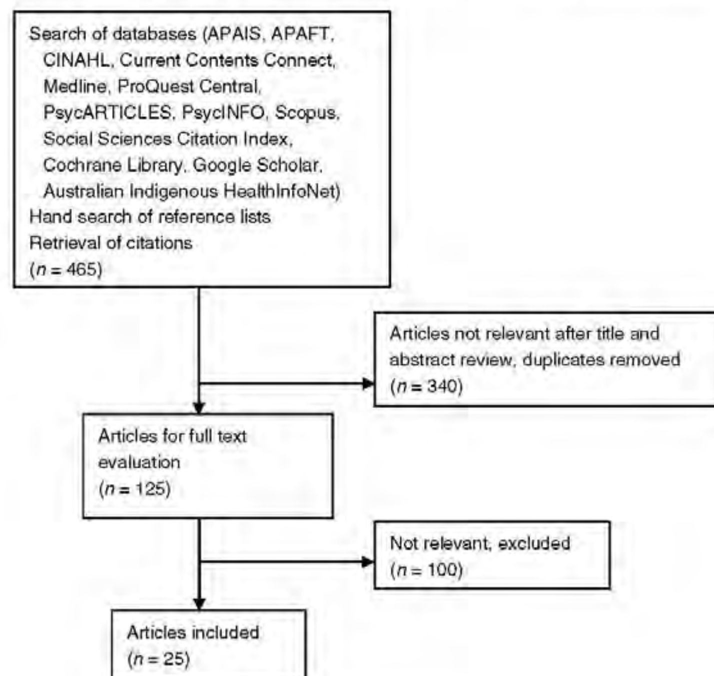

Fig. 1. Search strategy.

Table 1. Summary of relevant literature

BI, brief intervention; CCI, community capacity index; CI, confidence interval; *n*, number in sample; NHS, National Health Service; OR, odds ratio; PAR, participatory action research; QI, quality improvement; SNAP, smoking, nutrition, alcohol and physical activity; US, United States; WHO, World Health Organization

Paper	Purpose	Sampling[A] and participants	Study design and data collection	Measures	Identified enablers and barriers for increased health promotion organisational capacity	Limitations (general)
Quantitative study designs[B]						
Barrett *et al.* (2007)[40]	To examine organisational leadership and its relationship to organisational action to promote health.	Convenience sample of representatives from regional health authorities. Alberta, Canada ($n = 144$)	**Design:** Analytical cross-sectional study **Data collection:** Self-administered survey	(1) Perceived collective organisational leadership including: practices for organisational learning; wellness planning; workplace milleu; and organisation member development. (2) The relationships of the organisational leadership components with organisational actions. 19 dependent variables were grouped into three areas: health promotion; heart health promotion; and global outcomes that were aggregated scores for settings, activities and actions on the heart health determinants model.	Practices for organisational learning and wellness planning were significantly, positively associated with the outcome variables. Organisation member development had a significant positive association with health promotion implementation. **Enablers:** organisational learning, wellness planning and the presence of a champion for heart health promotion had the greatest relationship with health promotion actions. Health promotion actions included: assessment; implementation on Ottawa Charter action strategies for health promotion; and evaluation.	Focus on organisational leadership only. Authors stated values were significant but did not provide p values. Selection bias may be present due to volunteer and recall bias. The study may not be generalisable to other organisations outside of regional health authorities in Alberta.
Devine *et al.* (2009)[37]	The effect of health promotion workforce training on longer term practice Evaluation at conclusion of course and 6 months later	Health service staff who attended the 5-day short course. Queensland, Australia ($n = 39$ out of 54)	**Design:** Pre test–post test **Data collection:** Self-report postal survey, focus group and phone interviews	Perceived opportunities and barriers for participants to undertake health promotion in their work environment and whether there was organisational support to do so following the training course in health promotion.	**Barriers:** No significant associations were reported. However the qualitative data indicated the following barriers: management support; mentoring for new or inexperienced health promotion workers; lack of time; lack of internal funding; health promotion was not incorporated into overall strategic planning; lack of understanding from co-workers and managers; lack of organisational support and commitment; lack of resources, and; competing clinical priorities.	Focus on workforce development only. Selection bias may be present with those who volunteered to be in the post test comprising 39 of the 54 possible respondents.

Guo *et al.* (2007)[30]	To identify the attitudes of managers involved in health promoting hospitals.	Managerial employees from selected health promoting and control hospitals. Beijing, China ($n = 106$ hospitals; $n = 281$ managerial employees)	**Design:** Analytical cross-sectional study **Data collection:** Face-to-face interviews	Effectiveness of health promoting hospital implementation included: long-term planning of health promotion; specialised funding for health promotion; training for medical staff; training skills in health promotion; provision of health education for patients by professionals. Managerial perspectives were measured for: understanding of health promoting hospitals; attitude about need for health promotion in hospitals; and achievements and barriers for health promotion in hospitals.	Significant positive association with health promotion hospital implementation when long-term planning and specialised funds for health promotion were allocated (OR 12.05 (95% CI: 1.48–97.91) and 2.71 (95% CI: 0.79–9.29) respectively). **Enablers:** commitment to health promotion evidenced through long-term planning and identified funding; and knowledge and understanding of the concept health promoting hospitals. **Barriers:** shortages of funds, personnel, time management and professional skills.	Confidence intervals are wide. Confounding bias may be present. Results may not be generalisable outside of Beijing hospital settings.
Kardakis *et al.* (2014)[23]	To investigate health professional work with lifestyle interventions in primary health care and describe the knowledge, attitudes and organisational support that is available.	Purposive sampling of nurses and physicians in primary health care. Sweden ($n = 315$)	**Design:** Descriptive cross-sectional study **Data collection:** Web-based questionnaire	Attitudes and knowledge of lifestyle interventions; extent to which professionals and primary healthcare centres work with patient lifestyles; and perceived organisational support. A 5-point Likert scale was used to quantify responses (item responses ranged from 'completely disagree' to 'completely agree').	78% of professionals perceived a need for national guidelines for lifestyle interventions and this was statistically significant between professional groups. ($P < 0.05$) **Enablers:** management support and local guidelines to guide work with the promotion of healthy lifestyles.	Study may not be generalisable outside of Swedish primary healthcare organisations. Selection bias may be present due to volunteer bias of those that completed the web-based questionnaire.
Panaretto *et al.* (2010)[42]	To report on the organisational capacity to perform opportunistic BIs for SNAP risk factors.	Clinical staff (Aboriginal Health Workers, nurses, doctors and practice managers) at 4 urban Aboriginal and Torres Strait Islander medical services. Queensland, Australia ($n = 46$)	**Design:** Analytical cross-sectional study; case series; focus groups **Data collection:** Self-administered survey, medical chart audit and focus groups	Survey: knowledge and attitudes pertaining to BI, screening tools available, frequency of BI, availability and use of referral services and provision of training. Medical chart audit: risk assessment of SNAP, delivery of BI and completion of key clinical indices. Focus groups: enablers and barriers to the delivery of BI including the role of the workforce, information technology, management support, past training and perceived support needs.	Significant difference in the participating clinics for conducting risk assessments and brief interventions in smoking, nutrition, alcohol and physical activity than comparison clinics ($P < 0.001$) **Enablers:** time available with clients and the adult health check screening process prompted brief interventions. **Barriers:** inflexible staff training, lack of confidence of staff to conduct brief intervention, competing health priorities and high levels of staff turnover.	Focus was on the delivery of brief interventions by the organisations only. Selection bias may be present due to volunteer bias of those that completed the survey and participated in the focus groups.

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Table 1. *(continued)*

Paper	Purpose	Sampling^A and participants	Study design and data collection	Measures	Identified enablers and barriers for increased health promotion organisational capacity	Limitations (general)
Tang *et al.* (2005)[24]	To describe the development and implementation of the project and the impact of the technical assistance project.	Convenience sample of participants in the training, key stakeholders of the project. China (n = 219)	**Design:** Pre test–post test **Data collection:** Self-administered questionnaires, annual reports	Participants' perceived changes to organisational support and capacity measured through 8 domains: leadership, expertise, structure, reward, helpful mechanisms, relationships, purpose and attitude to change. Evidence of policy, strategy and guideline development in annual reports. Evidence of improved project management in project proposals and project reports.	Significant improvement as a result of the training in all of the domains (P < 0.0001) **Enablers:** technical assistance providing training in health promotion (knowledge and skill application); support from political leaders and senior managers; and consultant expertise in health promotion and in developing a respectful working relationship.	There may have been other external influences of organisational practice in health promotion in China at this time. Difficult to attribute change to this intervention only without a comparison group. Selection bias may be present due to volunteer bias of those that completed the survey and recall bias over the 3-year period.
Van den Broucke *et al.* (2010)[26]	Three objectives: to integrate health promotion into the health policy plans at the national, provincial and district level; strengthen health promotion capacity in two provinces; and support the development of tools for the monitoring and evaluation of health promotion	Identified participants in the health promotion projects and stakeholders. South Africa (n = 58)	**Design:** Pre test–post test **Data collection:** Document analysis, site visit, focus groups and face-to-face interviews.	Stakeholder participation in activities and perceived quality and usefulness of the project activities through project documents and interviews. Increase in health promotion capacity was scored using the CCI to measure indicators on a 5-point scale (substantial decrease, small decrease, no change, small increase, substantial increase), in the domains of: partnerships, knowledge transfer, problem solving and infrastructure.	A substantial increase in capacity was found for two of the CCI domains as scored by the external evaluator based on focus group data: (i) network partnerships, capacity to identify the organisations and groups with resources to implement/sustain a health promotion program; and (ii) knowledge transfer, capacity to develop a health promotion program that meets the needs of the community. **Enablers:** health promotion recommendations in strategic planning documents; ability to identify the organisations and groups with resources to partner with; skills and knowledge to develop and implement health promotion programs. **Barriers:** policy makers focused on cure rather than health promotion.	There may be selection bias from volunteers who participated in the focus groups and interviews. Study findings may not be generalisable outside of this context of an external country (Belgium) and the WHO providing support to South Africa.

Qualitative study designs						
Bensberg (2000)[21]	To describe how infrastructure can be strengthened to influence the delivery of local health promotion action.	Health promotion practitioners, managers, academics and program advisors. Victoria, Australia (n = 45)	**Design:** Qualitative **Data collection:** Interviews: not stated if individual/group or phone/face-to-face	Respondents commented on what they perceived supported or influenced health promotion action. The responses were combined and translated into the regional infrastructure for improving health promotion model.	**Enablers:** health promotion knowledge; organisational support; alliances; management support; practitioner delivery; community participation and communication.	The model generated provides a framework for planning and coordinating organisational health promotion infrastructure improvements. Adoption of the model in an organisational setting was not part of this study.
Flaman et al. (2010)[43]	To explore facilitators and barriers to individual and organisational capacity to address priority strategies for community-level chronic disease prevention	Convenience sampling from a stakeholder workshop conducted for the project. Alberta, Canada (n = 11)	**Design:** Qualitative **Data collection:** One-on-one semi-structured interviews	How participants had taken action on 3 priority strategies identified at the workshop; their individual and organisational capacity to take on the priorities; and facilitators and barriers to taking action on the priorities.	**Enabler:** organisational support for the priority strategies **Barriers:** organisations lack of or competing priorities; disconnect between the organisation and community priorities; disconnect between priorities of various community organisations; disconnect between organisations and government/funder priorities; limited resources, and; bigger community issues.	Small sample size. Perceived barriers were identified when strategies for action were nominated.
Fuller et al. (2007)[44]	To increase the capacity of community-based organisations delivery of HIV prevention interventions, and to explore the organisations ability to implement the intervention and identify barriers to implementation	Self-selected community-based organisations. United States of America (n = 16 organisations)	**Design:** Qualitative **Data collection:** Phone interviews at 1, 6 and 9 months	Project implementation challenges and costs, agency fit, monitoring and evaluation strategies, recruitment and retention, utilisation of the materials, training and technical support needs and agency barriers and challenges.	**Enablers:** providing intervention materials, high-quality comprehensive training and ongoing technical assistance, including project monitoring and evaluation; specialised assistance and guidance early in the process with all phases of the program implementation; and assessing agency capacity and resources prior to implementation. **Barriers:** managing internal agency issues (details not specified)	Focus on workforce development. High turnover of staff and new staff who did not receive the training were involved in the follow-up evaluation.

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Table 1. (continued)

Paper	Purpose	Sampling[A] and participants	Study design and data collection	Measures	Identified enablers and barriers for increased health promotion organisational capacity	Limitations (general)
Germann and Wilson (2004)[42]	To identify key organisational elements that contributes to delivery of successful chronic disease activities at a community development level	Purposive sampling of front-line workers and organisational leaders. Alberta, Canada (n = 22)	**Design:** Qualitative **Data collection:** Semi-structured interviews in person and by phone	Identification of prerequisites that a Regional Health Authority needs to have in place in order to engage successfully in chronic disease initiatives: organisational elements; skills and knowledge; and personal qualities.	**Enablers:** organisational commitment rooted in particular values and beliefs, leadership and shared understanding; supportive structures and systems such as job design, flexible planning processes, evaluation mechanisms and collaborative processes; and allocation of resources.	Themes from the interviews were used to design a model for practice. Application of the model was not included in the study.
Griffiths and Thorpe (2007)[43]	To identify ways to sustain the capacity of the public health workforce in the context of constant structural changes.	Sampling from public health specialists NHS. United Kingdom (n = not stated)	**Design:** Primarily qualitative **Data collection:** Questionnaire distributed by email. Key themes identified by the survey are discussed in the NHS context 3 years after the survey was completed.	Statements from selected public health specialists were rated by the participants on the future of their roles and ways of working to sustain workforce capacity on a 5-point Likert scale: 'strongly agree, agree, neither agree nor disagree, disagree and disagree strongly'. General themes identified by the survey are discussed.	**Enablers:** leadership skills that ensure a proactive approach to staff development and succession planning; joint work with other health professionals; use of target regimes as a mechanism for focusing attention and resources on health protection issues. **Barriers:** lack of resources and capacity to achieve specified targets; reduced budget and access to training; and commitment to treating illness rather than prevention.	Results of the quantitative component relating to Likert scales were not provided. Unknown sample size, no information provided about participant recruitment (how, where, etc.). Findings may not be representative of the actual public health workforce.
Haalboom *et al.* (2006)[46]	To identify how research activities have influenced organisational capacity and health promotion practice.	Key informants from heart health projects. 5 provinces, Canada (n = 66)	**Design:** Parallel case study **Data collection:** Interviews: not stated if individual/ group or phone/ face-to-face	Interviews explored: project objectives; meanings of capacity; intervention effectiveness; contextual factors; and facilitators and barriers.	**Enablers:** knowledge and skills of practitioners in monitoring and evaluating practice; improved planning and prioritising; and improved buy-in and cultivation of relationships with other partners.	Research as intervention was not a primary study focus for the heart health projects.
Heward *et al.* (2007)[45]	To highlight organisational change as a necessary component of capacity building frameworks in health promotion practice.	Health promotion organisations and staff. Victoria, Australia (n = 880)	**Design:** Qualitative 3 case study examples **Data collection:** Policy and document review, survey and interviews/ focus groups	Contextual features of the organisation or system were themed to illustrate organisational change required for health promotion effectiveness and sustainability.	**Enablers:** communication with all layers of the organisational system; active commitment and involvement of managers; having a clear consistent vision; having adequate resourcing for practice and internal change; communicating to staff the vision, values and priorities; and health promotion planning across inter-disciplinary teams.	Selected case studies chosen to highlight the role of organisational change in health promotion capacity building.

					Barriers: lack of reflection on the implementation of policy strategies; staff lacked readiness for change; and managements' lack of understanding of health promotion.	
Joffres *et al.* (2004)[35]	To measure organisational capacity for heart health promotion	Community agencies involved in heart health promotion. Nova Scotia, Canada (n = 14 organisations; n = 182 heart health staff)	**Design:** Qualitative and quantitative measures **Data collection:** Survey of community agencies by phone and self-administered mail surveys; questionnaire administered by phone; interviews not specified if phone or face-to-face	Community agency survey measured: level of priority and level of involvement in heart health activities. Organisational questionnaire measured: extent to which practice had been implemented. Interviews measured: environmental factors supportive or challenging to heart health promotion.	Results were reported in terms of the percentage of organisations involved in heart health activities and the identified barriers and enablers to practice. The following enablers and barriers represent 35% or more of respondents' views. **Enablers:** support from management and boards; overall organisational interest; and partnerships. **Barriers:** lack of time; insufficient staffing; lack of resources; lack of knowledge and skills in health promotion; challenges maintaining strong partnerships; and competing organisational priorities.	Results may not be generalisable outside of Nova Scotia or to non-heart health promotion work.
Joffres *et al.* (2004)[29]	To explore the factors that influenced organisational capacity building efforts for heart health promotion.	Organisations with a mandate for health promotion or an interest in heart health promotion. Nova Scotia, Canada (n = 76)	**Design:** Participatory action research **Data collection:** Reflection logs and semi-structured, face-to-face interviews	Measures included: activities conducted to support capacity building; factors that challenged or facilitated organisational development; who was involved in these factors; and the circumstance in which these factors came into play.	**Enablers:** partnerships were able to influence intra-organisational policies and staff knowledge and skills; innovative leadership to link capacity building activities; bottom-up and top-down leadership, ability to build on the organisation's strengths and overcome challenges; congruence in relation to mandate, objectives and the organisational values; and organisational readiness. **Barriers:** not all levels of staff were equally supportive of the project; entrenchment of organisational objectives, values and policies can hinder change; resistance to change from competing organisational priorities and	Results may not be generalisable outside of Nova Scotia or to non-heart health promotion work.

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Table 1. *(continued)*

Paper	Purpose	Sampling[A] and participants	Study design and data collection	Measures	Identified enablers and barriers for increased health promotion organisational capacity	Limitations (general)
					incongruence around the project's and organisation's objectives, values and working procedures.	
Judd and Keleher (2013)[18]	The role that training interventions played in the reorientation of primary healthcare staff and the strategies to shift practice more upstream in terms of a population health approach.	Purposive sampling from an urban community health setting. Northern Territory, Australia ($n = 2$ settings; $n = 100$ participants)	**Design:** PAR **Data collection:** Survey ($n = 61$), pre and post questionnaire ($n = 30$), in-depth semi-structured interviews ($n = 20$), participant observation ($n = 8$), workplace diaries ($n = 9$) and nominal groups ($n = 12$)	Workforce development measures included pre and post knowledge components of the training intervention, and practical application.	**Enablers:** management support; supportive policy environment within the workplace and broader organisation; support from health promotion specialists; and targeted health promotion training.	Results may not be generalisable as the study was conducted with one primary health service in the Northern Territory.
Judd and Keleher (2013)[33]	To identify what the core dimensions are to build health promotion capacity in a primary healthcare workforce in a real-world setting.	Purposive sampling from an urban community health setting. Northern Territory, Australia ($n = 2$ settings; $n = 100$ participants)	**Design:** PAR **Data collection:** Survey ($n = 61$), in-depth semi-structured interviews ($n = 20$), participant observation ($n = 8$), workplace diaries ($n = 9$) and nominal groups ($n = 12$)	Staff experiences, understanding and application of health promotion concepts; mapping of practice: upstream, midstream and downstream; barriers to implementing prevention and health promotion activities into practitioner's work.	**Enablers:** workforce training; adaptable workplace structure to create a health promotion team; consistent with QI processes; regular review and evaluation of activities and projects through formal business planning; relieving staff from clinical practice to undertake specific projects; health promotion leadership (developing partnerships; collaborations and linkages within the community); local team leadership became drivers for change; and PAR facilitated the translation of evidence into practice.	Results may not be generalisable as the study was conducted with one primary health service in the Northern Territory.
Lawn (2010)[31]	To describe the organisational change processes for service improvement to embed chronic disease	Participants involved in the chronic condition self-management course Flinders University.	**Design:** Grounded theory **Data collection:** Semi-structured interviews, written critiques	Participants described steps taken to build chronic-condition self-management initiatives into their health service practice; themes were identified and participants then rated to what degree they	**Enablers:** clear leadership to ensure investment of time and resources; workplace change champions; targeted training; collaboration within the organisation; and committed resources.	All participants were familiar with and trained in the Flinders program and views may be bias towards what is covered in that

	management into practice.	Australia ($n = 107$)		agreed or not with the overall themes.		program for effective chronic condition self-management support.
MacLean *et al.* (2003)[27]	To describe the partnership and organisational development processes that increase capacity for heart health promotion.	Organisations working on health promotion projects or improving population health. Nova Scotia, Canada ($n = 20$ organisations) Number of participants not specified.	**Design:** PAR **Data collection:** Questionnaire, face-to-face interviews and work logs	The number, type and effectiveness of capacity building strategies; and influencers of partnership and organisational capacity building.	**Enablers:** specific health promotion positions created; existing committees reorientated to support an increased focus on health promotion; health promotion included in strategic focus of the organisation; increased skills in health promotion through training; working in partnership (internally and externally); long-term resource commitment; adaptability to changing environments; and leadership.	Results may not be generalisable outside of Nova Scotia or to non-heart health promotion work.
McPhail-Bell *et al.* (2007)[35]	To describe what has worked and not worked in a capacity building process undertaken with HIV/AIDS prevention.	Project evaluation. Solomon Islands ($n = 3$)	**Design:** Observational review **Data collection:** Reflective practice of the volunteer and project team	Reflective practice on the reorientation of an awareness-raising approach to a broader health promotion approach.	**Enablers:** health promotion specialist to guide the change in practice; developing a strategic plan; implementing project management systems (including monitoring and evaluation); encouraging independent learning, and; providing managerial support.	Article describes the observed experiences by the authors of a health promotion capacity building process.
Riley *et al.* (2003)[69]	To examine the factors influencing changes in the implementation of heart health promotion activities.	Two public health units implementing heart health promotion. Ontario, Canada ($n = 2$ organisations). Number of survey respondents and interviews not specified	**Design:** Comparative case study **Data collection:** Previously collected data including surveys and in-depth interviews	Change in organisational predisposition (motivation to undertake heart health promotion activities), and change in organisational practices.	**Enablers:** public health leadership; organisational structure; skills of staff **Barriers:** using funding as an incentive to undertake health promotion prevented sustainability after funding ceased.	Results may not be generalisable outside of heart health promotion in Ontario public health agencies
Sharma *et al.* (2013)[17]	The role of a clinical assessment for systems strengthening framework in building capacity of organisations that can endure and adapt to changing	Stakeholders form the organisations implementing the framework. Kenya, Zambia and Nigeria ($n = 68$)	**Design:** Phenomenlogical approach **Data collection:** Group, individual and face-to-face and phone interviews	Stakeholder's motivations for building organisational capacity and their perceptions of the sustainability of those changes.	**Enablers:** desire for organisational growth and excellence; aspiration for improved health outcomes; internal continuous quality improvement processes, ownership; prioritisation;resource mobilisation; and access to technical assistance	The change process was mandatory as US-based international partners transitioned to locally owned organisations in Kenya, Zambia and

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Table 1. (continued)

Paper	Purpose	Sampling[A] and participants	Study design and data collection	Measures	Identified enablers and barriers for increased health promotion organisational capacity	Limitations (general)
	financial and policy environments.					Nigeria. The findings may not be generalisable outside of this context.
Wills and Rudolph (2010)[53]	To report on a training program aimed at developing capacity and capability of health promoters.	Health promotion students. South Africa (n = 20)	**Design:** Qualitative **Data collection:** Semi-structured interviews	Acquisition of knowledge and skills; subsequent application of new knowledge; and its impact on the organisation and their role in the organisation.	**Enablers:** training increased perceived knowledge and confidence to practice health promotion; staff had clarity of what health promotion is and confidence to describe health promotion practice in their workplace. **Barriers:** lack of management support to change practice; manager's expectations and understanding of health promotion in conflict to new understanding of staff after the training; and disease-orientated healthcare system where health promotion workers were seen as less important than clinical staff.	The interviews were conducted at the completion of the course, with little time for application into their organisational setting.
Yeatman and Nove (2002)[26]	To describe the actions aimed at building organisational support for health promotion.	Senior and middle managers, and service delivery staff. New South Wales, Australia (n = 23)	**Design:** PAR/ qualitative **Data collection:** Document analysis of written reports, semi-structured interviews and focus groups	Managers perspectives of the training course and the implementation of the learnings in the workplace; application of workplace changes in comparison to the recommendations; and participants perceptions of the implementation of the recommendations and their knowledge of the new structures introduced.	**Enablers:** leadership that maintains focus overtime as well as motivates and supports staff; partnerships internally and externally (funding body and academic); and building, demonstrating and maintaining commitment over the long term. **Barriers:** lack of recognition for health promotion activities within the organisation; lack of management support; lack of resources; difficulties in getting health promotion initiatives to be considered priorities; variable quality of health promotion work; and lack of higher level skills training in health promotion.	Describes the experiences of one regional health service in NSW. Difficult to attribute change to this intervention only without a comparison group.

[A]Sampling process is described for those articles where it was explicitly stated.
[B]A limitation of all cross-sectional studies is that the direction of association cannot be determined. Cross-sectional studies were conducted by Barrett *et al.* (2007),[40] Guo *et al.* (2007),[51] Kardakis *et al.* (2014)[33] and Panaretto *et al.* (2010).[42]

Table 2. Summary of enablers for increasing health promotion capacity within healthcare organisations

Enablers	Key points
Management support	Influence on staff work practice: – time allocation, resources and funds[21,22,25] – access to expertise, workforce development and training[21,22,25] – recruitment of skilled staff[21,22,25] – priority given to health promotion approaches.[25,26] Influence on the organisation's ethos and practice: – aligning health promotion with the organisation's vision, values and priorities[20,[illegible]] – long term commitment to health promotion[26,29] – culture of collaboration[27,31] – sound knowledge of health promotion[30] – build on previous initiatives[25] – identify further funding[30] – embedding health promotion activities into planning and reporting, including quality improvement processes.[22,32,33]
A skilled and knowledgeable workforce	– targeted training to meet identified need[31,35] – support to staff following training[18,24,32,36] – specific skills included project planning, monitoring and evaluation, and cultivating relationships with partners[34–36]
External specialist assistance	– mentoring of staff to adopt new skills[18,24,32,35,37] – mentoring of the organisation to adapt systems such as diversifying funding sources, broadening policy, integrating health promotion outcomes into strategic planning and reporting[24,32,35]
Resource allocation	– resources include staff and project funds[20,22,27,31] – accessing resources from both within and outside of the organisation[32] – pre-developed health promotion materials and guidelines[23,34]
Leadership	– ensure investment of time and resources[21,33] – oversee organisational learning, policy adoption, planning and workplace culture[33,39,40] – proactive approach to staff development and succession planning[33] – support joint work with key stakeholders[33]
External partnerships	– access to external partners (key stakeholders including community members) to work on health promotion approaches[18,25–27]

staff who lacked skills or confidence in health promotion;[25,30,39,42] competing priorities;[25,26,29,37–39,41,43] and a lack of time and resources allocated to health promotion activities.[29,30,37,41] A summary of these barriers is presented in Table 3.

Discussion

This literature review has demonstrated that, very few studies have comprehensively reviewed building health promotion capacity within a health organisation. Most of the included studies focused on specific areas such as training for the workforce, leadership development or delivery by staff of a new health promotion program. The majority of the articles ($n = 15$) referenced the work of Hawe and colleagues[16] and/or the NSW Health Department capacity building framework for health promotion to guide their interventions. Interestingly, all enablers and barriers identified in the 25 articles reflected at least one of the five areas of this framework (organisational development, workforce development, resource allocation, leadership and partnerships).

There was consistency in the literature regarding the importance of health promotion work in improving overall health outcomes and the challenges faced by health organisations to achieve this. Many authors acknowledged the challenges of the political environment, through changing priorities, access to resources and long-term funding.[18,22–24,26,30,35,38,41]

Only one study related to an Indigenous health service.[42] This study examined the organisation's capacity to conduct brief interventions with clients. The enablers and barriers identified were consistent with other studies in this review.[25,28,30,38,39,41,43] Brief intervention by itself is a single strategy health promotion approach. The narrow focus of evaluating a single strategy, and that only one study was found, highlights the limited knowledge in this area. Further and more comprehensive research is required to understand the enablers and barriers to increasing health promotion capacity in Indigenous health organisations.

Methodological limitations were present in all of the studies identified in this review. Many studies included a small sample size (less than 25 participants), and selection bias was present in most studies. This is particularly relevant for quantitative studies. Selection bias is expected in qualitative research designs due to purposive sampling, which was required here to ensure those involved in health promotion approaches were included in sharing their experiences. With these limitations the findings may only be generalisable to the relevant organisational context. However, the enablers and barriers identified were common across the studies and despite these limitations there are several key findings that

Table 3. Summary of barriers found when increasing health promotion capacity within healthcare organisations

Barriers	Key points
Management support	– difficult to embed health promotion practice within the organisation without management support[26,37,38] – hindered if the manager had limited knowledge of health promotion[20,37]
Dedicated health promotion staff	– difficult to implement health promotion approaches without a dedicated health promotion workforce[25,26,32,41]
Staff skills or confidence in health promotion	– staff lacked health promotion knowledge and skills[25,30,39,42] – high turnover of staff hinders investment in training[47] – no access to tailored training or support in health promotion[26,37,41,42] – unable to establish or maintain effective partnerships[25,28]
Competing priorities	– health promotion work not prioritised above more immediate organisational tasks such as treatment of illness[25,28,38,41] – difficult to adopt in organisations whose aims, values or structure were incongruent with a health promotion approach[29,37,39]
Time and resources	– insufficient time and resources to plan and implement activities over the long term[29,30,37,41] – require internal commitment to the program once external funding ceases[19,43]

can be explored further: management support, leadership, external specialist assistance, skilled staff, partnership work, resource allocation, and the challenge of competing work priorities in health organisations.

Management support was the most commonly reported enabler and barrier. Management support was often referred to as the line manager's role. Managers are leaders for the direction of the work team and translate strategic direction and policies into activity. However, their influence is limited by organisational constraints such as political agendas, funding and reporting requirements. Organisational policies supportive of health promotion practice can limit the influence of these constraints.

Only a few studies identified managers' perspectives on the enablers and barriers to health promotion capacity.[26,30,37] The majority of studies reported the enablers and barriers from a practitioner's point of view.[18,21–25,33,37,38] As managers were identified as gatekeepers to many of the enablers and barriers to health promotion practice within an organisation, further exploration of the supports required to assist the management role would be useful.

Managers were identified as crucial for providing leadership within the organisation about health promotion practice. The ability to assess readiness for change and to motivate and support new ways of working was identified as an important leadership skill.[26,29,33] Additionally, staff who model good health promotion practice can lead a change in practice throughout the organisation,[33] demonstrating that the influence of leadership in this process is not solely the responsibility of managers.

There were several interventions where external specialist assistance was provided and valued by the participants when evaluated.[18,24,32–35] Access to expertise outside the organisation during and after the change process was important. One-off, short-term assistance such as training would not embed the skills and systems learned without support to translate this into practice.

A skilled workforce is essential for effective health promotion practice.[21] This was identified in studies that addressed the need to improve knowledge and skills through training[24,26,27,31,33,34,37,38] and by practitioners who identified that health promotion knowledge and skills were required to effectively deliver health promotion approaches.[25,29,36,39,40,42] While this finding is not necessarily surprising, the frequency with which it was mentioned in the studies highlights its importance.

Partnerships can achieve greater health outcomes than an individual organisation can do on its own. Working in partnership combines resources and expertise to address a health issue of concern. A practitioner's skills in partnering with external stakeholders, and the organisation's ability to work in partnership, increases the organisation's own health promotion capacity.[21,25–27] For partnership to occur there needs to be openness and commitment from the organisation to allow staff to build robust relationships.

The strength of an organisation's commitment to health promotion can be measured through its allocation of resources. This includes dedicated staff to work on health promotion programs[20,22,25,26,30,31,41] and financial support for resources needed to develop, deliver and evaluate health promotion programs. In an environment where additional funds for prevention work are not available, understanding how best to utilise existing resources is essential.

Influencing quality improvement processes to support health promotion practice can increase an organisation's health promotion capacity.[24,29,32,33] The process of adhering to and reflecting on practice through quality improvement reviews can be a driver for improving practice where incremental standards for health promotion practice have been articulated. Continuous quality improvement processes have been used effectively to sustain improvements in Aboriginal and Torres Strait Islander primary health care settings.[44,45] Combining this with a focus to assess health promotion practice has been shown to build an organisation's confidence in identifying health promotion improvement strategies

and actions.[46] Further work is underway to assess how this confidence will impact on organisational health promotion capacity.[46]

Many health organisations provide both treatment and health promotion services. If other priorities are deemed more important, a health promotion and prevention focus can be lost.[28,29,37–39,41,43] This could be due to lack of dedicated resources for health promotion approaches, lack of management support, or health promotion not being identified as a priority in the organisation's strategic focus. In primary healthcare organisations that are clearly involved in both treatment and health promotion work, it would be useful to explore further how this challenge is addressed in a resource-poor environment.

Conclusion

Reorientating health services to increase health promotion capacity requires systematic change within the organisation. The enablers and barriers identified critical parts of the system to target change processes; however, the interdependency between these enablers and barriers was not identified in this literature review. Taking a systems approach to better understand the interdependent relationships between management support, leadership, external specialist assistance, skilled staff, partnership work, resource allocation and competing work priorities may help to better understand how organisational capacity for health promotion can be increased within health service organisations. This is particularly important within Aboriginal and Torres Strait Islander communities where problems are complex and there is strong interconnectedness between the health service and the community.

The literature review identified consistent themes in the enablers and barriers for organisations to increase their health promotion capacity. For health services to deliver both treatment and health promotion functions to the communities they service, organisational systems need to support managers and practitioners, ensuring there is a skilled health promotion workforce with opportunities to work in partnership. The challenge of competing work priorities will remain. However health promotion needs to be recognised as a priority and embedded into organisational roles and responsibilities. A supportive policy environment that identifies health promotion as a core part of business will reinforce this within the organisation.

With limited information on how health promotion capacity has been increased in Aboriginal health organisations, the relevance of these findings for ACCHS is not clear. Further research into how ACCHS deliver health promotion, and the identification of enablers that assist practice in that setting, will address this knowledge gap.

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As identified in the literature review, there is a gap in knowledge about how health promotion is delivered in Aboriginal and Torres Strait Islander health organisations, and the challenges these organisations face in the delivery of health promotion. The findings from the literature review assisted in defining the research questions and objectives.

1.6 Significance of the research

This research is significant for a number of reasons. Firstly, it will contribute to the evidence base to understand how health promotion is practised and how it can be strengthened in an Indigenous health setting. As highlighted in the literature review, there are very few published studies on the enablers and barriers to health promotion practice in Indigenous health services. Much more (published) work is needed.

Secondly, this research is conducted within an ACCHS over a period of time with a focus solely on understanding how health promotion can be strengthened in the organisational setting. There have been no other studies where the researcher has worked alongside staff in an ACCHS for an extended period. The participatory action research approach was specifically chosen to facilitate practitioner insights into how health promotion practice may be strengthened, and to involve staff in identifying actions applicable to the work environment. This approach will provide practice-based evidence of how health promotion can be strengthened in an ACCHS.

Thirdly, the study is timely. With an identified need to increase focus on health promotion and prevention approaches, this study will provide insights into the constraints of reduced national and state government investment in health promotion at an ACCHS.

1.7 Thesis structure and organisation

The thesis contains seven papers (three published, two in press, the remainder under review). Paper one (presented as part of this chapter, in section 1.5) is a narrative literature review in which the enablers and barriers to building health promotion capacity in health organisations were identified. Paper two describes the steps the candidate undertook to establish and maintain a research partnership with an ACCHS.

Papers three to seven, comprise the results chapters. Each of these papers relate to one of the five participatory action research cycles. Each chapter (and paper) comprises its own abstract, introduction, methods, results, discussion and references. Each chapter is preceded by an overview which details the aim and context, and is followed by a summary of the main findings presented in the paper. Papers one, two and three are presented as published in a PDF format (journal copyright permission has been granted, refer to Appendix Q), and papers four to seven are presented as submitted. For consistency, the reference style for papers four to seven has been modified to Vancouver style. However, the structure of each paper reflects the style of the journal to which the paper was submitted. Consequently, there is some inevitable duplication within the thesis, and some unavoidable style differences between chapters.

Chapter One: Introduction

This introductory chapter provides an overview of the study and the context of the importance of health promotion practice in Indigenous primary health care organisations. The aims and objectives of the research are stated and a description is provided of the workplace and region where the research was undertaken. This chapter includes a narrative literature review of the enablers and barriers to increase health promotion capacity in health organisations. The significance of this research is clearly defined.

Paper one **Reorientation of health services: enablers and barriers faced by organisations when increasing health promotion capacity**. Health Promotion Journal of Australia. 2016; 27(2): 118-33.

Chapter Two: Methods

This chapter outlines and justifies the research methods used in this study. It provides an explanation of the importance of using participatory action research and how this approach was appropriate for the research area explored and the setting in which the research was undertaken. Ethical considerations and the research design are explained. An overview of the data collection methods, sampling strategy and data analysis is presented. A detailed description of how the partnership with the researcher and the organisation was established and maintained is presented in a published brief report.

Paper two **Research with an Aboriginal Health Service: Building an effective partnership, step by step**, Australian Indigenous Health Bulletin. 2016; 16(4)

Chapter Three: Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service

Chapter three is the first of five results chapters. This chapter is presented in a publication of the baseline survey findings for health promotion practice at the workplace. The paper identifies the types of health promotion practice that are occurring and the enablers and barriers practitioners experience in their practice. The chapter concludes by summarising the main findings and states how these results were used to inform the future PAR cycles.

Paper three **Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service**. Australian Journal of Primary Health. 2017; http://dx.doi.org/10.1071/PY16033

Chapter Four: Skills, systems and supports: an Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff

This chapter outlines the researcher's involvement in planning and implementing strategies to strengthen evaluation practice at Apunipima, as identified by the staff, and included mentoring staff in the health promotion team. The researcher mentored and supported the Health Promotion Team Leader to be the lead author on a paper describing the process and outcomes of this workforce strategy. This paper presents the actions taken to strengthen health promotion evaluation practice at Apunipima. The chapter concludes by stating how the findings from this study informed future PAR cycles.

Paper four **Skills, systems and supports: an Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff.** Health Promotion Journal of Australia (in press).

Chapter Five: Australian Indigenous primary health: Challenges in reporting health promotion outcomes

This chapter describes how health promotion work is captured and reported to decision-makers. The findings highlight the challenges faced by ACCHS in reporting health promotion efforts and the need to develop new measures to inform decision-makers of how health promotion approaches contribute to improving health outcomes.

Paper five **Australian Indigenous primary health: Challenges in reporting health promotion outcomes.** Health Promotion International (under review)

Chapter Six: How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice

This chapter describes how staff access skill development and expertise in health promotion to assist their work practice. The findings demonstrated that staff value access to skill development, advice and support to assist health promotion practice. Support is accessed from a variety of sources and this study identifies the creative ways staff in rural and remote primary health care organisations access support in a resource-poor setting.

Paper six **How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice**. Rural and Remote Health (in press).

Chapter Seven: Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service

This chapter describes health promotion practice, perceived organisational enablers and barriers to implement health promotion approaches, as well as changes in staff attitudes and confidence in health promotion practice over the duration of the research project. Staff confidence in the organisation's ability to deliver health promotion significantly increased. Having the researcher based at the organisation facilitated the participatory action research process. Findings suggest this enhanced organisational focus on health promotion practice and provided practitioner-informed evidence of how health promotion can be strengthened in an ACCHS setting.

Paper seven **Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service**. Global Health Promotion (under review)

Chapter Eight: Discussion, recommendations and conclusions

The final chapter summarises the principal findings from the research. The strengths and limitations of the research are discussed. The chapter concludes by identifying the implications for future research, policy and primary health care practice, and a number of recommendations are made relating to each of these areas.

1.8 Chapter summary

Primary health care settings, including ACCHS, are important providers of health promotion approaches and practice. However, organisational challenges can affect their capacity to deliver these approaches and there is a gap in the literature on how ACCHS face these challenges. Using a participatory action research approach, this thesis documents how health promotion is practised in an ACCHS and identifies the enablers and challenges ACCHS face in delivering health promotion approaches.

The next chapter (chapter two) describes the research approach and positioning of the researcher within the organisation. It concludes by describing the steps taken by the researcher to establish and maintain the research partnership with Apunipima (paper two).

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Chapter 2. Methods

2.1 Overview of the chapter

Chapter two describes the research approach, the positioning of the researcher, and concludes by describing the steps taken by the researcher to establish and maintain a partnership with Apunipima. An overview of the data collection and analysis process is described in this chapter. As described in chapter one, each subsequent chapter of the thesis (chapters three to seven) comprises its own abstract, introduction, methods, results, discussion and references. Hence, greater detail on data collection and analysis is provided in each result chapter (chapters three to seven). An overview of the methodological approach, rather than the methods used in each of the specific chapters, is presented here.

2.2 Research approach

As stated in chapter one, little is known about how health promotion is practised in Aboriginal and Torres Strait Islander health settings (1). The purpose of this research was to explore how health promotion is practised in an ACCHS and to understand how health promotion practice could be strengthened in this organisation. In choosing a research design, it was essential to consider both the purpose of the research and its application in an Aboriginal and Torres Strait Islander primary health care setting. Successful health promotion research projects in Indigenous populations involve the target audience in the research (2). This insight ensures the research is conducted in a respectful manner, participants are involved in a meaningful way and the research addresses priorities of importance to the target community (2,3).

The nature of this research was exploratory (4). A Participatory Action Research (PAR) approach was used as it engaged the workforce in the research process, and was integral for providing insight into how health promotion practice could be strengthened in this setting.

2.2.1 Study design

PAR is a process of collective, self-reflective inquiry that researchers and participants undertake, to understand and improve upon the practices in which they participate (5). The PAR process is a structured reflective cycle of gathering insight and solutions from participants to identify areas to action. In each PAR cycle questions are asked and information is collected (data collection), findings are analysed and discussed to collectively understand the issues, priorities are identified and appropriate strategies are selected to instigate action to effect change (see Figure 2.1). Participants and the researcher are actively involved in each step of the reflective cycle.

Figure 2.1 The PAR cycle (6)

The PAR approach is an empowering process. Intrinsic to PAR is a respect for the participants' knowledge (7). Engaging participants in the process of inquiry acknowledges their competence and worth and develops productive relationships that build trust and understanding (8).

PAR in this workplace setting was a process of systematic inquiry in which those who are involved in the area of interest participated with the researcher in deciding the focus of knowledge generation, in collecting and analysing information, and in taking action to address an issue (9). 'Action' describes the change efforts of the workplace participants or organisational systems that may be altered in an attempt to improve the conditions or to resolve the issue completely (9). Where staff are consulted and participate in projects likely to affect them, positive outcomes and changes are more likely to be sustainable (9). Research control is shared with the participants and requires time to establish relationships with the participants, to explore and understand the issues before together identifying priorities (8). The PAR approach has been criticised as time consuming and some researchers find it difficult to share control of the research

process (10). In this scenario, the researcher worked closely with the organisation over an 18 month period and PAR was the appropriate method to meet the aim of the research which was to investigate and explore how health promotion was practised in an ACCHS.

By using a PAR process, staff at Apunipima were active participants in the research. In addition, PAR is consistent with National Health and Medical Research Council values for research conduct with Aboriginal and Torres Strait Islander populations, in particular the values of reciprocity, respect and equality in the research process (11). This was an important consideration when working with this ACCHS.

PAR is ideal in a workplace setting as it is flexible and moves at the pace of the participants. A similar study using PAR was successful in increasing the health promotion capacity in a primary health care setting in the Northern Territory (6).

The number of PAR cycles depend on the priorities the participants identify to explore. In this study, there were five PAR cycles in total (See Figure 2.2).

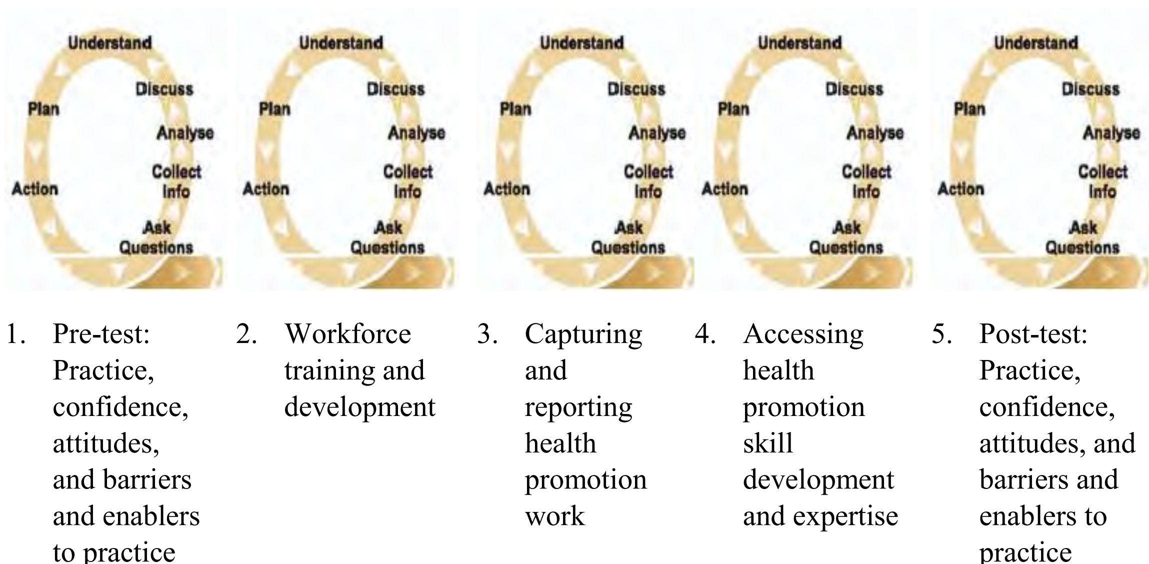

Figure 2.2 Participatory action research cycles (6)

The PAR approach captured current practices, identified enablers and barriers as experienced by the workforce and engaged the workforce in implementing and reflecting on actions to strengthen health promotion practice. The cyclical process of reflection involved the researcher and the workforce in understanding the experiences

and work context of ACCHS and in identifying what could be strengthened to increase health promotion capacity in this ACCHS.

2.2.2 Ethical considerations

The study received ethical clearance from the James Cook University Human Ethics Committee (HE5787) (Appendix A). The research process was endorsed by the Apunipima Clinical Research Council and protocols were consistent with the values of Aboriginal and Torres Strait Islander health research: reciprocity; respect; equality; responsibility; survival and protection; spirit and integrity (11).

Participants were provided with information on the purpose of the research, how they could be involved, and how the data would be stored and used. This information was provided to staff through email and information sheets prior to their participation in all PAR cycles. Informed consent was sought at the start of each survey and interviewed participants were provided with a printed and verbal outline of the consent form to sign prior to interview. All data was de-identified and securely stored adhering to the Australian Code for the Responsible Conduct of Research (12).

2.2.3 Research methodology

A mixed methods approach was used. Mixed methods involved collecting, analysing and integrating quantitative and qualitative data to understand the areas of research inquiry (13). By using quantitative and qualitative data collection, a comprehensive understanding of how health promotion practice could be strengthened was gathered. The quantitative component was able to measure and quantify the factors and antecedents that are related to health promotion practice (4). The qualitative component allowed a deeper exploration and understanding of staff experiences. Figure 2.3 shows the process of how both measures were merged in a convergent design as a way of comparing and validating the quantitative and qualitative data together (13). Triangulating the findings in this way was useful to confirm and identify discrepancies in organisational processes and the experiences of the workforce.

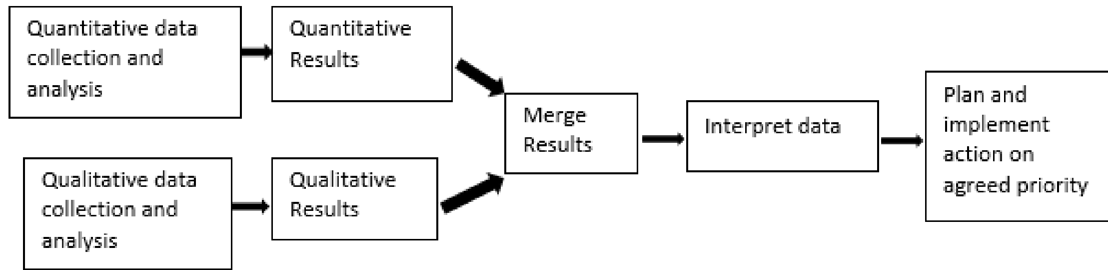

Figure 2.3 Mixed methods convergent design (13)

2.2.4 Data collection

2.2.4.1 Participants

Participants were staff at Apunipima Cape York Health Council, previously described in chapter 1. Approximately 150 staff work for Apunipima and include Aboriginal and Torres Strait Islander health workers and health practitioners, outreach midwives, podiatrists, audiologists, speech pathologists, physiotherapists, dieticians and nutritionists, diabetes nurse educators, health promotion officers, social and emotional well-being staff, paediatricians, general practitioners and administration staff (14). Their main office is in Cairns, with staff using Cairns as a base for remote service delivery to 11 Cape York communities. Table 2.1 details the demographics of the workforce during the research project.

Table 2.1 Demographics of Apunipima staff (15)

Demographics	**February 2015 (N=152)**	**May 2016 (N=179)**
Clinical staff	101 (66%)	121 (68%)
Administration staff	51 (34%)	58 (32%)
Community based staff	32 (21%)	39 (22%)
FIFO staff	58 (38%)	70 (39%)
Male	32 (21%)	41 (23%)
Female	120 (79%)	138 (77%)
Identify as Aboriginal and Torres Strait Islander	81 (53%)	93 (52%)

2.2.4.2 Sampling strategy for staff

Staff were invited to participate in the research in a number of ways. As the culture of the organisation was to embed health promotion in all roles, all staff were invited via email to complete the pre- and post-surveys. Staff who were not directly involved in delivering health promotion approaches, such as some administrative roles, were able to opt-out of some survey questions noting that it was not applicable to their role. Purposive sampling was used to invite staff to participate in face to face interviews on identified areas of interest that arose following the initial survey. Staff were also informed about the research project and the opportunities to participate via presentations at staff meetings, posters on notice boards, a link on the internal home web page, articles in the staff newsletter and in person from the researcher and key staff members at Apunipima.

Feedback summaries from each data collection process were sent to staff for further comment. Survey data results were sent to staff within eight weeks of the survey closing. Staff who participated in the interviews were sent a summary of findings with opportunities to comment further. The summary findings were discussed in detail with members of the Apunipima Reference Group who identified the priorities to action and explore further.

2.2.4.3 Data collection methods

The quantitative and qualitative data were gathered from staff and organisational documents. Data were collected through each PAR cycle. The pre- and post-survey included closed and open-ended questions. Document analysis assessed the ways health promotion practice was discussed and reviewed the templates used in reporting health promotion practice. Small group and one-on-one interviews with staff were digitally recorded and transcribed verbatim by the researcher.

The areas of investigation explored in the surveys and interviews were designed in partnership with Apunipima staff. Some survey questions were adapted from previous research in health promotion workplace practice (16). The survey was pilot tested with four Indigenous and non-Indigenous primary health care workers who did not currently work for Apunipima. After feedback, minor wording changes were made to improve clarity of some questions.

The semi-structured interview questions were developed to gather specific data to understand the priorities identified from previous PAR cycles. Lines of inquiry were identified to explore priorities and the questions were adapted to suit the individual conversations, ensuring all areas were covered in each interview (4).

The health promotion framework (Figure 1.2) (17), was used to define health promotion practice. The activities in the framework defined the types of health promotion activities staff delivered and what health promotion practice was documented in the organisation.

2.2.4.4 Data analysis

The quantitative data collected from the surveys were analysed using summary statistics (e.g. frequency counts, mean/medians, standard deviations, interquartile ranges). Comparison of pre- and post- data was conducted using paired and independent t-tests.

The qualitative data collected from the interviews and open-ended questions in the surveys were thematically analysed. Thematic analysis is a systematic approach to the analysis of qualitative data and involves classifying data according to themes and interpreting the results by seeking commonalities, relationships, or theoretical

constructs (18). The identified themes were reviewed and refined to respond to the specific research areas explored.

The dual data gathering was used to identify how organisational systems influenced practice. The analysis of each data source built on the collective knowledge of how health promotion approaches are delivered by Apunipima. The analysis identified health promotion practice from multiple perspectives and engaged a variety of staff in the research process.

A summary of the data collection process for each of the five PAR cycles is outlined in Table 2.2.

Table 2.2 Data collection process for the five PAR cycles

PAR Cycle	Aim	Data sources	Sample
1	To identify and explore staff practice, attitudes, confidence and perceived enablers and barriers to implement health promotion approaches in their workplace.	All staff survey	n = 63
2	To build health promotion evaluation capacity through workforce training and mentoring.	Pre- and post-survey with the health promotion team	n = 4
		Post survey sent to all participants in the workshop training sessions	n = 33
		Mentor and mentee surveys	n = 27
		Document review	n = 4
3	To explore, from a practitioner's point of view, how health promotion practice is captured and to identify the challenges practitioners face in articulating the effectiveness of health promotion practice to decision-makers.	Semi-structured interviews	n = 12
		Document analysis	n = 36
4	To explore how staff currently access skill development and expertise from the health promotion field, and identify what support is preferred and practical in a work environment where staff deliver health promotion activities across a large geographical area to a number of remote and disadvantaged Aboriginal and Torres Strait Islander communities.	Small group and individual semi-structured interviews	n = 9
5	To compare health promotion practice, perceived organisational enablers and barriers to implement health promotion approaches and changes in staff's attitudes and confidence in health promotion practice since the initial all staff survey.	All staff survey	n = 48

2.2.5 Positioning of the researcher

As discussed in chapter one, the researcher had previous experience in building health promotion capacity through workforce training and organisational change. A priority target group of that project was building the health promotion capacity of the Aboriginal and Torres Strait Islander health workforce. The researcher worked closely with many Aboriginal and Torres Strait Islander health staff through training and mentoring during that time. This experience and local reputation in the field of health promotion assisted the researcher to form the research partnership with Apunipima.

The researcher was based at Apunipima for the duration of the research project, approximately 18 months. Being based in the organisation allowed the researcher to be both an 'outsider' observing how health promotion is practised and an 'insider' becoming an accepted member of the workplace. This enabled ongoing access and availability to staff based in the Cairns office and also to community-based staff visiting the office as part of regular work meetings. The researcher also visited the Cooktown office on a regular basis to mentor a staff member based there. Having an ongoing presence in the organisation allowed relationships to develop. Awareness of the research project and its purpose was sustained over the duration of the research project. The researcher provided updates every six weeks to the reference group members, and regular updates to staff on the research project formally through the staff newsletter and informally through conversations with staff in the general office area.

The researcher had an understanding of how health promotion is delivered in the Cape York communities as she had previously practised and managed a health promotion team in north Queensland. In PAR this understanding and experience is acknowledged in a transparent way, allowing participants to be aware of the researcher's own background, areas of interest and the influence this has on the research (19). This detail was provided to staff. The researcher's local experience in health promotion practice and clear motives for the research assisted to build relationships with staff across the organisation. Building effective relationships with staff is particularly important in PAR, as participants work closely with the researcher to identify and investigate priorities of significance to them, with the aim of understanding and improving their situation or environment (5).

In PAR, initially the researcher enters into the field as a 'foreigner', and as time goes by this relationship changes, with the researcher becoming accepted as a 'mobiliser' for change (20). With the opportunity to be based in the workplace and existing staff relationships, this researcher was able to remove the 'foreigner' tag relatively quickly and engage staff in the PAR process.

2.2.6 Research credibility

According to Patton (21), to enhance the quality and credibility for qualitative inquiry a number of distinct but related inquiry elements are required:

- Rigorous techniques and methods for gathering data, with attention to issues of validity, reliability and triangulation;
- The credibility of the researcher, which is dependent on experience, track record and presentation of self; and
- Philosophical belief in the value of qualitative inquiry, with a fundamental appreciation of naturalistic inquiry.

To ensure integrity of analysis, each time data were collected and analysed, the summary findings were shared with all participants inviting further comment and to clarify understanding. The findings were discussed with the reference group members in detail to consider other logical possibilities of interpretation and to identify any organisational changes that may have influenced the findings. The use of mixed methods meant that multiple sources of data were gathered to triangulate findings. This included collecting quantitative and qualitative data, and comparing the different sources within the qualitative data.

Multiple perspectives were actively sought. All staff were constantly reminded and encouraged to participate in each of the PAR cycles. This has been detailed in 2.2.4.2. The members of the reference group were active in identifying key staff and organisational champions to promote participation in all PAR cycles to encourage a variety of staff from all work teams to provide their insight to the research. The reference group members assisted in identifying who to approach to interview, noting who may have different views on the area of interest. This process included approaching staff from different work teams, different employment levels and those

who worked in different communities. This process also allowed a comparison from different points of view: managers and on-the-ground staff, staff from different work areas, staff completing reports, and staff who then compiled reporting information for external funding bodies. Systematic bias was reduced through this process of checking the findings with staff, comparing data sources and gathering insight from multiple perspectives (21).

The researcher was seen as an experienced health promotion practitioner, with an understanding of health service delivery in Cape York and experience working with Aboriginal and Torres Strait Islander health staff. The researcher's credibility was further enhanced by her regular presence in the organisation and her availability to staff over the duration of the research project.

In addition, the PAR approach championed the involvement of practitioners in understanding and interpreting the research findings. The practitioner's point of view on priorities to explore and action meant the research was relevant to current organisational issues and findings were considered in light of their implications for the organisation and the workforce.

2.2.7 Relevance of the research

Managers and practitioners are interested in research that demonstrates how evidence is applied to practice (22), as this defines what needs to be done in the 'real world' to ensure intended effects occur (23). Seeking practitioner insights allows practice-based evidence to inform future strategies that will strengthen health promotion practice in ACCHS. Practitioner insights also provide an understanding of the effects on changing social, political and economic circumstances in which ACCHS practise health promotion. At the time of this research, there were very few published articles that documented how Aboriginal health organisations increase their capacity to deliver health promotion approaches. This research provided an opportunity for practice-based evidence to inform and contribute to the evidence base of how health promotion capacity can be increased in an ACCHS.

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2.4 Establishing and maintaining the research partnership

Research relationships in Aboriginal and Torres Strait Islander health are important. A paper was published in 2012 by a group of experienced Indigenous health researchers to guide emerging researchers in the field of establishing relevant, effective and culturally respectful health research partnerships. The following brief report describes how their identified principles were applied in the establishment and maintenance of the research partnership with Apunipima. A key principle missing from the list that was necessary to maintain this successful research partnership was transparency of roles and responsibilities throughout the partnership.

2.5 Paper two - Research with an Aboriginal Health Service: Building an effective partnership, step by step

Paper Two McFarlane K, Devine S, Judd J, Canuto K, Watt K. **Research with an Aboriginal Health Service: Building an effective partnership, step by step.** Australian Indigenous Health Bulletin. 2016; 16(4).

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Research with an Aboriginal Health Service: Building an effective partnership, step by step

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Introduction

Principles to guide new researchers working in Aboriginal and Torres Strait Islander health have been defined to ensure that relevant, effective and culturally respectful research relationships are formed [1]. This paper describes how a PhD candidate applied these principles in practice to establish a research partnership with an Aboriginal Community Controlled Health Service (ACCHS). A series of steps outline the development of the research partnership. The research explored how organisational capacity could be strengthened to deliver health promotion using a participatory action research approach. Data was gathered from staff and through analysis of organisational systems.

Research relationships in Aboriginal health

Primary health research partnerships must be effectively planned to provide new knowledge on priority areas and inform future practice. To ensure both parties achieve their desired outcomes, the partnership between the researchers and the participants needs to be nurtured throughout the duration of the research. This is especially so for research relationships with Indigenous Australians that in the past have viewed Aboriginal and Torres Strait Islander participants as subjects only, rather than participants in the research process [2].

National Health and Medical Research Council (NHMRC) guidelines outline values for ethical conduct in Aboriginal and Torres Strait Islander health research [3]. The researcher demonstrates how the values of: spirit and integrity; reciprocity; respect; equality; survival and protection; and, responsibility will be applied to their research [3]. Additional guiding documents have been developed to ensure Aboriginal and Torres Strait Islander participants are explicitly involved in the planning and the conduct of the research [1, 4-6].

A group of experienced Indigenous health researchers have collectively defined 10 principles to assist new researchers to apply the NHMRC guidelines [3], and to involve Aboriginal and Torres Strait Islander participants in the planning and conduct of the research [1]. Five principles are essential: addressing a priority health issue determined by the community; conducting research within a mutually respectful partnership framework; capacity building is a key focus of the research partnership; flexibility in study implementation while maintaining scientific rigour; and,

Contents

Introduction.....1
Research relationships in Aboriginal health.....1
Discussion.....3
Conclusion.....3
Acknowledgements.....4
References.....4

Core funding is provided by the Australian Government Department of Health

respecting communities' past and present experience of research. The remaining principles are desirable. Three are relevant to the example used in this paper: ensuring extended timelines do not jeopardise projects; preparing for Indigenous leadership turnover; and, supporting community ownership [1].

Other authors have acknowledged the contribution these principles have provided to new researchers. Gwynn and colleagues applied the principles retrospectively to describe effective governance structures of existing research projects [7]. O'Donohoo and Ross expand on the principles to capture culturally appropriate engagement, particularly in remote communities [8]. Our paper describes how the principles can be applied in practice to establish and manage a research partnership with an ACCHS. The following distinctive steps describe the development of the research partnership and highlight how the principles were applied in practice.

Step 1. Seeking a research partner

Principles for:

- Addressing a priority health issue determined by the community/ organisation;
- Respecting the organisations' past and present experiences of research; and
- Capacity building as a key focus of the research partnership [1].

The PhD candidate, now referred to as the 'researcher', led the engagement to seek a research partner. The ACCHS was presented with an overview of the research process. This included the research question, proposed involvement of staff, types of access and data sources, possible outputs and timeframe. This allowed two-way discussion of how the research aligned with current organisational priorities and how the research could benefit the ACCHS.

Existing research projects were acknowledged and current opportunities or barriers were discussed that might impact on the research process. Consideration was given to staff capacity to participate in this research opportunity. The ACCHS shared previous research experiences detailing what has worked well to engage staff. The existing research structure with the ACCHS provided guidance on how the relationship would be managed and what they required to establish the partnership.

The researcher provided an overview of her research and professional experience in health promotion capacity building work with Indigenous communities. There was a level of pre-established trust as the researcher had worked with some staff previously, and others were familiar with her work. This existing familiarity with the researcher was beneficial in building the research partnership in this early phase.

The ACCHS considered whether the topic aligned with their research priorities and timeframes, whether the proposed process and outputs would build capacity of staff, and if they could support the researcher over the agreed time period. To maintain the research focus and timeframe, the researcher, in consultation with staff, negotiated how to best adapt the research to meet the ACCHS priorities and available resources.

Step 2. Establishing the partnership

Principles for:

- Conducting research within a mutually respectful partnership framework; and
- Flexibility in study implementation while maintaining scientific rigour [1].

Once the researcher and the ACCHS agreed in principle that the research process met both parties' expectations, firming up of the research question and outputs occurred. To achieve this, the researcher met with senior staff and provided an overview of the research aim, process and timeframe. This allowed staff to identify potential concerns and suggest how and when to engage staff. These meetings initiated development of key staff relationships that championed the research project within the ACCHS.

Based on conversations with staff, the researcher drafted how the research could demonstrate the values and ethical guidelines for working in Aboriginal and Torres Strait Islander health research [3]. Once drafted, further input was sought from key staff to clarify and discuss the values in practice.

The research process was documented using the university's ethics template for research with Indigenous populations. The template articulated clearly the involvement of the ACCHS and its staff, identified how and when data would be gathered, and how the data would be used. The ACCHS' research committee reviewed this document and formalised their commitment to the project by providing a letter of support to accompany the ethics application.

Step 3. Commitment

Principles for:

- Supporting community ownership; and
- Preparing for Indigenous leadership turnover [1].

A Memorandum of Understanding (MOU) was drafted to outline how the researcher and the ACCHS would interact. The MOU detailed: conduct; Intellectual Property and publications; ethics and data management; risk and liability; term and termination processes; as well as a dispute process.

The MOU defined responsibilities of both parties and stated the organisation's commitment to the project beyond individual staff members' interests or personal support. The ACCHS led this process, demonstrating their commitment to being an active participant throughout the research project.

A project schedule was included in the MOU. This covered objectives of the research, timeframe, project deliverables, budget, and requirements of both the researcher and the ACCHS. Each partner was responsible for a number of tasks. The researcher needed to: comply with policies, procedures and codes of conduct; translate and disseminate research results; facilitate the action research process; and, provide training and mentoring in research processes. The ACCHS agreed to: participate in the action research process; provide office space and access to relevant organisational systems and internal documents; assist with recruitment; and, participate in preparation of publications and research feedback.

At the end of this step, both parties had a clear understanding of how the research partnership would operate. The needs and safe guards for both parties were outlined and agreed to.

Step 4. Managing the partnership throughout the relationship

Principles for:

- Conducting research within a mutually respectful partnership framework;
- Ensuring extended timelines do not jeopardise the project;
- Preparing for Indigenous leadership turnover; and
- Supporting community ownership [1].

The ACCHS established a reference group to support the researcher and research process. The group assisted in clarifying processes, identifying opportunities, troubleshooting any difficulties in accessing staff or documents and championing the project throughout its duration. Regular meetings allowed timeframes to be monitored and encouraged organisational ownership.

Utilising existing communication methods such as the staff newsletter, internal posters and attendance at team meetings allowed research progress to be shared across the organisation and assisted in fostering a respectful research partnership.

Members of the reference committee changed due to staff turnover. New staff were invited to join to assist the ongoing monitoring and championing of the project. The structures established in the early phases of the project acknowledged and prepared for staff turnover.

Step 5. Planning to end the partnership

Principles for:

- Supporting community ownership; and
- Respecting the organisations future experience of research [1].

Planning the end of the partnership meant knowing what commitments were agreed to and delivering on them. Agreed commitments and deliverables were outlined at the start of the project and were monitored by both parties via the reference group. The key deliverable was sharing and providing direction on how the research outcomes could be applied to practice. Considering how the research aligned with organisational priorities in the initial steps strengthened the ability to sustain the research outcomes. For the researcher, it is crucial that the research process and outputs align.

Meeting agreed commitments allowed both parties to reflect positively on the research partnership, even after the project has ended. The legacy of the research partnership displays the commitment of the staff and researcher, and will influence future research partnerships. What worked well or not so well in the management of the partnership, will affect how the ACCHS negotiates in future research. A positive experience for the researcher will likewise, influence their future research.

Discussion

The principles for establishing an effective research relationship outlined how the researcher and the organisation interact [1]. A number of documents can assist ACCHS to represent their communities' values when negotiating research partnerships [4-6]. As stated in step two, it was also necessary to distinguish how the values defined in the NHMRC guidelines [3] were demonstrated when the researcher interacts with staff as participants to ensure the values cascade from research partnership to research participation.

The series of deliberate steps aided two-way engagement to operationalise the research partnership. Aligning relevant principles with each step assisted in applying the NHMRC ethical guidelines into practice [1, 3]. There was a clear overlap with the values of reciprocity, respect, equality, responsibility and survival and protection. In addition, following the steps allowed identification of the responsibilities and accountabilities for both parties in a transparent way. Trust and honesty, an important part of ethical practice, was built through this transparent process. We suggest that an additional principle should be considered to complement the 10 outlined by Jamieson *et al* [1], that is, transparency of roles and responsibilities throughout the research relationship.

Conclusion

A successful research partnership requires clear planning and transparency of how the two parties will interact from initial engagement to research completion. Considering the principles for effective health research with Aboriginal and Torres Strait Islander populations through each step of the research process was found to be an effective way to establish and manage a long term research partnership with an ACCHS and researcher.

Acknowledgements

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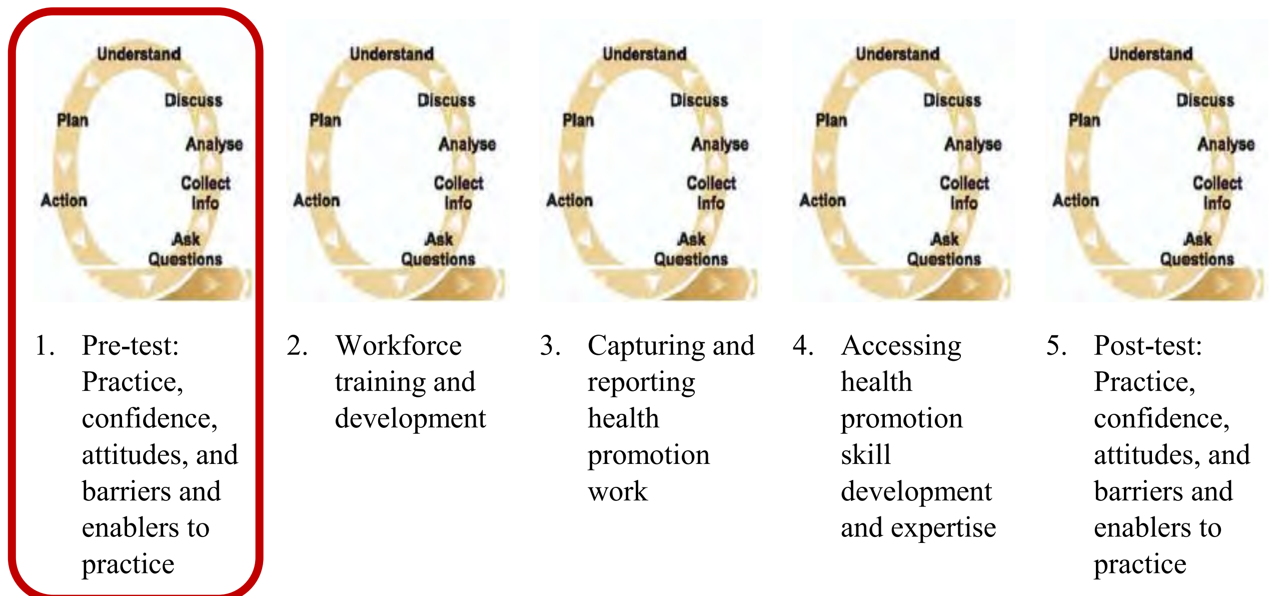
2.6 Chapter summary

This chapter described the research approach, the positioning of the researcher in the organisation and how the research will contribute to the evidence base. The chapter concludes by describing how the researcher established and maintained the research relationship with Apunipima.

The next chapter is the first of five results chapters. Chapter three describes the baseline findings of how health promotion is practised, staff and organisational confidence in their practice, perceived enablers and barriers to practice, and the attitude towards health promotion as part of primary health care.

Chapter 3. Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service



Participatory action research cycle[1]

3.1 Overview of the chapter

This chapter describes the findings from the initial baseline survey of Apunipima staff conducted in February 2015, and is presented as a published journal article. The survey explored how health promotion is practised, staff and organisational confidence in their practice, perceived enablers and barriers to practice, and the attitude towards health promotion as part of primary health care (Appendix F).

This initial PAR cycle found that health promotion activities occur across a continuum of one-on-one approaches through to population advocacy approaches. The participants' attitude towards health promotion practice in primary health care was very positive. The workforce insights from the survey identified areas at both an individual and organisational level that could be targeted to strengthen health promotion capacity

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[1] Adapted from Judd J, Keleher H. Reorienting health services in the Northern Territory of Australia: a conceptual model for building health promotion capacity in the workforce. Global Health Promotion. 2013;20(2):55.

at Apunipima. The findings from this initial PAR cycle informed the subsequent PAR cycles.

This is the first publication to describe how health promotion is practised in an ACCHS. This paper informs the primary health care sector of the current enablers and barriers to health promotion practice that are experienced in an ACCHS setting. This paper is inserted as published. The citation is:

McFarlane K, Devine S, Judd J, Nichols N, Watt K. **Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service.** Australian Journal of Primary Health. 2017; http://dx.doi.org/10.1071/PY16033

3.2 Paper three – Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service

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Research Paper

Workforce insights on how health promotion is practised in an Aboriginal Community Controlled Health Service

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Abstract. Aboriginal Community Controlled Health Services deliver holistic and culturally appropriate primary health care to over 150 communities in Australia. Health promotion is a core function of comprehensive primary health care; however, little has been published on what enables or challenges health promotion practice in an Aboriginal Community Controlled Health Service. Apunipima Cape York Health Council (Apunipima) delivers primary health care to 11 remote north Queensland communities. The workforce includes medical, allied health, Aboriginal and Torres Strait Islander health workers and health practitioners and corporate support staff. This study aimed to identify current health promotion practices at Apunipima, and the enablers and challenges identified by the workforce, which support or hinder health promotion practice. Sixty-three staff from across this workforce completed an online survey in February 2015 (42% response rate). Key findings were: (1) health promotion is delivered across a continuum of one-on-one approaches through to population advocacy and policy change efforts; (2) the attitude towards health promotion was very positive; and (3) health promotion capacity can be enhanced at both individual and organisational levels. Workforce insights have identified areas for continued support and areas that, now identified, can be targeted to strengthen the health promotion capacity of Apunipima.

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Introduction

Health promotion approaches are an integral part of comprehensive primary health care. Management of disease is only one component of primary health care. Health promotion approaches complement disease management by empowering individuals to increase control over their health and, by forming collaborative partnerships with other sectors, address the social, environmental and economic impacts that influence health outside of the individual's control (World Health Organization 1986). Strengthening health promotion practice in primary health care improves the health of individuals and population health (Public Health Association of Australia 2014).

A recent literature review of the factors that influenced health organisations' capacity to deliver effective health promotion work found management support, leadership, skilled staff, working in partnership, competing clinical priorities and resource allocation were major influencers (McFarlane *et al.* 2016). Only one publication was found that discussed these factors from an Indigenous health service perspective (McFarlane *et al.* 2016).

There are over 150 Aboriginal Community Controlled Health Services (ACCHS) in Australia providing culturally appropriate, comprehensive primary health care that empowers individuals and groups to increase self-efficacy and improve their health (National Aboriginal Community Controlled Health Organisation 2014). ACCHS have been identified as ideal models of comprehensive primary health care; integrating clinical care, health promotion and community capacity building (Wakerman *et al.* 2008). However, similar to other health organisations (McFarlane *et al.* 2016), ACCHS face challenges delivering effective health promotion approaches (O'Donoghue *et al.* 2014). Although specific tools have been developed to assist Indigenous health promotion practice, very few have been evaluated to show if practice has been strengthened (McCalman *et al.* 2014).

Apunipima Cape York Health Council (Apunipima) is the largest community-controlled health organisation in Queensland. Apunipima was established in 1994 originally as a health advocacy organisation for Cape York communities. The organisation now delivers comprehensive primary health care to 11 Cape York communities. Whereas some staff are community-based, others provide fly-in–fly-out services from Cairns. Of the ~150 staff, just over half identify as Aboriginal or Torres Strait Islander and one-quarter of the workforce are male. Staff include Aboriginal and Torres Strait Islander health workers and health practitioners, outreach midwives, podiatrists, audiologists, speech pathologists, physiotherapists, dieticians and nutritionists,

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What is known about the topic?

- Health promotion is an important approach within primary health care. However, little has been published on what enables and challenges health promotion practice in an Aboriginal Community Controlled Health Service.

What does this paper add?

- Insights into the types of health promotion activities an Aboriginal Community Controlled Health Service is involved in and identification of enablers and challenges to practice.

diabetes nurse educators, health promotion officers, social and emotional wellbeing staff, paediatricians, general practitioners and corporate support staff (Apunipima Cape York Health Council 2013). Approximately one-third of the staff at Apunipima have a clinical role, one-quarter have a non-clinical community role and remaining staff have a corporate support or management role with minimal client contact. Although corporate support staff may not have a direct role in delivering approaches, they are involved in operationalising access to resources, including funding and reporting systems. All staff have a role in supporting health promotion practice.

Ten of the eleven Cape York communities are considered very remote and one community is classified as remote. In this context, remoteness is relative to the range of services available within the community and road distance from the closest urban centre base on the *Accessibility/Remoteness Index of Australia* (Commonwealth Department of Health and Aged Care 2001). Community population numbers range from 80 to 2000 residents (Australian Bureau of Statistics 2011). The residents of these communities have minimal services and basic infrastructure. Their health needs are greater than those of their urban or regional counterparts (Australian Institute of Health and Welfare 2014).

The Apunipima model of care incorporates health promotion and supports upstream determinants of health as essential components of comprehensive primary health care (Apunipima Cape York Health Council 2014). Apunipima acknowledges that:

> ...primary health care prevention has often focussed on the tertiary and individual level; however, by including upstream activities, more sustainable and effective outcomes will be achieved and health issues can be addressed at both [the] population and community level [Apunipima Cape York Health Council 2014, p. 10].

At Apunipima, health promotion is built into all aspects of primary health care work using an adapted health promotion framework that is based on previous work by Labonte (1992) (Talbot and Verrinder 2005). This framework (Fig. 1) is used to describe the variety of health promotion activities from an individual through to a population approach. Although the framework is useful to describe how health promotion practice can be captured within the primary healthcare service, little is known about how well the organisation is implementing activities across the whole framework, or what the challenges and enablers are for the workforce to deliver health promotion approaches.

Apunipima has been involved in research partnerships with tertiary institutions since 1999. Previous research projects have focussed on specific health issues or ways of delivering clinical care. This is the first research project to focus on health promotion practice. This study aimed to identify and explore staff practice, attitudes, confidence and perceived enablers and barriers to implement health promotion approaches at their workplace.

Methods

A cross-sectional survey was designed to measure current health promotion practice, confidence to undertake health promotion tasks, views on enablers and barriers to practice, staff attitudes to health promotion, years of experience and training completed in health promotion. A mixture of closed and open-ended questions and Likert scales were used to gather quantitative and qualitative data.

To measure current health promotion practice, types of activities and frequency of delivery were mapped against the health promotion framework (Talbot and Verrinder 2005) (Fig. 1). Staff rated their perceived confidence to undertake health promotion tasks against the health promotion core competencies for practice (Australian Health Promotion Association 2009) and how well they perceived their organisation demonstrated these competencies.

Enablers and barriers for health promotion were based on key findings from a literature review of health organisations' experiences in building health promotion capacity (McFarlane et al. 2016). Staff were asked to identify which enablers or barriers applied to their work and were asked, through open-ended questions, to identify any further enablers and barriers. Staff were also asked to rate their attitudes to health promotion practice within the primary healthcare context using Likert scales. Details about their experience and training in health promotion and their specific work area were also gathered.

To encourage staff to complete the survey, presentations were given to workplace teams detailing the purpose of the survey. These teams included: family health (maternal and child health), men's health, social and emotional wellbeing, healthy lifestyles, health reform and corporate support services teams. To better understand how different roles view health promotion within the organisation, all staff were invited to participate.

The survey was designed in partnership with Apunipima to confirm the areas of investigation. Some questions were adapted from previous research in health promotion workplace practice (Devine et al. 2009). The survey was pilot tested with Indigenous and non-Indigenous primary healthcare staff who did not work at Apunipima and was adjusted after feedback. A link to the survey was electronically sent to all Apunipima staff in February 2015 by SurveyMonkey (Palo Alto, CA, USA), and informed consent was sought at the start of the survey. All responses were anonymous. The survey was open for a 6-week period and was promoted by reminder emails, workplace posters and recruitment of team leaders to encourage their teams' involvement.

The following definition of health promotion was provided at the start of the survey as a reference for respondents:

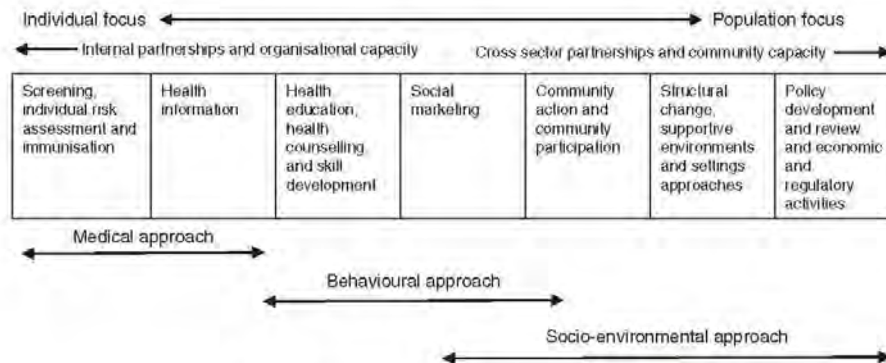

Fig. 1. Health promotion framework (Talbot and Verrinder 2005).

Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. Health promotion approaches are designed to both strengthen the skills and capabilities of individuals, groups and the broader population and also to influence the social, environmental and economic determinants of health (WHO 1986). Health promotion approaches target the protective and risk factors of ill-health to make the healthy choice the easy choice.

Analysis of quantitative data was performed using the Statistical Package for the Social Sciences, ver. 22 (SPSS Inc., Chicago, IL, USA). Descriptive statistics described: practice across the health promotion framework; confidence in practice; perceived enablers and barriers to practice; and rating of the importance of health promotion in primary health care. Numerical data were described using mean values and standard deviations, as is the convention when the number of respondents is greater than 30. Open-ended responses were analysed manually using an inductive approach to theme the participant responses.

The survey was part of a larger study to strengthen health promotion practice using a participatory action research (PAR) approach. PAR is a structured reflective cycle of gathering insight from participants and involving them in the identification of solutions. The survey was the initial PAR cycle to identify a baseline of how health promotion is practised in this organisation. The study was approved by the James Cook University Human Ethics Committee (HE5787) and the Apunipima Research Committee.

Results

Of the 150 staff at Apunipima, 42% ($n = 63$) of the workforce responded, representing all work teams. Just under 20% ($n = 12$) of the respondents were managers or team leaders.

Staff who responded to the survey were involved in health promotion strategies across all areas of the health promotion framework, from one-on-one approaches to population-focussed advocacy and policy change efforts. The frequency of staff involvement in health promotion activities is mapped against the health promotion framework (Talbot and Verrinder 2005) (Fig. 2).

On a weekly basis, the most frequent health promotion activities undertaken by the majority of staff were providing health information ($n = 24$, 38.1%) and delivering health education, health counselling and skill development activities ($n = 23$, 36.5%). On a monthly basis, community action and participation ($n = 17$, 27.0%), social marketing ($n = 14$, 22.2%) and policy development and review and economic and regulatory activities ($n = 14$, 22.2%) were undertaken most frequently.

Overall, the majority of staff are involved in providing health information ($n = 48$, 77.4%) and the least number of staff are involved in advocating for supportive environments ($n = 25$, 41%). In total, 90% of staff who responded felt all of these health promotion activities were important for Apunipima to lead or deliver in Cape York communities.

Over one-third (37%) of respondents had greater than 4 years' experience in delivering health promotion approaches. Over half (58.7%) had completed some form of training in health promotion. The majority of these staff had completed health promotion subjects or a qualification at university (41.3%), whereas the remainder had completed a workshop, short course or TAFE subjects (17.4%).

Respondents rated their own confidence and how well they believed the organisation performs against the health promotion competencies (Table 1). Staff were most confident working in partnership with other key organisations and with community in planning and implementing a health promotion program. Staff were least confident in evaluating health promotion programs, writing program plans and completion reports, and using evidence-based strategies in health promotion programs.

Staff identified that as an organisation, Apunipima is most confident to give presentations and facilitate meetings, assess and understand the needs of the community, and work in partnership with the community and other key organisations to plan and implement health promotion programs.

Respondents stated that the most important enablers for health promotion practice were skilled staff ($n = 39$), communities willing to work on health priorities ($n = 38$), funding for programs ($n = 36$) and evaluating and sharing lessons learnt from previous programs ($n = 35$).

Analysis of responses to the open-ended questions identified several areas that supported health promotion practice at

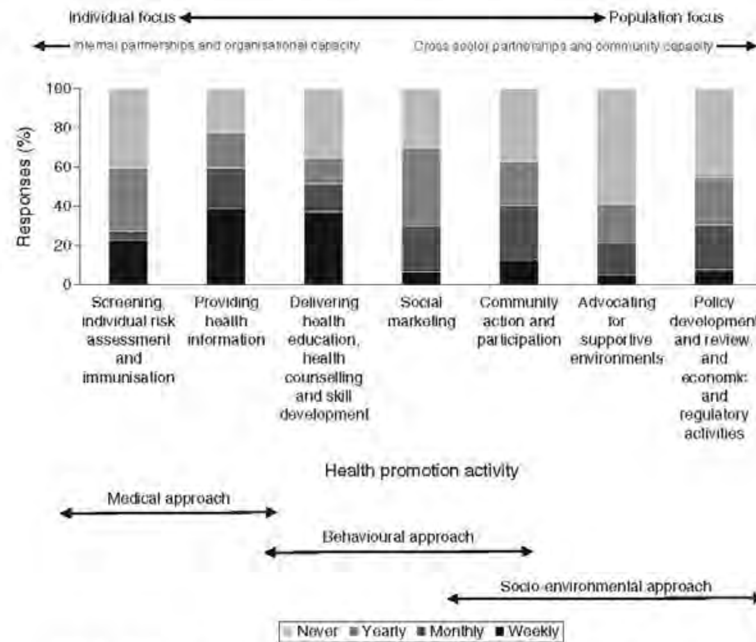

Fig. 2. Frequency of staff involvement in activities across the health promotion framework.

Table 1. Perceived staff confidence to perform health promotion competencies and their views on how well the organisation performs these competencies

For the number of responses, respondents could select 'not applicable to my role/the organisation'. Only respondents that rated their confidence from one to five are recorded in this table. For Confidence of staff to perform this aspect, these ratings ranged from 1, not at all confident, to 5, very confident, and for Confidence of organisation to perform this aspect from 1, does not do this well, to 5, does this really well

Health promotion competencies	Confidence of staff to perform this aspect		Confidence of organisation to perform this aspect	
	Number of responses (n = 47)	Mean score (±s.d.)	Number of responses (n = 50)	Mean score (±s.d.)
Working in partnership with other key organisations in planning a health promotion program	47	4.45 (0.75)	50	3.60 (0.99)
Working in partnership with the community to plan and implement a program	47	4.36 (0.76)	50	3.66 (1.08)
Explaining to others what health promotion is	47	3.98 (1.11)	49	3.37 (1.18)
Planning a health promotion program	44	3.95 (1.01)	50	3.56 (1.07)
Giving presentations and facilitating meetings	47	3.89 (1.18)	49	3.88 (1.09)
Assessing and understanding the needs of the community	43	3.77 (1.07)	50	3.70 (0.97)
Using evidence-based strategies in health promotion programs	45	3.73 (1.12)	50	3.48 (1.07)
Writing program plans and completion reports	47	3.68 (1.22)	49	3.22 (1.03)
Evaluating health promotion programs	43	3.65 (1.11)	50	3.00 (1.25)

Apunipima. These included having experienced staff within the organisation who are strong advocates for health promotion activities, as well as having a dedicated health promotion team. The organisation was seen as having a strong focus on community engagement and involving community in the identification of health priorities.

Staff in a variety of roles delivered health promotion approaches. Clinical staff were able to integrate clients into health promotion programs, and community-based staff and health workers within the organisation were seen as an enabler for health promotion engagement with the communities. Health promotion was also seen as an enjoyable work activity.

The barriers for health promotion practice included clinical priorities being seen as more important (n = 23); lack of understanding of health promotion practice (n = 23); lack of funds (n = 23); and insufficient time available for activities

($n = 23$). Respondents acknowledged that delivering health services in remote Indigenous communities is challenging. Comments identified a lack of resources to implement and maintain programs; a lack of community-based services to partner with; and a lack of infrastructure that, if available in these remote communities, would support healthier lifestyles.

Attitudes about health promotion were assessed using four statements that were combined for reliability (Cronbach's $\alpha = 0.56$). The mean value was 4.64 ($\pm$0.51), indicating that staff view health promotion very positively within Apunipima (1, strongly disagree; and 5, strongly agree).

Discussion

Gathering workforce insights into how health promotion is practised and perceived by ACCHS staff was a useful strategy to identify areas that can strengthen the organisation's capacity to deliver health promotion. Enablers and barriers exist at both an individual and organisational level. At an individual level, the identification of where health promotion practice most frequently occurs and which health promotion competencies staff are most or least confident with allows a tailored skill development approach to address these gaps. At an organisational level, policies and procedures, resource allocation and leadership approaches can be reviewed based on the findings to strengthen the organisation's approach to health promotion.

Staff are working across the framework (Talbot and Verrinder 2005), from individual to population approaches. Some health promotion strategies are being delivered more frequently than others, such as those targeting individuals. This is consistent with the nature of clinical roles that make up the majority of positions providing health care in the communities every week. However, advocacy remains a key population focus.

There was a strong acceptance that health promotion is an important part of comprehensive primary health care, and both clinical and non-clinical staff have a role in delivering health promotion approaches. However, the authors acknowledge that the definition of health promotion provided at the start of the survey may have influenced this response.

A skilled health promotion workforce is recognised as an important enabler for effective health promotion delivery (McFarlane *et al.* 2016). A lack of confidence to use evidence-based strategies, document health promotion projects and evaluate their outcomes is not unusual. A survey of Australian Health Promotion Association members also showed staff were least confident in applying evidence-based practice to the planning and evaluation of health promotion approaches (James *et al.* 2007).

As identified in the present study, and also by others (Victorian Healthcare Association 2009; McFarlane *et al.* 2016), limited access to resources such as time and funding affect health promotion delivery. Additionally, this study identified the importance of access to community-based resources in remote communities to support individuals to adopt healthier lifestyles.

Involving communities in health decision-making is necessary to address the determinants of health (Hawe *et al.* 1997). This study confirmed ACCHS staff are confident to partner and engage with communities in health planning. This is a recognised strength of ACCHS, and not all primary healthcare organisations do this well (Wakerman *et al.* 2008).

This paper identified current health promotion practice in an ACCHS at one point in time. The survey was the initial data-gathering process of a larger PAR project with the organisation. From this PAR cycle, priorities have been identified and future research will identify the effect of those changes to practice.

No previous results have been available on how health promotion is practised across the health promotion framework (Talbot and Verrinder 2005), or the enablers and barriers to health promotion practice in Cape York. Gathering workforce insights improves understanding of how health promotion is practised, and identifies what supports and hinders health promotion work in remote northern Australian communities.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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3.3 Chapter summary

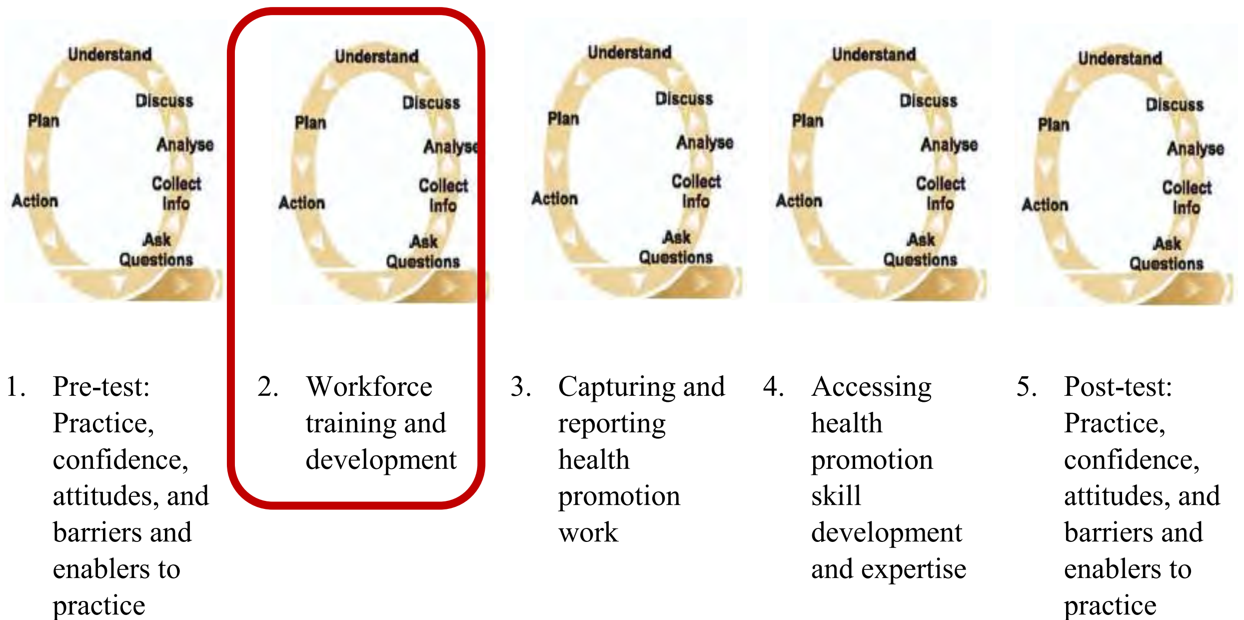
The key learnings from this initial PAR cycle were that health promotion activities occur across a continuum of one-on-one approaches through to population advocacy and policy change efforts. While the attitude towards health promotion practice in primary health care was very positive, participants lacked confidence in evaluating health promotion programs.

All staff were sent a summary of the survey findings and were invited to identify areas where health promotion practice could be strengthened. Feedback from staff was discussed with the reference group and a number of priorities were identified. The prioritisation process considered the findings from this survey, feedback from staff and current opportunities in the organisation to influence practice. The initial priorities identified were to:

- increase the evaluation capacity of the health promotion team and other staff working on health promotion activities;
- increase the profile of health promotion by sharing project impacts and outcomes with other staff in the organisation, with community and with external peers; and
- explore how health promotion work is being captured and used in decision-making.

The next chapter describes how health promotion evaluation capacity was strengthened through workforce training and mentoring, and how the evaluated projects were shared with internal and external stakeholders.

Chapter 4. Skills, systems and supports: An Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff



Participatory action research cycle[2]

4.1 Overview of the chapter

This chapter describes how the ACCHS increased health promotion evaluation capacity within the health promotion team through workforce training and development, and is presented as a published manuscript. This chapter addresses the first two priorities identified from the baseline survey (chapter three), which were to:

- increase the evaluation capacity of the health promotion team and other staff working on health promotion activities; and

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[2] Adapted from Judd J, Keleher H. Reorienting health services in the Northern Territory of Australia: a conceptual model for building health promotion capacity in the workforce. Global Health Promotion. 2013;20(2):55.

- increase the profile of health promotion by sharing project impacts and outcomes with other staff in the organisation, with community and with external peers.

The ACCHS utilised support from the researcher and other experienced researchers to provide training and to mentor staff working in health promotion. Through targeted training, individual mentoring, and the revision and adoption of project planning and evaluation templates, health promotion capacity increased. All health promotion staff completed their project evaluations and presented their findings to staff at meetings and to peers at national conferences. The lead author on this paper was the health promotion team leader, and this publication is an example of the new skills developed to share health promotion findings through a peer-reviewed publication.

4.2 Role of the PhD candidate

The doctoral candidate provided advice and direct support to build health promotion evaluation capacity in the ACCHS. Advice was provided when planning the workshop series, and the candidate delivered and evaluated one of the workshops. The candidate mentored three of the four health promotion staff to apply their learnings from the training into practice, and provided advice and support to other staff who attended the workshops.

The paper describes how health promotion evaluation capacity can be strengthened in an ACCHS. The candidate supported the team leader to publish the findings of this project in a peer reviewed journal.

This paper is presented as submitted to the journal. The paper has been accepted for publication. It is in the format required by the journal. The citation is:

Nichols N, McFarlane K, Gibson P, Millard F, Packer A, McDonald M. **Skills, systems and supports: An Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff**. Health Promotion Journal of Australia (in press).

4.3 Paper four - Skills, systems and supports: an Aboriginal Community Controlled Health Service approach to building health promotion evaluation capacity of staff

Abstract

Issue addressed: Building the health promotion evaluation capacity of a workforce requires more than a focus on individual skills and confidence. We must also consider the organisational systems and supports that enable staff to embed learnings into practice. This paper describes the processes used to build health promotion evaluation capacity of staff in an Aboriginal Community Controlled Health Service (ACCHS).

Methods: To build health promotion evaluation capacity three approaches were used: 1) workshops and mentoring; 2) strengthening systems to support program reporting; and 3) recruitment of staff with skills and experience. Pre- and post-questionnaires determined levels of individual skills and confidence, updated systems were assessed for adequacy to support new health promotion practices and surveys captured the usefulness of workshops and mentoring.

Results: There was increased participant skills and confidence. Participants completed program impact evaluation reports and results were successfully presented at national conferences. The health promotion team was then able to update in-house systems to support new health promotion practices. Ongoing collaboration with experienced in-house researchers provided basic research training and professional mentoring.

Conclusions: Building health promotion evaluation capacity of staff in an ACCHS can be achieved by providing individual skill development, strengthening organisational systems and utilising professional support.

So what? Health promotion practitioners have an ongoing professional obligation to improve the quality of routine practice and embrace new initiatives. This report outlines a process of building evaluation capacity that promotes quality reporting of program impacts and outcomes, reflects on ways to enhance program strengths, and communicates these findings internally and to outside professional bodies. This is particularly significant for ACCHSs responsible for addressing the high burden of preventable disease in Aboriginal and Torres Strait Islander populations.

Introduction

Program evaluation is a core competency of health promotion practice; (1-3) focussing on systematic examination of health promotion programs to assess effectiveness, appropriateness and sustainability (4). It can also identify unexpected outcomes, opportunities for improvement and cost-effectiveness (5). The information gained can be used to advance health promotion practice, inform stakeholders of program outcomes and build a business case for program continuity (6, 7). Evaluation findings from smaller community-based interventions complement larger-scale interventions conducted by research organisations and contribute to the evidence-base for action that effectively improves health and well-being.[4]

Comprehensive evaluation requires time, appropriate skills of the evaluators, collaboration with project partners and stakeholders, and adequate resources (8). Building pertinent evaluation skills is a critical component of workforce development. Organisational and structural supports are then required to translate evaluation skills into practice (9).

In a recent review of the type of support health promotion practitioners need, three aspects were identified. The first was staff evaluation knowledge and skills. The second was an organisational focus on achievement of a program's purpose rather than satisfying auditing requirements; and the third was translation and sharing of evaluation findings to shape future practice(8). Other studies have shown that staff trained in health promotion have difficulty translating new learnings into practice without organisational support (10, 11). The adoption of new health promotion practice was more likely when supported by updating organisational planning and reporting systems in line with new knowledge plus ongoing mentoring for trained staff (12, 13).

Apunipima Cape York Health Council (ACYHC) is an ACCHS that employs just over 150 people. ACYHC provides comprehensive primary health care to Aboriginal Australians and Torres Strait Islanders residing in Cape York, far north Queensland, Australia. The organisation has a health promotion team comprising a team leader and three health promotion officers that forms part of a multidisciplinary workforce of health professionals delivering services to 11 remote Cape York communities. The main role of the health promotion team is to plan, implement and evaluate culturally appropriate, community-based programs that meet community need and support

ACYHC's model of community-controlled, comprehensive primary health care. This work is done in collaboration with a whole range of primary health care staff, community-based Health Action Teams, community members, service partners and providers.

ACYHC strives for health promotion outcomes that enhance community involvement, build local capacity, improve access to health services, and create healthier lifestyles and environments. However, it is always a challenge to effectively demonstrate to communities, current and potential funders and decision makers within the organisation, just how these health promotion efforts have contributed to improving overall health outcomes for the people of Cape York.

ACYHC certainly invests in health promotion, but readily available evidence highlighting the value of the organisation's health promotion program is also essential for justifying ongoing commitment of resources for service improvement and service continuity (14). Additionally, feeding back information about completed program outcomes to communities is critical to keeping potential beneficiaries informed and involved in future decision making.

Project background

In the past, ACYHC health promotion programs have, for the most part, been carefully planned and process evaluations have demonstrated quality of implementation, successful program reach and participant and stakeholder satisfaction. However, there have been few impact and outcome evaluations that formally assessed resulting changes in health behaviours, levels of knowledge and the health environment. To address this issue, ACYHC's health promotion team collaborated with in–house researchers to design, plan, implement and evaluate a project aimed at building staff health promotion evaluation capacity.

Methods

The project was inspired by the acceptance of three abstracts at the 2015 Population Health Congress in Hobart, Tasmania. Experienced in-house ACYHC researchers were recruited to support three health promotion officers to write and submit the abstracts, which described planning processes from existing health promotion programs. Project

methods were designed to improve individual skills and confidence in program evaluation together with high-quality presentation and publication of findings.

Improving skills and confidence

Four members of the health promotion team participated in a workshop series that was designed to build individual skills and confidence, to bring program evaluation to completion and to present and publish findings. Eight workshops were conducted over a nine-month period and were open to all ACYHC staff. Three members of the health promotion team also participated in four one-on-one mentoring sessions over a five-month period to achieve project objectives (Table 4.1).

Table 4.1 Project timeline

2015	Event
February	Health promotion team identify the need to build program evaluation capacity
May-September	Participant mentoring
May	Workshop: Why do research? Provider: Apunipima Research Officer
	Workshop: Ethics approval process Provider: HREC representative, James Cook University
June	Abstracts accepted for 2015 Population Health Congress
	Workshop: Evaluation methods Provider: PhD scholar, James Cook University
July	Workshop: Data collection and analysis Provider: Clinical Research Fellow, ACYHC, James Cook University
August	Workshop: Conference presentations Provider: Specialist Physician/Researcher, ACYHC, James Cook University
	Workshop: Evaluating community-level health promotion programs Provider: The Australian Prevention Partnership Centre
September	Conference presentations 2015 Population Health Congress, Hobart
October	Workshop: Understanding research master class Provider: Wardliparingga Aboriginal Research Unit, South Australia Health and Medical Research Institute
	Workshop: Publishing Provider: Specialist Physician/Researcher, ACYHC, James Cook University
December	Conference presentation Indigenous Allied Health Australia National Conference, Cairns

The skills and confidence of the health promotion team were measured in three ways. First, participants were asked to rate their skills and confidence to conduct research, collect and analyse data, present their findings and write for publication. This was done

using self-reported pre- and post-questionnaires based on Likert scales. The post questionnaire included open-ended questions on participants' perceived impact of the mentoring and workshops on their evaluation practice. Second, skills and confidence were appraised according to completion of evaluation reports, and a third measure was quality of presentation of their evaluation findings to a professional audience.

Strengthening organisational systems

The health promotion team reviewed internal evaluation documentation and reporting processes to determine how systems could be strengthened to support new evaluation practices. Systems were updated accordingly.

Recruitment of professional support

From the inception of the project, the health promotion team sought to collaborate with experienced academics within the organisation. ACYHC has a senior research officer plus a group of clinical staff with additional university affiliations. ACYHC also supports a PhD scholar whose participatory action research project is focused on building organisational capacity for health promotion. This linking of staff with experienced in-house researchers has been well received by all involved and provides a way to increase structural supports to small teams with limited available resourcing (14).

The workshops were mostly delivered by the ACYHC researchers, each of whom had appointments with James Cook University (JCU). Networks were utilised to attract additional external expertise (Table 4.1). All participants were asked to complete a short survey at the end of the workshops to assess usefulness.

Two ACYHC/JCU researchers were responsible for the mentoring. Mentors and mentees rated on a Likert scale the usefulness of each mentoring session and indicated whether evaluation completion reports were on track using an online survey tool. All workshops and mentoring sessions were delivered at no cost to the organisation.

Data analysis

Numerical data were analysed using means and standard deviation. Open-ended responses were analysed manually to theme participant responses using an inductive approach.

The Far North Queensland Human Research Ethics Committee determined that this project met the definition of a Quality Assurance Project HREC/16/QCH/26 – 1034 QA. All study data is kept secure on password-protected ACYHC computers and will be kept for 5 years.

Results

Improving skills and confidence

Participants reported increased confidence to conduct research, collect and analyse data, present findings to peers and to the community and to write up program findings for publication. This was identified in results of the pre- and post-questionnaires. The small number of participants (n=4) precluded formal statistical analysis.

Two themes emerged from responses to open-ended questions about the impact on evaluation practice. First, participants gained new knowledge on how to prepare findings, write for publication and as one participant stated:

> I've gained a better understanding of the seemingly complex process of applying for ethics or quality assurance. (Participant 1)

Second, participants reported improved skills, ability and confidence to analyse and write up evaluation findings for reporting, presentations and publication. Changes to practice were captured in the following quotes:

> Health promotion officers are now preparing for evaluation in the planning phase of community-based programs. (Participant 2)
>
> Having access to professional mentors has greatly improved my confidence to 'write up' findings and to support others to evaluate their programs. (Participant 3)

Participants submitted completed program evaluation reports and presented findings at an internal forum. Three participants then presented the findings at national conferences in 2015, including the Population Health Congress in Hobart and the Indigenous Allied Health Conference in Cairns.

Two team members are currently writing up evaluation findings for peer review publications. This paper is a direct output of the project.

Strengthening organisational systems

The health promotion team reviewed and updated organisational systems supporting program evaluation. The team now has access to program plan, status report and completion report templates that guide them through process, impact and outcome evaluation. A database for the collection of evaluation data was updated and team members now have access to software for data analysis and reporting, such as EndNote and NVivo.

Team members provided feedback on updated systems during a team meeting and stated that system changes had enhanced documentation of program evaluations. The team leader identified improvement in team members' ability to prepare program completion reports as a result of the updated systems.

Recruitment of professional support

All four health promotion team members attended at least seven of eight workshops along with other interested staff from the organisation. All workshops were rated as useful by those who attended. The number of participants at each workshop was small and varied from five to eight participants. The overall usefulness of workshops is presented in Table 4.2.

Three team members each attended four dedicated mentoring sessions. The mentoring sessions were seen as useful throughout the duration of the project (Table 4.2).

Table 4.2 Overall usefulness of workshops and mentoring

Workshops combined	**n**	**Mean ± s.d. (1=poor; 5=excellent)**
Overall usefulness of the workshops to staff	33[A]	4.45 (± 0.56)
Mentoring sessions combined	**n**	**Mean ± s.d. (1=not useful; 5=extremely useful)**
Overall usefulness of mentoring sessions to mentors and mentees	27[B]	4.59 (± 0.57)

[A]Number of post workshop surveys completed over the series of workshops.
[B]Number of post mentoring session surveys completed.

Discussion

This project shows that building small-team health promotion evaluation capacity in an ACCHS is achievable by improving individual skills and confidence, although not in isolation. Central to the project's success was a wider collaboration that improved practice through better program reporting, strengthened organisational systems and connected staff with experienced researchers.

The newly acquired skills and confidence of the ACYHC health promotion team enhanced program evaluation design and planning. This included a range of approaches to data collection and evaluation methods that can now be built into the planning of future programs with the aim of ongoing quality improvement. This was also the first time the team had presented evaluation findings at conferences and submitted a quality assurance application to an ethics committee; both important learning experiences.

A review of internal health promotion systems by the health promotion team led to the strengthening of evaluation documentation and reporting. A team approach meant that staff had the opportunity to use new evaluation skills to improve the whole teams' day-to-day health promotion practice.

The ready access to experienced researchers for advice and guidance had a positive impact and the relationships established through the project continue to influence the professional development of the health promotion team.

This project demonstrates that, with minimal financial outlay, the utilisation of in-kind support can enhance the health promotion evaluation capacity in an ACCHS. Similar to previous research, this type of professional development is only effective if there is organisational support (11, 13). Other health promotion capacity building projects report access to ongoing specialist support was important to achieving project milestones (12, 13). However, little has been published on how health promotion capacity has been developed in an ACCHS (15). As far as we can determine, the report of this project to increase health promotion evaluation capacity in an ACCHS is unique.

Numerical analysis was not possible because of the small number of participants. More statistical power could be gained through collaboration between ACCHS service partners, perhaps through an umbrella organisation, and adoption of a multi-site, even multi-state approach. After all, in the setting of Aboriginal and Torres Strait Islander

health, health promotion teams share many common themes and encounter many common challenges to service delivery.

While some recommendations can be made from this research and applied in other settings, there was no doubt that having access to experienced researchers and in-kind support for training and mentoring may be a limitation for other ACCHS.

Conclusions

A formal process of ongoing reflection and refinement, as part of professional development, should be built into all ACCHS health promotion programs. Building staff capacity to enhance the quality and reach of effective community-based initiatives is particularly important when engaging with Aboriginal and Torres Strait Islander populations because the burden of ill-health is so great and service delivery, especially to remote communities, can be uniquely challenging.

Such a process of building health promotion evaluation capacity is best done in collaboration with experienced researchers. This provides a strong academic backing and enhances skills of program promotion through presentation and publication.

Whenever possible the process of program evaluation and service delivery outcomes should find their way into the public domain through presentation at professional conferences and publication. This is one of the important paths to wider program recognition and better funding for Aboriginal and Torres Strait Islander programs and resources.

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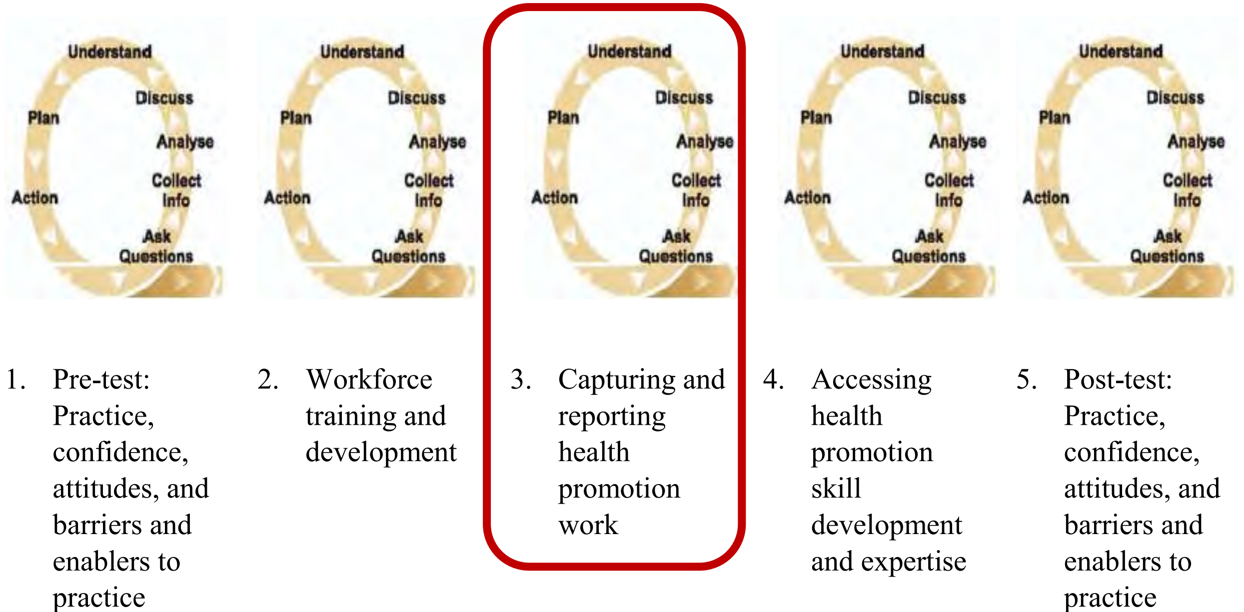
4.4 Chapter summary

This chapter highlighted that health promotion evaluation capacity can be strengthened through targeted training, mentoring and adapting organisational templates and processes to capture project outcomes.

Reflecting on this PAR cycle, the reference group identified that in-kind health promotion support was important for ongoing skill development of the workforce. This was added to the priorities for the research to explore further and is discussed in chapter six. The reference group also identified that while health promotion project evaluation templates were useful to capture project outcomes, many health promotion activities were not being reported within the current organisational systems. How health promotion work is being captured and used in decision-making was identified as a priority from the first PAR cycle. The reflection from this second PAR cycle added further weight not only to explore, but to understand what health promotion activity is and is not being captured and reported in the organisation. This is the focus of the next chapter, which describes how health promotion practice is captured and reported to decision-makers and identifies the challenges ACCHS face in reporting health promotion effectiveness.

Chapter 5. Australian Indigenous primary health: Challenges in reporting health promotion outcomes



Participatory action research cycle[3]

5.1 Overview of the chapter

Chapter five describes how health promotion practice is captured from a practitioner's point of view, and identifies the challenges practitioners face in articulating the effectiveness of health promotion practice to decision-makers. Chapter five addresses the third priority identified from the baseline survey (chapter three) which was to:

- explore how health promotion work is being captured and used in decision-making.

This chapter was a mixed-methods study (document review and semi-structured interviews with staff, refer to Appendix G, H and I). The document review included organisational strategic and operational plans, quality standards, and national and organisational key performance indicators. The main conclusion of this study is that

[3] Adapted from Judd J, Keleher H. Reorienting health services in the Northern Territory of Australia: a conceptual model for building health promotion capacity in the workforce. Global Health Promotion. 2013;20(2):53-63.

new measures must be adopted that capture effects on the social determinants of health in order to better inform decision-makers at all levels of how health promotion approaches are contributing to improve health outcomes.

This paper has been submitted to a peer-reviewed journal and is currently under review. The paper is presented as submitted to the journal. However the reference style has been modified to Vancouver style. The citation is:

McFarlane K, Devine S, Canuto K, Watt K, Judd J**. Australian Indigenous primary health: Challenges in reporting health promotion outcomes.** Health Promotion International. (under review).

5.2 Paper five - Australian Indigenous primary health: Challenges in reporting health promotion outcomes

Summary

Background: Health promotion approaches are effective for improving long-term health outcomes. Recently in Australia, there have been significant funding cuts and removal of agencies responsible for disseminating evidence of best practice in achieving health outcomes through health promotion approaches. Measuring the effects of health promotion on health outcomes in the short term can be difficult to do. Indigenous primary health care services in Australia are constrained by short-term accountability, but they must show evidence of health promotion's effectiveness to receive more support and to sustain improvements in health outcomes.

Methods: A descriptive mixed-methods study assessed how health promotion practice was being captured and reported in an Aboriginal Community Controlled Health Service. Data came from a review of organisational documents (n=36) and semi-structured interviews with staff (n=12). Documents were analysed for their individual and population focus on health promotion activities. Interview data was thematically analysed to identify how health promotion practice was captured and reported to decision-makers.

Results: This organisation focuses on population and individual health promotion approaches in their guiding documents. However, reporting requirements are focused

only on individual measures. Staff recognised the constraints of accountability to justify resources, but without long-term population health measures it is difficult to communicate the breadth of health promotion activities and their contribution to health outcomes.

Conclusion: For decision-makers, at all levels, to be better informed of the how health promotion approaches are contributing to health outcomes, new measures must be adopted that capture effects on the social determinants of health.

INTRODUCTION

Primary health care organisations are able to improve health outcomes at both individual and population levels. They do this through a comprehensive primary health care approach which includes health promotion, early detection, treatment and management of ill health (1). Aboriginal Community Controlled Health Services (ACCHS) emerged in the 1970s as stand-alone primary health care organisations to provide culturally appropriate health care to Aboriginal and Torres Strait Islander populations (2). In a review of primary health care services in Australia, ACCHS were found to be more effective at delivering comprehensive primary health care, with a strong focus on addressing the underlying determinants of health, than non-Indigenous primary health care services (3). This focus on the social determinants of health is essential as clinical services alone will not improve population health outcomes (4).

Health promotion approaches improve population health by supporting individuals to adopt healthy behaviours and by targeting the determinants of health, as an individual's health is influenced by the social, cultural and physical environment in which they live (5). Health promotion approaches have demonstrated long-term improvements in population health outcomes. For example, reduced smoking rates have resulted in a reduction in lung cancer and cardiovascular diseases (6). These changes in population health outcomes can take years to demonstrate. Thus capturing and measuring the impact of health promotion efforts in the short term can be difficult (7).

ACCHS are required to report on a number of key performance indicators. Those that are defined as preventive health indicators include clients' smoking status, alcohol consumption, health assessment, cervical screening, immunisation and body mass index (BMI) classification (8). While these can be monitored over time to see changes in

clients' health, the focus is on individual measures rather than capturing changes that will improve population health through influencing the social determinants of health.

Globally, health promotion has increasingly needed to articulate evidence of its effectiveness in the short term to improve health outcomes (9). However, defining how health promotion efforts impact on the social determinants of health in the short term is lacking (10-12). Without relevant information on how a program is impacting on health outcomes it is difficult for decision-makers to support continuation of programs (13).

Health promotion efforts are vulnerable to political contexts and are dependent on the values of who is in power at the time (14, 15). Recently in Australia, dominant neo-liberal governments have come to power at national and state levels. This has resulted in a number of significant state and national funding cuts to the health promotion workforce and to leadership in best-practice population health approaches (16). The neo-liberalist paradigm is focused on individual responsibility for maintaining good health rather than population approaches which focus on reducing inequities and addressing the social determinants of health through supportive environments and policy approaches (4).

ACCHS, while currently seen as effective in adopting health promotion approaches that address the determinants of health, may be at risk of reductions in funding for their capacity to continue working in this way. Without appropriate measures, the efforts of health promotion practice remain vulnerable to disinvestment. In an environment with reduced resources there is less capacity for effective evaluation and an increase in accountability from decision-makers (7, 17). Practitioners in ACCHS are responsible for improving the health outcomes of one of the most disadvantaged populations in Australia with limited leadership and resources. The aim of this paper is to explore, from a practitioner's point of view, how health promotion practice is being captured and to identify the challenges practitioners face in articulating the effectiveness of health promotion practice to decision-makers.

METHODS

This descriptive mixed methods study was conducted in 2015-2016 with an ACCHS as part of a larger participatory action research project. Data collection comprised of a document analysis and semi-structured interviews with staff.

Setting

Apunipima Cape York Health Council (Apunipima) is an Aboriginal community controlled health organisation, established in 1994, and provides comprehensive primary health care to 11 remote Cape York communities in north Queensland, Australia (18). These communities have a very high proportion of Aboriginal and Torres Strait Islander people who suffer a disproportionate amount of ill health compared to non-Indigenous Australians and those living in urban locations (19). Apunipima employs approximately 150 staff including general practitioners, allied health staff, community based health staff and corporate support staff. The state and federal governments provide the majority of funding.

Document Analysis

Organisational documents reviewed by the Principal Investigator included operational plans, business and team plans, quality standards, reporting requirements and templates used by staff for reporting. Documents were included only if they detailed health promotion activities. The documents were themed into four main categories: reporting requirements; guiding documents; tools to capture health promotion practice; and, policies and procedures.

The health promotion framework (Figure 5.1) was used as a referral point for the types of health promotion activities when thematically organising the documents (20). This framework, adapted from Labonte (21), is used by the organisation to guide health promotion practice.

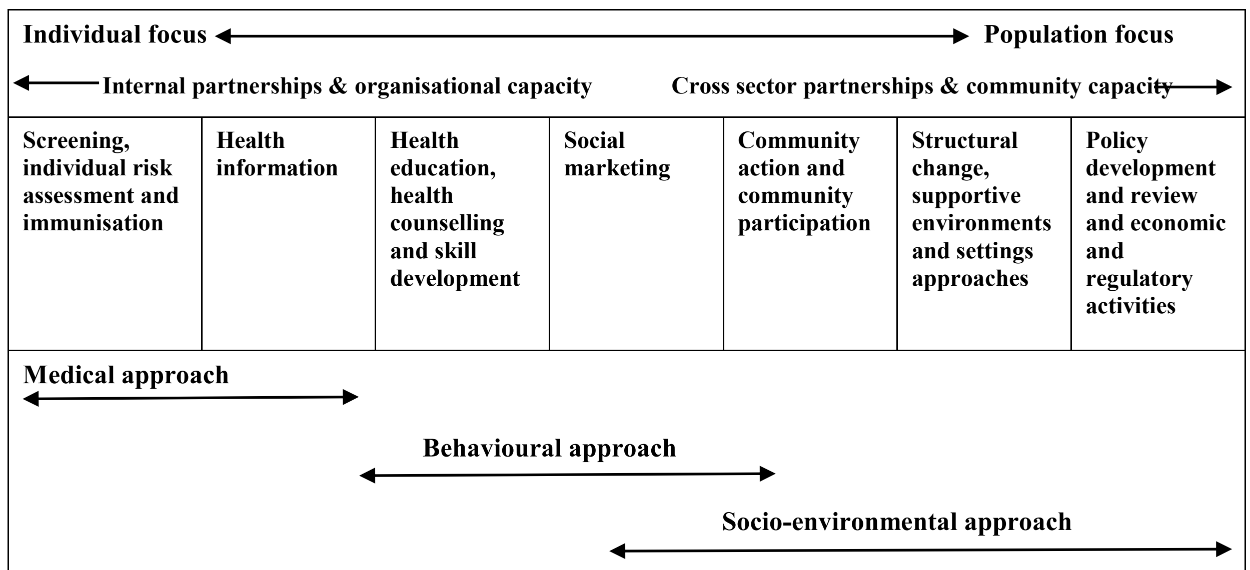


Figure 5.1 Health promotion framework (20).

The organisation-based reference group provided oversight and guidance on the documents that were included. Member checking was used as a validation technique (22). Members of the reference group checked and agreed as to how the health promotion activities were coded for each of the documents.

Interviews

Staff were invited to participate in semi-structured interviews to explore how health promotion practice is captured, what information is requested and what information they would like to provide to demonstrate the health promotion practice that they do. Purposive sampling targeted team managers and staff who compiled reports for internal and external stakeholders. All staff were invited to participate through an all-staff email list and posters were displayed on notice boards. Managers were representative of all the primary health care teams; one staff member was interviewed who compiled reports for the organisation; and a sample of on-the-ground staff who represented most primary health care teams were interviewed (n=12).

Interviews were digitally recorded and transcribed verbatim. The transcripts were coded and analysed using a theoretical thematic approach where the codes were organised into the themes that related to the key areas of inquiry (23). Commonalities between the themes and document analysis were also noted.

Ethical clearance

The research received ethical clearance from James Cook University Human Ethics Committee (HE5787). All research procedures reflected the six values of Aboriginal and Torres Strait Islander health research which are: reciprocity, respect, equality, responsibility, survival and protection, spirit and integrity (24).

RESULTS

Document Analysis

Thirty-six documents were included and themed into four main categories:

1. Reporting requirements (n=17)
2. Guiding documents (n=9)
3. Tools to capture health promotion practice (n=6)
4. Policies and procedures (n=4)

The types of health promotion activities mentioned in the documents are displayed in a spider graph, Figure 5.2. The spider graph displays the seven health promotion activities on the individual axis shown radially around a central point. The number of documents that detail each of the health promotion activities is shown on the node of each respective axis. By differentiating between the four types of documents, outlined in the key, the spider graph shows which types of documents detail which types of health promotion activities.

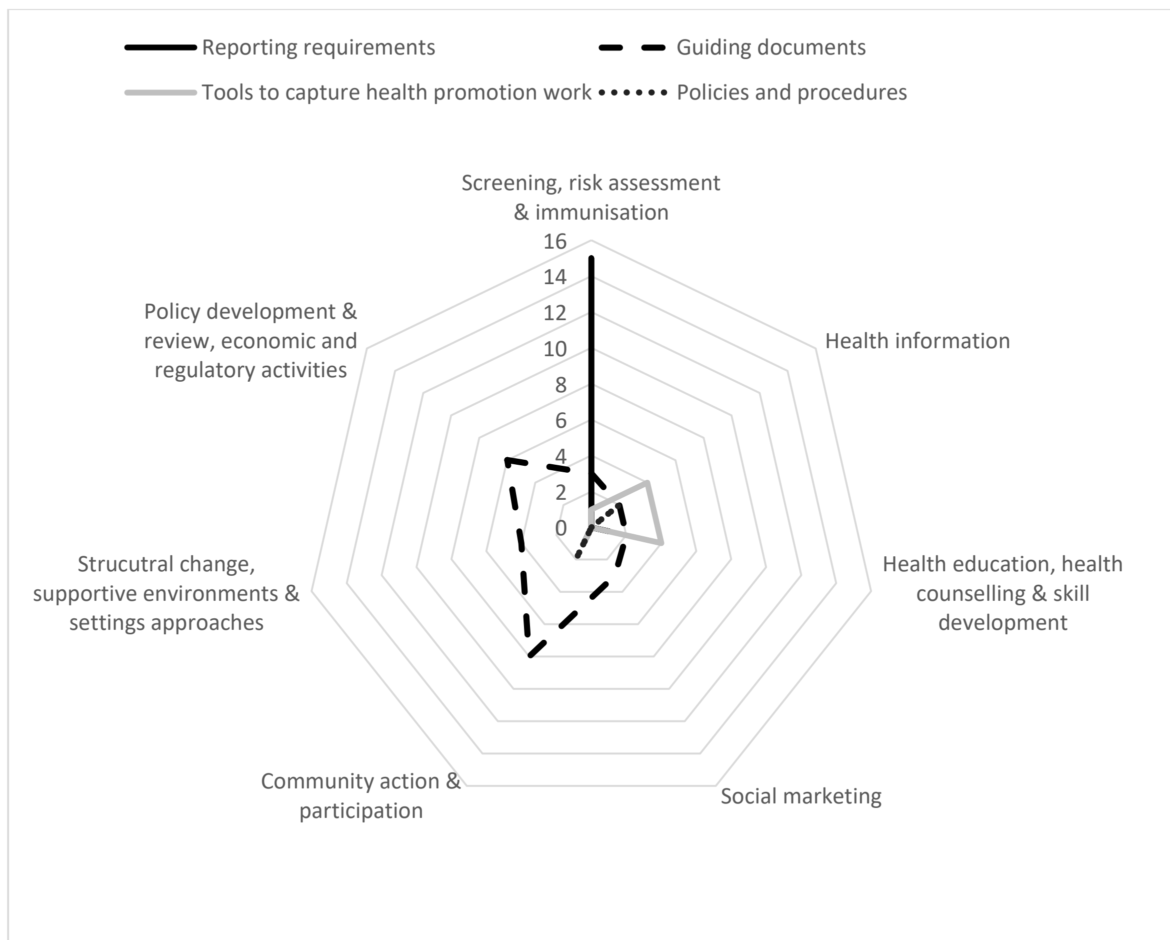


Figure 5.2 Health promotion activities described in organisational documents.

Reporting requirements included national key performance indicators (nKPIs) and organisational performance indicators. The majority of these documents required reporting on screening, risk assessment and immunisation activities, with one each on health education and community participation activities.

Guiding documents included the organisation's Model of Care, business plan, operational plans, and community plans. The guiding documents covered all of the health promotion framework areas and had a greater population focus.

Tools to capture health promotion practice included activity templates; health screening forms; and templates to capture and report health promotion activities. These tools captured health information, health education, and community action and participation activities.

Policies and procedures included documents written in response to accreditation requirements for the Australian General Practice Accreditation Limited (AGPAL) and

Royal Australian College of General Practitioners (RACGP) standards for general practices. Health information and community action and participation were the only health promotion activities mentioned.

Staff interviews

Six key themes emerged that described the: i) difficulties in capturing and reporting health promotion practice, ii) strengths of the organisation in relation to reporting, iii) impact of national and state government changes, iv) key performance indicators' impact on decision-makers, v) funding constraints, and, vi) challenges of communicating change in health outcomes.

i) Difficulties in capturing and reporting health promotion

Participants were frustrated that there was nowhere to capture broader health promotion approaches such as work done advocating for changes to policies that affect communities' health. They spoke about wanting to provide more context of the work they were doing in health promotion but were unsure what funding bodies really wanted to know. Participants noted that requests for information changed frequently and it was confusing to know what information to gather on a regular basis. All participants agreed that reporting needed to be simple, not onerous, and with minimal time required.

Participants recognised that the organisation does not capture or report the full extent of the work they do.

> Apunipima is underselling itself at this point in time with the breadth of its capacity across the health care continuum to work well, to really deliver comprehensive primary health care. (Participant 1)

They felt that existing reporting is focused on monitoring rather than evaluating the outcomes of work efforts.

> Reporting long-term outcomes is difficult. We report engagement as that is the first step in building community capacity. (Participant 4)

They also mentioned the challenges their clients face day-to-day living in remote communities.

> [We] need to report in the context of the challenges we face – disengaged community [and] other community priorities than health. (Participant 6)

Participants noted that formal reporting back to the community provides a minimal amount of information. They emphasised that the communities needed to be informed to make decisions and reporting needed to capture what is important to the community.

> [It's] not just going out and saying to community members, 'what is it that you want?' actually having that feedback mechanism where communities have the opportunity to hear about the health of their community and what's going on… being well informed about what the situation is helps people make the best informed judgement. (Participant 12)

> Solutions come within the community. (Participant 4)

ii) Strengths of the organisation (in relation to reporting)

A number of participants recognised that in recent years, the organisation had produced more strategic and operational planning documents to guide work focus. Participants also noted that the organisation has good relationships with funding bodies and are confident to negotiate with these organisations in regard to reporting requirements for project funding. One participant provided an example where they had been asked to report in response to the broad statement, 'tell us about your activities over the last 6 months'.

> We have existing measures [about the health issue] that are really good… we will tell them, they're your five measures, put them in [the agreement] and we will report against them. That's us being proactive. (Participant 3)

iii) Impact of national and state changes

All participants discussed the recent resource cuts that occurred at a state and national level and how they thought this had impacted on their work. They noted a lack of policy to lead their health promotion practice. *We are in a policy vacuum (Participant 1).* They also noted that with fewer partners to work with, their capacity to affect health

promotion outcomes was also reduced and they believed this had a direct impact on the outcomes measured at a national level. Participants also felt vulnerable working in health promotion and in response to this vulnerability some felt the need to capture all their efforts as they were cautious that this detail might be needed to justify their work in the future.

> I think the biggest risk is when the finances get tight and funding is reduced, is that if there isn't a clear track record documented of performance and productivity, then there is a risk that positions will be cut from the prevention programs. We are extremely vulnerable. (Participant 1)

iv) Key performance indicators

Participants believed decision-makers' understanding of health promotion was influenced by having only one organisational indicator for health promotion: 'number and type of health promotion activities'.

One participant thought there was pressure on decision-makers to use only national key performance data when making organisational decisions:

> We only kind of look at the nKPIs and not how it is we are going to get there… it's only a tiny bit of a really big complex picture. (Participant 12)

v) Funding

Participants noted that funding agreements impacted on project outcomes. Funding may be for a three-year project but it is often reviewed each financial year and staff were employed year-by-year in line with guaranteed funding. This results in staff looking for other employment as their contract nears its completion. The project momentum is stalled when new staff are recruited and orientated to the project:

> We will employ people on an 18 month contract, and by May need to notify them that their contract will end 30 June, and because the [mid-point funding] evaluation will occur around the financial year, I expect the results to be available in August in which case, we would have lost our entire team (Participant 3)

vi) The challenge of communicating change in health outcomes

Participants commented that health promotion work is difficult to see an impact on health outcomes in the short-term. Behaviours take time to change and further time is then needed before this shows an impact on health outcomes. In comparison, clinical work was seen as providing more immediate impacts on health and, for some participants, was therefore more rewarding.

> You see the outcomes straight away. Go to the doctor, get what you need. Whereas… we don't have a product really to give to people. ... It's stuff that takes time to see a result from. (Participant 11)

Staff noted that there was no process for reporting changes in health behaviours such as skills, knowledge, values, practice and attitudes, either to the organisation or in national reporting requirements. While some long-term measures are recorded in the nKPIs, the ability to follow the impact of health promotion work is affected by limited time, funding and short turnaround of reporting at the end of project cycles. Staff recognised that both internal and external decision-makers were not getting the whole picture of the impact that health promotion practice is having in the long term.

DISCUSSION

This study aimed to explore how health promotion practice is being captured, and to identify the challenges ACCHS staff face in articulating the effectiveness of health promotion practice to decision-makers. The study found that ACCHS are focused on improving health in their communities using both individual and population health approaches. This was reflected in both the guiding documents and interviews with staff. There were inconsistencies with the types of health promotion practice this ACCHS sees itself responsible for, evidenced in the guiding documents, and the work they report to decision-makers via the national and organisational key performance indicators.

The nKPIs, while useful to provide consistency across ACCHSs in Australia, contribute to a narrow view of health promotion focusing on individual activities: risk assessment, screening and immunisation. By including measures that target social, political and economic structures, population activities can be captured that have been shown to reduce vulnerability to unhealthy living conditions (12). Population-based key

performance indicators would not only capture health promotion efforts affecting the social determinants of health but, as shown by Percival and colleagues, can influence decision-makers' view of health promotion success (25). Decision-makers' understanding of the broader scope of health promotion and how short-term gains can be measured may strengthen the support for health promotion and prevention work, particularly when scrutinised under reduced health promotion funding.

Continuous quality improvement tools and processes, such as One21Seventy (available from: http://www.menzies.edu.au/page/Resources/Health_Promotion_CQI_Tools/), have been developed to improve health promotion practice in ACCHS settings, resulting in an increased ability to record the breadth of health promotion activities (25). The accreditation standards used by this ACCHS focus on a narrow view of health promotion activity: community engagement and health information. However, if standards were adopted that focussed on the breadth of health promotion practice, a structured process for the organisation to regularly monitor health promotion work would occur.

This is the first study to provide insight from an ACCHS of the challenges to capture and report health promotion practice. Very little has been documented about how ACCHS practise health promotion or the challenges they face (26). Highlighted in this study was practitioners' frustration that they were unable to provide short-term measures that were seen as contributing to long-term health outcomes. This frustration has also been reported by health promotion practitioners from a number of Victorian health agencies in a review of evaluation practices (17). In a work environment constrained by short-term accountability, measures that can capture short- and long-term health promotion efforts need to be identified to capture social, environmental and cultural influences on health. The adoption of these types of measures is needed to secure population level work in health promotion.

Without suitable measures, decision-makers are unable to know how health promotion efforts are contributing to improving health outcomes. Decision-makers value knowledge about their local area, knowing what has been successfully delivered in a similar setting with similar constraints to themselves (27). Defining what constitutes 'success' in the short term to impact on the determinants of health, as also found by Rowley and colleagues, requires local community and local practitioner involvement

(10). This point was also emphasised in these interviews, that reporting must be relevant to community for them to make informed decisions. Additionally, these interviews highlighted that staff thought community members needed more information on efforts addressing population health to understand the effectiveness of comprehensive primary health care delivered in their communities. Informed community participation in health decision-making is required to sustain effective, comprehensive primary health care (28).

We acknowledge that the study included only one ACCHS and a small number of staff. However, the staff represented a broad cross-section of the type of primary health care staff involved in health promotion activities, not just dedicated health promotion positions. By analysing organisational documents, we were able to validate their difficulties in reporting and capturing health promotion practice. The benefit of a case example such as this, is that it provided context and insight from the workforce on reporting constraints.

CONCLUSION

Population approaches addressing the social determinants of health is needed to improve health outcomes, particularly in disadvantaged populations. This study found that while ACCHS are focussed on delivering population and individual health promotion approaches, future decision-making is reliant only on individual measures. By defining population and individual measures, decision-makers, including community members, managers and external funding bodies, would have a clearer understanding of how health promotion approaches are contributing to address health outcomes.

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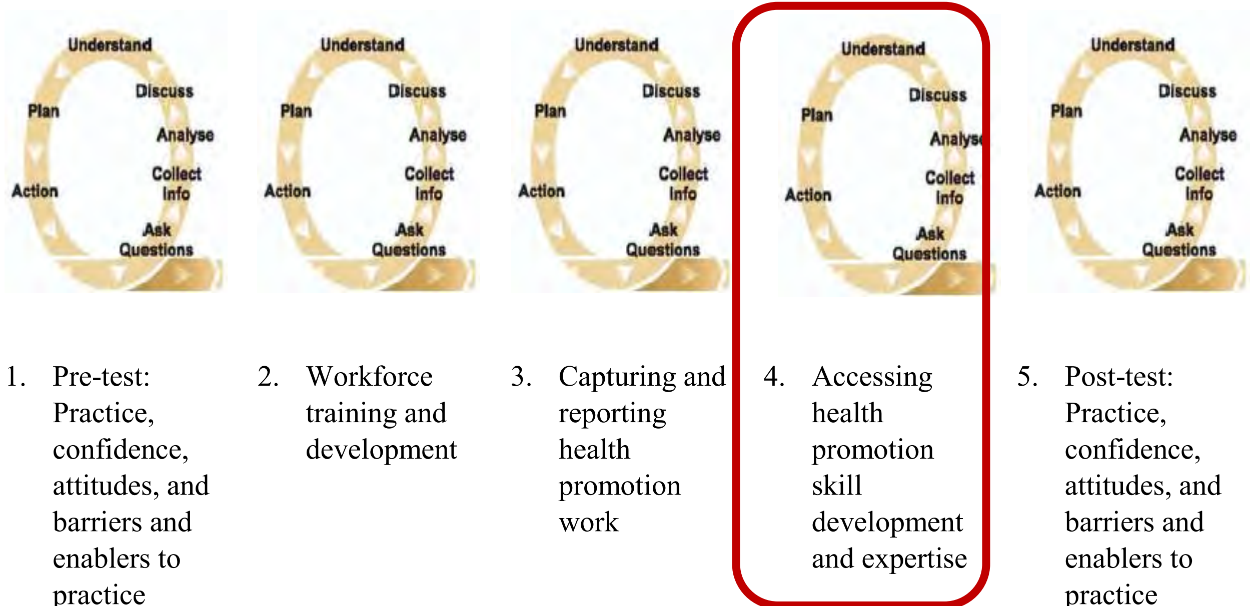
5.3 Chapter summary

This chapter identified the lack of scope provided to decision-makers on the effectiveness of health promotion practice in this ACCHS. There is a need for new measures to be developed and adopted in ACCHS to capture and support health promotion practice that targets population level change, rather than only monitoring individual health measures.

The next chapter further explores the organisational priority that was identified in chapter four. Specifically, how do primary health care staff access skill development and expertise to support health promotion practice?

Chapter 6. How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice



Participatory action research cycle[4]

6.1 Overview of the chapter

Chapter six describes how primary health care staff working in rural and remote areas access skill development and expertise from the health promotion field to support their practice. This chapter also addresses the organisational priority identified after the workforce training and mentoring was conducted with staff to increase their health promotion evaluation capacity (chapter four). The organisation recognised that in-kind support for health promotion training was often utilised and wanted to explore further how staff currently accessed skill development and advice to support their health promotion practice.

[4] Adapted from Judd J, Keleher H. Reorienting health services in the Northern Territory of Australia: a conceptual model for building health promotion capacity in the workforce. Global Health Promotion. 2013;20(2):55.

Staff at this ACCHS work across a large geographical area with many staff providing fly-in, fly-out primary health care to a number of remote and disadvantaged Aboriginal and Torres Strait Islander communities. This was a qualitative exploratory study (semi-structured-interviews, refer to Appendix J and K). The findings of this study highlight that the focus on health promotion and prevention approaches must be strengthened in order to improve health outcomes in rural and remote communities.

This paper has been accepted for publication. It is presented in the format required by the journal. The citation is:

McFarlane K, Judd J, Wapau H, Nichols N, Watt K, Devine S. **How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice.** Rural and Remote Health (in press).

6.2 Paper six - How primary health care staff working in rural and remote areas access skill development and expertise to support health promotion practice

ABSTRACT

Introduction: Health promotion is a key component of comprehensive primary health care. Many primary health care staff have a role to play in health promotion practice, but their ability to integrate health promotion into practice is influenced by their previous training and experience. For primary health care staff working in rural and remote locations, access to professional development can be limited by what is locally available and prohibitive in terms of cost for travel and accommodation. This study provides insight into how staff at a large north Queensland Aboriginal Community Controlled Health Service access skill development and health promotion expertise to support their work.

Methods: A qualitative exploratory study was conducted. Small group and individual semi-structured interviews were conducted with staff at Apunipima Cape York Health Council (n=9). A purposive sampling method was used to recruit participants from a number of primary health care teams that were more likely to be involved in health promotion work. Both on-the-ground staff and managers were interviewed. All participants were asked how they access skill development and expertise in health

promotion practice and what approaches they prefer for ongoing health promotion support. The interviews were transcribed verbatim and analysed thematically.

Results: All participants valued access to skill development, advice and support that would assist their health promotion practice. Skill development and expertise in health promotion was accessed from a variety of sources: conferences, workshops, mentoring or shared learning from internal and external colleagues, and access to online information and resources. Irrespective of where the advice came from, it needed to be applicable to work with Aboriginal and Torres Strait Islander remote communities.

Conclusions: To improve health outcomes in rural and remote communities the focus on health promotion and prevention approaches must be strengthened. Primary health care staff require ongoing access to health promotion skill development and expertise to increase their capacity to deliver comprehensive primary health care. Practice-based evidence from staff working in the field provides a greater understanding of how skill development and advice is accessed. Many of these strategies can be formalised through organisational plans and systems which, would ensure that a skilled health promotion workforce is sustained.

Introduction

More than ever health promotion and prevention approaches are needed to reduce the growing burden of chronic diseases. In 2011 chronic diseases were estimated to contribute to 90 per cent of all deaths in Australia (1). Approximately one-third of chronic diseases can be attributed to lifestyle factors such as tobacco smoking, risky alcohol use, physical inactivity, poor nutrition, and excess weight (2). Health promotion and prevention approaches play a key role in assisting individuals and communities to modify and address these risk factors and their underlying causes.

Over recent years, national policy documents have consistently stated the need for a greater focus on health promotion and illness prevention approaches (3). Yet at the same time, the capacity of health organisations to undertake health promotion and prevention activities has been significantly reduced (4). In 2012, the Queensland Government cut resources for health promotion services, removing most of the health promotion workforce and reducing funding for prevention approaches (5). At a national level, the Australian National Preventative Health Agency, responsible for leadership in evidence-based prevention practice was closed in 2014 (6). Australia's spending on

public health activities, which includes health promotion activities, has reduced from 2.2% (2008) to 1.4% (2014) of total health expenditure (1). These cuts have impacted on health promotion leadership and health organisations' ability to undertake health promotion activities.

In remote Cape York Aboriginal and Torres Strait Islander communities, the burden of chronic disease is disproportionately higher than other Queensland residents (7). Residents in Cape York are more likely to be overweight or obese, have higher rates of smoking and risky alcohol consumption and lower levels of physical activity compared to the Queensland average (8). Apunipima Cape York Health Council (Apunipima) is an Aboriginal Community Controlled Health Service (ACCHS) that provides comprehensive primary health care to remote communities in Cape York, Queensland. The focus on prevention approaches to improve health outcomes in Cape York has been central to the organisation's mission since its inception in 1994 (9). As with all ACCHS, they have a clear understanding of social, environmental and cultural influences on health (10). Even with limited funding, non-government organisations such as ACCHS are more likely to prioritise health promotion approaches with a focus on addressing the underlying determinants of health than Government organisations (11). Currently, Queensland ACCHS cannot rely on additional government funding for health promotion work.

Health promotion is core practice in many health professions; however, their training in health promotion differs, which can result in a limited awareness of the broad scope of health promotion practice (12). Staff at Apunipima are from a number of health disciplines which include Aboriginal and Torres Strait Islander health workers and health practitioners, general practitioners, midwives, audiologists, speech pathologists, physiotherapists, diabetes nurse educators, dieticians, nutritionists, health promotion officers and social and emotional well-being staff (9). In 2015 a workforce survey was conducted with Apunipima staff to measure current health promotion practice, the enablers and barriers to practice, staff confidence and attitude to health promotion practice in the primary health care setting, years of experience, and training completed in health promotion (13). Forty-two per cent (n=63) of staff responded. The majority of those surveyed are regularly involved in health promotion activities (84%); however, just over one-third of the staff surveyed had never completed any training in health promotion (37%). Those who had received training reported that it included workshops,

short courses or health promotion related content and subjects as part of their qualifications.

The importance of building health promotion workforce capacity through staff training and specialist support has been discussed in a number of studies (14-18). The aim of this study was both to explore how staff access skill development and expertise from the health promotion field, and to identify what support is preferred and practical in a work environment where staff deliver health promotion activities across a large geographical area to a number of remote and disadvantaged Aboriginal and Torres Strait Islander communities.

Methods

An exploratory, descriptive study was conducted in 2015-2016 with Apunipima staff, as part of a larger participatory action research project. An article describing how health promotion is practised in this ACCHS has previously been published (13). Small group and one-on-one semi-structured interviews were conducted. All staff were invited to participate through service-wide invitations using email and posters on the notice boards. Purposive sampling was used to target staff and managers of teams who were able to provide more detailed responses due to their known experience in health promotion projects. By seeking participants with a known interest in health promotion practice, deeper insights into their experiences would provide greater understanding of how support is accessed (19).

Staff interviewed were from the Health Promotion, Nutrition and Family Health teams. Managers and on-the-ground staff were interviewed separately (n=9). All staff interviewed had been involved in delivering health promotion activities for at least five years.

Open-ended questions included:

- How do you currently access health promotion expertise to assist the health promotion and prevention work you do?
- What types of support do you prefer and why?

In addition to these questions, managers were asked how they assisted their staff to access health promotion knowledge and expertise.

Participation was voluntary and all participants were provided with an information sheet and consent form. Interviews were digitally recorded and transcribed verbatim by the principal investigator. The transcripts were coded by reading and re-reading the participant interviews identifying the initial ideas and interesting features that emerged. The codes were then analysed identifying themes that directly related to the research questions. In this way, a deductive approach was adopted (20). Overarching and sub-themes were reviewed and refined to describe how primary health care staff working in a rural and remote area currently access and prefer to access skill development and health promotion expertise. Data were de-identified and stored according to National Health and Medical Research Council protocols (21).

Ethics approval

Ethics approval was granted from James Cook University Human Ethics Committee (HE5787). Research procedures reflected the six values of Aboriginal and Torres Strait Islander health research which are: reciprocity; respect; equality; responsibility; survival and protection; spirit and integrity (22).

Results

A number of themes emerged that described how the participants access health promotion skills and knowledge and ways that ongoing access could be embedded within their organisation. Expertise in the health promotion field was sourced in a variety of ways. In all cases, participants emphasised that knowledge and skills must be relevant and applicable to working in remote Aboriginal and Torres Strait Islander communities. Throughout these interviews, it was clear that participants valued health promotion advice and support. The study findings will be reported under six main themes:

1. Sources of accessing health promotion expertise
2. Work context
3. Internal and external relationships
4. Challenges for continued up-skilling
5. Limited funds for health promotion
6. Ways to facilitate ongoing support in the organisation

1. *Sources of accessing health promotion expertise*

There were a number of ways participants sought to update their skills and knowledge in health promotion practice:

- Attend conferences or workshops to update knowledge or skills in current practice
- Attend in-house training for skills to improve their health promotion practice or knowledge of health issues relevant to current work priorities
- Visit similar worksites by participating in a study tour to link with colleagues and observe how similar workplaces tackle similar issues
- Participate in mentoring programs when offered through the organisation, and through professional associations
- Contact external colleagues met through previous employment, conferences or professional associations
- Link with colleagues in the organisation who have skills or knowledge in the particular area of interest
- Participate and attend webinars
- Seek information, resources and journal articles online
- Subscribe to electronic mailing lists to receive latest developments in practice
- Join professional associations and through membership receive journal access.

2. *Work context*

In relation to professional development, participants looked for presenters who have experience working in the Aboriginal and Torres Strait Islander context. They were more attracted to attend training and conferences that promoted an Indigenous or a remote focus. All participants spoke about the unique context in which they work, and said that any advice and skill development needed to be relevant to the practicalities of working in the remote Indigenous context. As one staff member stated:

> I think [training is] definitely helpful to help us do what we need to do if it's presented in a way that's appropriate to the context that we

> work in. Because it's no good us going to something if it's targeted at city folk and we don't use that. So it's always really useful to have someone who knows where we are working. Where we are coming from. What our perspective is. What our issues are. The challenges that we face. How unique our work is. Because I think our work is not always well understood. And remote work isn't easily understood at all [P3].

Participants were more interested in learning from what works in similar Indigenous communities. Some participants mentioned they valued opportunities to visit similar worksites and meet with staff in an informal way to discuss common work issues. As one participant explained:

> I get the value from seeing similar programs to mine. And how that's worked and what they did to get through that challenge [P1].

3. *Internal and External relationships*

The majority of participants believed that it was part of their role and part of the organisation's role to foster shared learning. All participants recognised that they had expertise in understanding the Cape York work environment and could assist other staff to some extent in applying health promotion approaches in this environment. This was especially important for two reasons. Firstly, some participants identified that there are very few external experts who both understand the Cape York context and could provide advice in health promotion approaches. And secondly, staff have limited access to professional development locally. Supporting other staff when they could and sharing external contacts to extend relationships beyond one critical contact were seen as important.

Managers recognised that there is a lot of expertise in the organisation amongst current staff. However, they also acknowledged that staff may not have the time or extensive expertise in applying health promotion approaches. One manager spoke about the access her team had utilised from a health promotion research partnership between the university and Apunipima:

> I'm sure [other] people have that knowledge and expertise, but they don't have the time. But again, there's not that specific health

> promotion expertise, and that's a key component of the work that we do at Apunipima… having access to that expertise over the last 12 months, I think, has really helped the team [P6].

External relationships with other health professionals were seen as important to nurture and assist their practice. Previous work colleagues and peers met through professional networks at conferences and workshops were important to remain in contact with to access for advice. Types of advice sought related to health promotion approaches, knowledge of the health issue or work context and assistance in how to seek external funding. Participants mentioned that due to limited funds to source external expertise they often invited these contacts to provide continued advice by requesting their involvement on project steering committees.

Some participants were part of special interest or community of practice groups accessed through their membership of a professional association, such as the Australian Health Promotion Association, the Public Health Association of Australia or the Dietitians Association of Australia. They valued the regular opportunity to share and troubleshoot common issues via teleconference or videoconference with other peers.

One manager noted that Apunipima is a well-respected organisation that attracts collaborations with external experts and staff in the organisation were adept in ensuring this relationship was reciprocated:

> We do something for them. They offer support to us and comment on work [P8].

There were notable advantages of external colleagues providing mentoring or support to staff, but as one participant noted there can be disadvantages as well:

> The disadvantage is that they may not fully understand the environment that you're working with and the situations that you've faced, but it is a fresh set of eyes on the issues as well. Because an internal mentor may be too tied up in the same situation that you are to really provide good guidance… I think there is definitely some advantages of external mentors [P5].

4. Challenges for continued up-skilling

Participants liked attending training as a team as it provides everyone with the same information and allows the team to discuss how new approaches can be implemented in their practice. Staff are able to support each other with the new approach and this was important when staff may not spend a lot of time together. As one participant noted:

> They can phone to support each other, because you've bonded over a couple of days training [P2].

However, managers noted that team training can be difficult to organise as training needs can vary greatly due to team members' knowledge, expertise and experience, which can range from novice to very experienced.

Some participants noted that clinical roles are supported for ongoing up-skilling as part of their professional accreditation requirements, but nothing exists to support staff specifically in health promotion and prevention practice.

5. Limited funds for health promotion work

All participants commented on the impact of recent funding cuts to health promotion and prevention work. Some participants previously worked closely with the Department of Health, Queensland health promotion team based in Cairns. The impact participants noted was a reduced peer network that understands the north Queensland context, reduced access to local professional development, and reduced partnering opportunities on projects. Participants also commented on a lack of strategic direction at a state level in health promotion and prevention practice. However, an informal public health nutrition network shares information on prevention work across the state in response to the loss of government leadership:

> We've got an email group that's Queensland specific to get updates and to share things… How we communicate is quite different now [compared to 2012]… Although the structures aren't there like they used to be, generally we're pretty well connected with external people [in the field] [P4].

Though not explicitly stated, all participants were conscious of accessing skill development opportunities with minimal cost to the organisation. With limited funds,

participants provided examples of creative ways to ensure continued learning in health promotion. Examples included:

- Funding received to enhance staff capacity to supervise student placements had been used to fund professional development for the respective team;
- Professional development was included in a project funding submission to up-skill the team with the capacity required to best deliver the project;
- Staff take a lead on a particular approach or health issue and then provide support to others in the team; and
- Staff submitted abstracts to present their work at conferences and applied for conference scholarships to reduce attendance costs.

6. Ways to facilitate ongoing support in the organisation

Participants identified a number of ways to facilitate ongoing health promotion skill development within the organisation. All suggestions focused on formalising what is already happening. This included developing a strategic workforce plan for health promotion as part of a comprehensive primary health care approach. This plan would highlight staff professional development needs to achieve organisational outcomes. Participants noted that without line management support, a new approach is difficult to adopt. Having a focus on specific health promotion needs for the organisation through a workforce plan aligns management support and sustains the importance of continued health promotion skills and knowledge over time as staff turn over.

Participants in dedicated health promotion and prevention roles suggested formalising the support they already provide to other staff by clearly stating this role in their job descriptions. Managers, in particular, noted that some internal and external relationships utilised by staff for health promotion advice existed only because of personal relationships. Ongoing advice to the team or organisation could easily be lost if key staff members left. They suggested formalising, where possible, these internal and external relationships through joint work plans (internal) or memorandums of understanding (external), which already exist in some cases.

Senior staff in the organisation were important facilitators of the relationships with external partners and paired staff to work together in a mentoring or side-by-side learning style. Mentoring relationships were seen as positive, but needed to be

formalised so both parties had clear expectations of the relationship. A more equal relationship was required when staff were both in the organisation rather than one taking the 'expert'/mentor role. An example provided was a pairing between a fly-in fly-out worker and a health worker based in community:

> We were paired together and wanted to enter into something more formal, but the only structure we could find was a mentee/mentor not an equal partnership which is what we were. So we actually really struggled to find anything that was going to suit us that didn't create a power imbalance [P4].

Discussion

The aim of this study was to explore how primary health care staff working in rural and remote communities access skill development and expertise from the health promotion field and identify what types of support are preferred. Results from this exploratory study highlighted that the primary health care staff who work in rural and remote communities of Cape York value the access they have to health promotion expertise and believed it was important to enhance their work. Most importantly, that expertise needed to be applicable to work with Aboriginal and Torres Strait Islander remote communities. Skill development and health promotion expertise was accessed from a variety of sources. In the current funding environment, participants were acutely aware of utilising in-kind or low cost options. The creative ways participants accessed skill development and expertise through reciprocal relationships, encompassing professional development in project applications, and sharing skills and knowledge within the organisation, are important lessons. Without a reliance solely on funds, these strategies are more likely to be sustained, particularly when embedded in organisational workforce plans (23, 24).

Other studies have also found that embedding health promotion professional development within organisational structures, supported by senior staff and formalised in workforce plans, assists in prioritising the importance of health promotion work in the organisation (12). Senior staff need to be involved and understand the breadth of health promotion practice to enable organisational changes that will support the application of new skills and knowledge in the workplace (16). The combined process of increasing staff's knowledge and skills in health promotion and supporting this by

formalising the process through organisational structures has been shown to strengthen health promotion capacity in primary health care services working with Aboriginal and Torres Strait Islander communities (25). This study provides additional detail on the methods preferred by staff to increase their knowledge and skills in health promotion with suggestions on ways to formalise the process within the organisation. A number of studies that have focused on training health staff in health promotion also emphasise organisational support to not only embed the new learnings (14, 16, 17), but to also foster ongoing workforce learning in health promotion (15, 18).

Staff valued access to experts in the field of health promotion, as the complexities of health promotion practice needs to be understood when advising others. This is consistent with other findings that health promotion advice provided to a variety of health professionals needs to come from someone with expertise in health promotion (17). Not only was expertise in health promotion important, but also an understanding of the work context. Conferences, workshops and expert advice engaged staff only if it demonstrated an understanding of how that new knowledge or skill could be applied in remote Aboriginal and Torres Strait Islander communities.

Peer mentoring is recommended as a way of strengthening the Aboriginal health workforce (26). The current study highlighted the importance of mentoring models that adopt a side-by-side learning approach. This could be a health promotion officer working with a community-based health worker. Both bring skills and knowledge that can strengthen effective health promotion practice in the community setting.

While the findings of the study provide insight into how ACCHS staff access health promotion advice, the study is limited in its scope. A small group of staff participated in the interviews from one ACCHS. It is not surprising that all participants saw the value in accessing health promotion advice as those who were attracted to participate were more likely to have a greater interest in health promotion. However, the study does provide insight into how these staff who work in rural and remote communities, with limited access to funds, source health promotion advice and expertise. The participants' insights were solution-focused, offering ideas of how organisational structures can support ACCHS staff to build workforce capacity in health promotion. The findings from this small study provide practice-based evidence to guide future research into how

workforce support in health promotion could be enhanced for other staff working in rural and remote locations.

Conclusions

Building the health promotion capacity of primary health care staff working in rural and remote areas is important to reduce the burden of chronic disease experienced more profoundly in Aboriginal and Torres Strait Islander communities. An important factor in building health promotion capacity is ongoing workforce development. The findings of this study provide practice-based evidence on how primary health care staff working in rural and remote communities access skill development and expertise, and also how they utilise relationships with internal and external colleagues to garner ongoing support and advice. With the support of senior staff, many of the strategies to access advice can be formalised through workforce plans and organisational systems. Formal processes such as these ensure health promotion practice is prioritised, with managerial directives to support ongoing workforce development.

If the national policies emphasising a greater focus on health promotion and prevention are to be translated into practice (3), primary health care staff working in rural and remote areas must have access to skill development and expertise in health promotion practice. They are the frontline workforce in health promotion and prevention and their role is needed to drive improvements in Aboriginal and Torres Strait Islander health.

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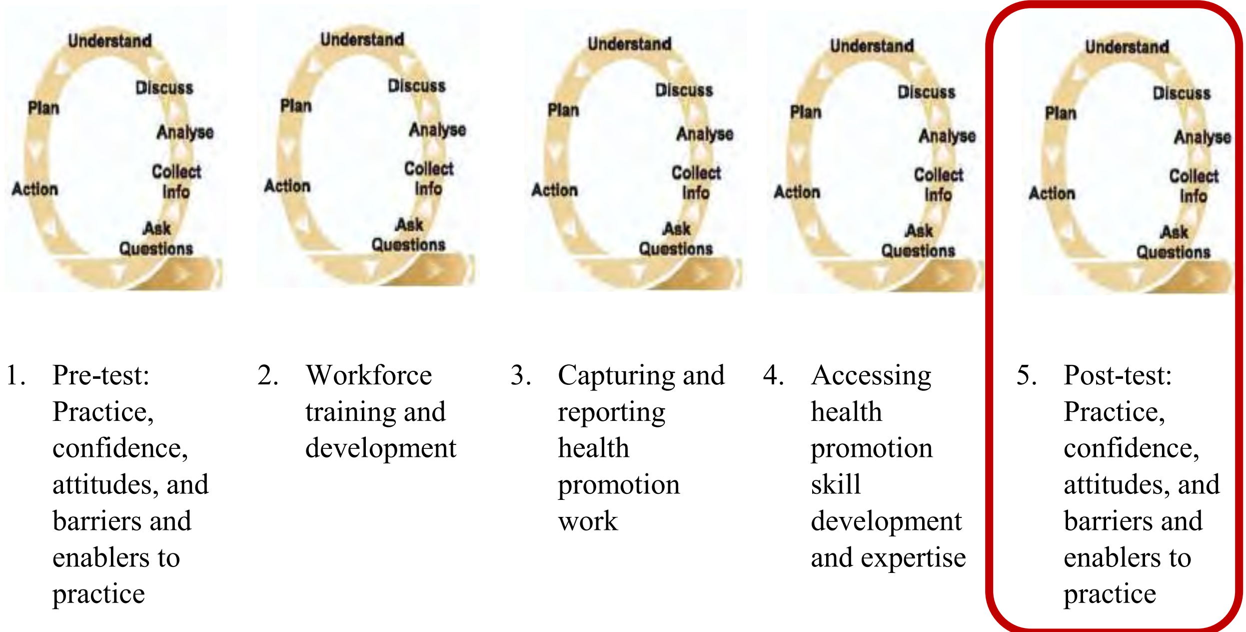
6.3 Chapter summary

This chapter identified a number of ways that staff currently access health promotion skill development and expertise. How staff access this support highlighted the creative ways that ACCHS engage in-kind expertise to support their learning and provide advice on their health promotion practice. As national health policies emphasise a greater focus on health promotion and prevention approaches in primary health care, the knowledge and skills of this workforce must continue to match contemporary practice. The findings from this study provide insight from practitioners working in remote areas to the challenges in accessing professional development for health promotion practice.

This was the last priority the organisation identified to explore in this research project. The next chapter describes the final PAR cycle which compares changes in the organisation over the duration of the research period.

Chapter 7. Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service



Participatory action research cycle[5]

7.1 Overview of the chapter

This final results chapter relates to the fifth PAR cycle and compares the changes to health promotion practice, staff and organisational confidence in their practice, perceived enablers and barriers to practice, and the attitude towards health promotion as part of primary health care, since the initial staff survey that was described in chapter three. The final (post-test) survey is attached in Appendix L. The workforce were active participants in this research process. Staff reviewed evidence and identified actions that could strengthen their health promotion practice. The priorities and actions identified by staff focused on workforce development, organisational changes and access to specialist support. These workforce insights provided a deeper understanding of organisational opportunities to strengthen practice.

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[5] Adapted from Judd J, Keleher H. Reorienting health services in the Northern Territory of Australia: a conceptual model for building health promotion capacity in the workforce. Global Health Promotion. 2013;20(2):55.

The following paper describes how Apunipima identified and increased their capacity to deliver health promotion through their active involvement in this research. This paper has been submitted to a peer-reviewed journal and is currently under review. It is presented in the format required by the journal. The citation is:

McFarlane K, Judd J, Devine S, Nichols N, Watt K. **Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service.** Global Health Promotion. (under review).

7.2 Paper seven - Using participatory action research to strengthen health promotion practice in an Indigenous primary health care service

Abstract: A health service's capacity to deliver health promotion is affected by a number of factors including organisational processes, health promotion skills and knowledge of the workforce, leadership in health promotion approaches, available resources and access to partnerships. As these factors constantly change, efforts to embed processes that support health promotion capacity ensure that change is minimised. This study at an Indigenous primary health care organisation, in northern Australia, describes their health promotion practice, perceived organisational enablers and barriers for implementing health promotion approaches, and changes in staff attitudes and confidence identified by this workforce. The researcher was based with the organisation for the duration of the research project and facilitated a participatory action research approach to identify ways to strengthen health promotion practice. Staff surveys were conducted in 2015 (n=63) and 2016 (n=48). In between surveys, staff identified priorities and actions that focused on workforce development, leadership, and organisational processes. Results indicated that having the researcher based at the organisation enhanced the organisational focus on health promotion practice. By working with the organisation to review evidence and involving staff in identifying

priorities to action, changes were noticed that improved staff's ability to practise health promotion. As a result of this organisational focus and engagement, staff were significantly more confident in the organisation's ability to lead health promotion practice in the region in 2016 compared to 2015. The involvement of the workforce in reviewing evidence and identifying actions provided a deeper understanding of organisational opportunities to strengthen practice. The participatory action research approach provided practice-based evidence of how health promotion can be strengthened in an Indigenous primary health care setting, a setting in which there is little published evidence.

Introduction

To deliver effective health promotion approaches an organisation needs more than just dedicated resources and health promotion staff (1). A number of factors impact on the capacity of an organisation to deliver health promotion. These include organisational processes, skills and knowledge of the workforce, available resources, access and ability to form partnerships, and leadership in health promotion (2). The enablers and barriers for an organisation to build capacity are influenced by management support, internal and external leadership, access to external health promotion expertise, skilled staff, access to partners, resource allocation and competing work priorities (3). Thus an organisation's capacity to deliver health promotion can be thought of as a system with any or all of these factors influencing the ability to deliver effective health promotion approaches. These individual factors can easily change over time and the way they interact with each other will either reduce or strengthen health promotion capacity within an organisation (4).

In Australia, health organisations' capacity to deliver health promotion has been hindered by a number of significant funding and resource cuts. Australia's spending on public health activities, which included health promotion activities, has reduced by a third between 2008 and 2014, from 2.2 per cent to 1.4 per cent (5). National leadership in health promotion and prevention approaches has been reduced by the closure of the Australian National Preventative Health Agency in 2014, which was responsible for guidance in evidence-based prevention and health promotion practice (6). Additionally, the National Partnership Agreement on Preventative Health ceased in 2014 (6). This partnership provided funds to the states to develop evidence of effective health promotion approaches to address lifestyle-related causes of chronic disease (7). At a state level in 2012, the Queensland Government removed the regional health promotion workforce which focused on reducing the burden of chronic disease and unintentional injury (8).

Apunipima Cape York Health Council (Apunipima) provides comprehensive primary health care to a population of approximately 7,000 residents dispersed across 11 remote communities in north Queensland, Australia (9). Comprehensive primary health care includes health promotion, treatment, early detection and management of ill health (10). Cape York has one of the most disadvantaged populations in Australia with the majority of the population identifying as Indigenous (9). In 2007, the burden of disease rate was 47 per cent higher for Indigenous Queenslanders living in remote areas compared to those living in major cities (11). Health promotion approaches as part of comprehensive primary health care are essential in reducing the modifiable risk factors that contribute significantly to this burden. Yet the national and state government changes have impacted on the health promotion capacity of this organisation. Leadership in evidence-based preventative approaches, available project funds, and the

ability to partner with the government-based health promotion workforce no longer exists.

To increase health promotion capacity in primary health care organisations, previous studies have focused on a combination of factors based on the health promotion capacity building framework (2). This combination has included workforce development such as staff training and mentoring and the creation of dedicated health promotion positions; organisational processes such as influencing quality improvement processes to include a greater focus on health promotion approaches; the adoption of health promotion planning and evaluation tools; and influencing organisational culture to build health promotion leadership within the organisation (12, 13). Accessing experienced health promotion practitioners to facilitate this process is an important factor in building health promotion capacity (12, 13).

There is little published evidence about the challenges Indigenous primary health care organisations face to build their health promotion capacity over time (3). To address this research gap, this study used a Participatory Action Research (PAR) approach to engage the Apunipima workforce to identify ways to strengthen health promotion capacity within the organisation. The researcher was based at the organisation for the duration of the research project. This paper describes health promotion practice, perceived organisational enablers and barriers to implement health promotion approaches and changes in staff attitudes and confidence in the delivery of health promotion practice over that time period.

Setting

Apunipima was established in 1994 and is the largest Aboriginal Community Controlled Health Organisation in Queensland (14). Apunipima employs approximately

150 staff. Staff are a mixture of community-based and visiting staff who provide care through fly-in, fly-out and drive-in, drive-out service provision. Just over half the staff identify as Aboriginal or Torres Strait Islander. The workforce includes Aboriginal and Torres Strait Islander health workers and health practitioners, general practitioners, midwives, audiologists, diabetes nurse educators, dieticians, nutritionists, health promotion officers, social and emotional well-being and corporate support staff.

Methods

Overview of approach

The PAR approach is a process of reflection, data collection and action in which the researcher and participants are collectively involved (15). In the workplace setting, PAR is a process of systematic inquiry in which those who are involved in the area of interest participate with the researcher in deciding the focus of knowledge generation, collecting and analysis of information, and taking action to address an issue (16). Intrinsic to PAR is a respect for the participants' knowledge and experience (17). By engaging participants in the process of inquiry the researcher acknowledges their understanding of the issues and develops trust and understanding of the research process (18).

Five participatory cycles were conducted in this study (Figure 7.1). The first cycle was a baseline assessment of how health promotion is practised in the organisation; attitudes about health promotion in a primary health care context; confidence to perform health promotion; and staff's perceived enablers and barriers to health promotion work. The final cycle repeated the baseline assessment to compare changes in the organisation over a 15 month period. Multiple data collection methods were used: surveys, interviews and document analysis. However, this paper will report on only the

comparison findings from the pre and post surveys conducted in the first and fifth cycles.

1. Pre-test: Practice, confidence, attitudes, and barriers and enablers to practice	2. Workforce training and development	3. Capturing and reporting health promotion work	4. Accessing health promotion skill development and expertise	5. Post-test: Practice, confidence, attitudes, and barriers and enablers to practice

Figure 7.1 Participatory action cycles

(adapted from Judd J, Keleher H. Reorienting health services in the Northern Territory of Australia: a conceptual model for building health promotion capacity in the workforce. Global Health Promotion. 2013;20(2):53-63.)

Data collection

A cross sectional survey was designed in partnership with the health service to confirm areas of investigation. The survey design has been described previously (19). All staff were encouraged to complete the anonymous survey via Survey Monkey (SurveyMonkey Inc., Palo Alto, CA, USA). The survey was open for six weeks in February-March 2015 and again in May-June 2016. Staff were invited to participate via email and reminders were posted on notice boards, presentations at staff meetings, and in person from key staff members at Apunipima.

The 20 item survey explored the types and frequency of health promotion activities that staff were involved in delivering; staff's confidence in health promotion practice; perceived strengths of the organisation in health promotion practice; perceived enablers and barriers to practice; the importance of health promotion in primary health care; and staff details such as years of experience, work team and role in the organisation. The 2016 survey also explored what changes staff noticed over the previous year in health promotion practice and if they had worked directly with the researcher, what influence this had on their work practice.

A combination of closed and open-ended questions and Likert scales were used to gather the quantitative and qualitative data. Health promotion practice was categorised on a continuum that described individual activities such as screening, immunisation, health information, education and skill development, through to population approaches such as community engagement, social marketing, and influencing the social and physical environments that support health through advocacy, economic and regulatory activities (20). Participants rated their level of confidence to perform the health promotion core competencies as defined by the Australian Health Promotion Association (ratings ranged from 1 – not at all confident to 5 – very confident) and how confident they perceived the organisation was at performing these same competencies (ratings ranged from 1 – does not do this well to 5 – does this really well) (21). Open-ended questions were used to explore the perceived enablers and barriers to health promotion practice, allowing participants to provide detail of their experiences. Survey respondents' health promotion attitudes were assessed by rating agreement to a number of statements on the role of health promotion in primary health care (5 point Likert; Strongly Disagree to Strongly Agree). Participants reflected on the influence of the researcher's role in the organisation using open-ended questions.

Data analysis

Numerical data were described using frequency counts, mean values and standard deviations. Quantitative data were analysed using SPSS version 23 (SPSS Inc., Chicago, IL, USA). Paired sample t-tests were used to compare mean scores for confidence of staff with mean scores for confidence in the organisation to perform the health promotion competencies for each year separately. Independent sample t-test were used to compare mean confidence in staff on each health promotion competency from pre (2015) to post (2016), then mean confidence in organisation from pre to post. Open-ended responses were analysed manually using an inductive approach to theme responses (22). From the responses, codes were initially identified and collated into themes. The themes were reviewed and refined to describe staff perceptions of the role of health promotion in the organisation, enablers and barriers to practice, and the changes staff observed over the past 12 months in health promotion practice. A summary of the findings was shared with staff in the organisation to consider other logical possibilities and ensure interpretation was accurate.

Ethical clearance

The study received ethical clearance from the James Cook University Human Ethics Committee (HE5787). Research protocols were consistent with the values of Aboriginal and Torres Strait Islander health research: reciprocity; respect; equality; responsibility; survival and protection; spirit and integrity (23).

Results

Sixty-three staff (42% response rate) completed the survey in 2015 and 48 staff (31% response rate) completed the survey in 2016.There was a twenty-seven per cent staff turnover between the two surveys (24). The survey was intentionally anonymous so it

was not possible to determine the overlap in response between the pre and post survey. The total number of staff increased by 15 per cent between the two surveys, however the types of positions at the organisation remained consistent (24).

Health promotion practice

There was no significant difference in the frequency and type of health promotion activities participants were involved in between the two time periods ($p>.05$). In both years practice occurred across the continuum of individual and population health approaches. At both time periods, most participants were involved in providing health information and social marketing activities, and were least involved in immunisation, economic and regulatory activities.

In both surveys participants thought it was very important for the organisation to deliver health promotion activities across the continuum, with 90 per cent or above rating each activity as important for the organisation's involvement.

Health promotion competencies

For confidence of staff to perform the health promotion competencies, ratings ranged from 1 (not at all confident) to 5 (very confident). For confidence in the organisation, ratings ranged from 1 (does not do this well) to 5 (does this really well).

Table 7.1 Staff confidence to perform health promotion competencies and their perceived confidence in the organisation to perform same competencies.

Health promotion competencies	Pre (2015) (*n*=63)		Post (2016) (*n*=48)	
	Confidence of staff Mean score (±s.d.)	**Confidence in organisation Mean score (±s.d.)**	**Confidence of staff Mean score (±s.d.)**	**Confidence in organisation Mean score (±s.d.)**
Assessing and understanding the needs of the community	3.77 (1.07)	3.70 (0.97)	3.82 (1.01)	3.67 (1.24)
Planning a health promotion program	3.95 (1.01)	3.56 (1.07)	4.06 (1.10)	3.89 (0.93)
Using evidence-based strategies in health promotion programs	3.73 (1.12)	3.48 (1.07)	4.06 (1.07)	4.00 (0.92)
Evaluating health promotion programs	3.65 (1.11)	3.00 (1.25)**	4.00 (1.01)	3.58 (1.20)
Working in partnership with the community to plan and implement a program	4.36 (0.76)	3.66 (1.08)**	3.97 (0.98)Ϯ	3.91 (1.12)
Working in partnership with other key organisations in planning a health promotion program	4.45 (0.75)	3.60 (0.99)**	4.08 (0.84)Ϯ	3.94 (0.92)
Giving presentations and facilitating meetings	3.89 (1.18)	3.88 (1.09)	3.97 (0.90)	4.17 (0.70)
Writing program plans and completion reports	3.68 (1.22)	3.22 (1.03)	3.78 (1.04)	3.78 (1.02)
Explaining to others what health promotion is	3.98 (1.11)	3.37 (1.18)**	4.10 (1.17)	3.75 (1.00)

**indicates differences between self and organisation (*p<0.05, **p<0.01)

Ϯ indicates differences over time (pre and post) (p<0.05)

Participants rated their confidence to perform the health promotion competencies (1: not at all confident; 5: very confident), and their confidence in the organisation to perform those same competencies (1: does not do this well to 5: does this really well). Mean scores in 2015 (pre) and 2016 (post) for staff and the organisation are captured in Table 7.1. In 2015, mean scores for staff confidence were significantly higher than mean scores for organisation on the following competencies: evaluating projects ($t=2.98$; $df=40$; $p<0.01$), working with community ($t=3.93$; $df=44$; $p<0.01$), planning projects with stakeholders ($t=4.70$; $df=44$; $p<0.01$) and explaining health promotion to others ($t=2.64$; $df=44$; $p<0.01$). There were no significant differences between self-confidence ratings and organisational ratings in 2016.

When confidence scores over time were compared, staff were significantly more confident to work with communities ($t=2.19$; $df=82$; $p<0.05$) and other organisations ($t=2.27$; $df=83$; $p<0.05$) in 2015 than they were in 2016. No significant differences in confidence in organisation were observed over time on any of the individual competencies.

Finally, a total combined competency score was computed (Cronbach's alpha =0.91). On this total score, staff confidence in the organisation was significantly greater in 2016 compared to 2015 ($t=-2.34$; $df=89$; $p<0.05$). Staff confidence in themselves did not change significantly from pre to post.

Perceptions of the importance of health promotion

Health promotion was rated positively as a core role in primary health care in both years. The statement, "Health promotion is necessary to improve health in our communities", was rated significantly higher in 2016 compared to 2015 ($t=-2.12$; $df=64$; $p<0.05$).

Participant responses to the open-ended question on why it is important for Apunipima to lead health promotion activities in Cape York differed between years. In both years, staff commented that it was important for Apunipima to lead health promotion in the region. However, responses to this question in the 2015 survey discussed what staff would like the organisation to be doing and challenges of why it was difficult for the organisation to lead health promotion, such as needing dedicated staff to lead and maintain collaborative partnerships. Comments included:

> If we are to truly deliver comprehensive primary health care, leading this work [health promotion practice] is extremely important.
>
> We cannot close the gap unless there is targeted action to stop the cycle of chronic disease. Apunipima should be taking the lead [in health promotion] but in partnership with the community and other services.

The responses to this question in the 2016 survey did not mention the challenges for being a lead organisation in health promotion practice. Participants commented that the organisation is well positioned to lead health promotion programs compared to other organisations working in Cape York. Similar to the 2015 responses, participants discussed what the organisation should be doing to lead health promotion but the 2016 responses implied a greater optimism to achieve this.

> We are leading the way in health.
>
> Apunipima should be very active in health promotion because of our presence in community, relationships with community and key stakeholders. [We] are in a position where we could have a very significant impact.

Enablers and barriers to health promotion practice

Participant perceptions of the enablers and barriers to health promotion practice were similar in both years. These comments illustrated that enablers for health promotion practice included having a dedicated health promotion workforce; organisational support and strong leadership within the organisation; access to resources; and engaged communities to work with.

The barriers external to the organisation included the challenges of working effectively across a large geographical area; challenges in the community that influence healthy behaviours and access to health services; lack of leadership at a state and national level; and unstable resources to plan and sustain health promotion work. Barriers identified internally included a small number of dedicated health promotion staff; competing clinical priorities; a lack of understanding of the scope of health promotion work; and as one participant noted:

> [Staff can spend] too much time doing feel good rather than necessary health promotion work.

Changes and outcomes noticed by staff

Respondents stated that there was an increased awareness of health promotion practice over the past 12 months with comments such as:

> There is more focus and awareness on prevention.

Examples of the types of organisational processes respondents recognised had changed in the last 12 months included updated project planning templates and registers to capture health promotion activities. Guiding documents were being developed that articulated a greater focus on population approaches in health promotion. There were greater opportunities for health promotion training in the organisation, more projects

were being evaluated, and staff were collaborating on health promotion projects. The organisation was also successful in attracting external project funds for a specific health promotion project which would provide additional staff and resources.

A number of respondents provided examples in the open-ended questions of the types of support they received from the researcher over the last 12 months. Examples were: project evaluation support, mentoring health promotion staff, providing advice, assistance to plan project work and prepare grant applications, being available to sit in on planning meetings, and reviewing documents such as templates to capture and monitor health promotion work.

The impact of this support noted by staff related to organisational changes and available support provided to staff. Organisational changes included a greater focus on health promotion project planning and evaluation and influencing the culture of health promotion in the organisation. As one response stated:

> It has made it very clear to the organisation that prevention is important and it's integrated and embedded into the [primary health care] strategy.

Discussion

This study described changes experienced in an Indigenous primary health care organisation after participating in a PAR process focused on strengthening health promotion practice within the organisation. Strengthening health promotion practice involved a number of strategies focused on workforce development, organisational changes and access to specialist support. Over this period, staff confidence in the organisation's ability to deliver health promotion significantly increased.

Organisational support for health promotion practice is an important enabler for building health promotion capacity (2, 3). This study found that staff's perception of the organisation's ability to deliver health promotion changed. Their confidence in the organisation's ability to effectively perform all health promotion competencies significantly increased. While many studies have focused on increasing staffs confidence to perform health promotion competencies (25-27), little has been written about the impact of increased workforce confidence in an organisation's capacity and ability to practise health promotion.

As comprehensive primary health care involves health promotion and clinical care, health promotion practice is often seen as a competing priority to clinical care (3), and this was consistent in the findings. Staff's positive attitude to health promotion's role in primary health care significantly increased. This was reassuring, as comprehensive primary health care must include a strong focus on health promotion, and staff attitude to its role in primary health care can influence the emphasis it is given in practice (28).

Staff deliver individual and population-based health promotion activities, and the types of activities did not change over the time period with most staff involved in health information and social marketing activities. The organisation was viewed by staff as influential within the region with the capacity to advocate for the remote Indigenous communities it services. In both years, staff believed the organisation had a responsibility to lead health promotion practice in the region, and in the second year staff statements changed from what they should be doing to statements that reflected a belief that they are leaders in the region. While there is a current lack of state and national leadership in health promotion and prevention practice (6, 8), it is especially important that local organisations can identify themselves as leaders in the region to address this gap.

Involving practitioners in the research process assisted both the researcher's and the practitioners' understanding of the context in which health promotion practice can be strengthened (29). By using a PAR approach, there was a systematic structure that encouraged ownership of the research by the organisation, demonstrated equality between the researcher and participants, and showed respect for the contribution of knowledge and understanding of the participants consistent with the values for research conduct with Aboriginal and Torres Strait Islander participants (23).

A key characteristic of this study was the positioning of the researcher within the organisation. Strengthening health promotion capacity was a key priority for the organisation, and plans to support the health promotion team to build their health promotion capacity were in development. Having access to an experienced health promotion specialist with a dedicated research focus on exploring how health promotion practice could be strengthened across the organisation assisted in expanding and maintaining a health promotion capacity building focus over a longer time period. Access to external health promotion expertise to facilitate a PAR approach has been effective to reorient the way health promotion is practised in primary health care organisations (12). In this study, the researcher was embedded in the organisation to facilitate the research process, provide continued access to health promotion advice, and ensure involvement of staff in reviewing evidence and setting priorities for action. This contributed to an increased profile of health promotion over an extended period of time, which was likely to influence staff confidence in the organisation, and to health promotion practice within the primary health care organisation.

Although all work areas were represented in both surveys, not all staff participated and selection bias may be present. That is, staff more interested in health promotion practice may have been more likely to participate in the surveys and the survey responses may

not be an accurate reflection of how all staff practise and view health promotion in the organisation. While there was staff turnover between surveys, the roles and responsibilities remained consistent. However, it is possible that the knowledge and skills of new staff may be different to those initially surveyed. Different participants in each of the surveys has implications for the comparisons made between the two years. Ideally, it would have been useful to follow individual participant responses for both surveys and compare changes in those staff over time. However, this was not possible because the organisation did not wish staff to be identified or potentially identifiable within the research process. In addition, in view of the staff turnover within this organisation, it is likely that at least some participants would have been lost to follow, which would have impacted on detection of an effect over time. By comparing the overall participant responses, the findings identified organisational changes that contributed to an increase in staff confidence in the organisation's ability to practice health promotion, and this was supported by the participant responses.

Self-confidence to work in partnership with others on health promotion projects decreased in the second survey. However, when this was explored further with staff, it was noted that the completion of some projects after the first survey reduced staff opportunities to work with others. This may have influenced the decrease in self-confidence, particularly as overall organisational confidence increased between the years. The survey asked participants that had worked with the researcher, what impact that support had on their practice. As staff knew responses would be read by the researcher, response bias is likely to be present and comments need to be considered within that context.

PAR approaches are effective in developing practice-based evidence in complex public health settings such as Indigenous health, as the involvement of the workforce in

reviewing evidence and identifying actions provides a deeper understanding of organisational opportunities to strengthen practice than an external researcher can achieve on their own (30). This understanding and translation of evidence into practice by the workforce will result in actions that are more likely to be sustained (16). The organisation is currently identifying ways in which the findings of this research project can continue to strengthen health promotion practice. Future follow-up with the organisation would be useful to assess how identified organisational changes have impacted on health promotion practice over a longer time period.

Conclusion

Health promotion and prevention approaches are essential to reduce the higher levels of chronic disease experienced in remote Aboriginal and Torres Strait Islander communities. An organisation's capacity to deliver health promotion can be strengthened through its active involvement in research. The PAR process provided practice-based evidence on what influences an organisation's capacity to deliver health promotion, and identified appropriate actions to strengthen health promotion practice. The findings from this study add to the currently limited evidence base on how health promotion capacity can be strengthened in Indigenous primary health care settings.

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7.3 Chapter summary

Chapter seven demonstrates how the PAR approach can effectively engage the workforce in identifying and strengthening health promotion practice in an Indigenous primary health care setting. The involvement of the workforce in reviewing evidence and identifying actions provided a deeper understanding of organisational opportunities to strengthen practice. This practice-based insight from the workforce provides evidence of how health promotion capacity can be increased, in a setting where there is very little published evidence.

The next and final chapter in this thesis summarises the principal findings, highlights the strengths of this research and discusses the research limitations. Implications and recommendations are made for future research, policy and primary health care practice.

Chapter 8. Discussion and Conclusion

8.1 Overview of the chapter

This final chapter reflects on the aim and objectives of the study, summarises the principal findings and highlights the strengths and lessons learned from this research. Implications for future research, policy and primary health care practice are discussed, concluding with a number of recommendations.

This mixed methods research explored how health promotion was practised and strengthened in an ACCHS. In doing so, the research provided insight on the enablers and barriers for health promotion practice faced by this ACCHS. By sharing the findings in seven peer-reviewed articles, this research contributes considerably to the gap in the literature for evidence on how health promotion is practised in Aboriginal health organisations. Through the process of PAR, workforce insights provided practice-based evidence on how health promotion capacity can be increased in ACCHS. In a setting where there is little published evidence, these practice-based insights provide a deeper understanding of how health promotion is practised and identify tangible ways health promotion practice can be strengthened in an ACCHS.

Five PAR cycles were conducted in this research:

- Cycle one identified and explored staff practice, attitudes, confidence, and perceived enablers and barriers to implement health promotion approaches in their workplace;
- Cycle two identified ways to build health promotion evaluation capacity;
- Cycle three explored how health promotion practice is captured through reporting mechanisms and identified the challenges practitioner's face in articulating the effectiveness of health promotion practice to decision-makers;
- Cycle four explored how staff currently access skill development and expertise in health promotion and identified what support is preferred in a work environment where staff deliver health promotion activities across a large geographical area to a number of remote and disadvantaged Aboriginal and Torres Strait Islander communities; and

- Cycle five compared health promotion practice, perceived organisational enablers and barriers to implement health promotion approaches, and confidence in health promotion practice to the findings approximately one-year previously in cycle one.

8.2 Health promotion practice in ACCHS

This is the first known research to capture how health promotion is practised in an ACCHS. By assessing practice against the framework for health promotion action (Figure 1.2) (1), this research provided a detailed understanding of the type of health promotion work staff most frequently are involved in. The framework was also used to map the types of health promotion activities that are reported and stated in guiding documents. By assessing how health promotion is practised, and documented against the framework, the research identified that some health promotion work is invisible to internal and external decision-makers. This research provided an opportunity to increase awareness and visibility of the scope of health promotion work that was actually occurring in the organisation. From this awareness, the organisation has identified ways that the contribution of health promotion approaches targeting individual and population change can be captured, reported and communicated to better inform decision-makers of the prevention work Apunipima is doing to improve health outcomes.

8.3 Engagement with community

Community controlled facilities, such as Apunipima, improve access to health care and health literacy, employ local people and empower community and individual capacity to engage and be involved in health decision-making (2). Building the capacity and empowering community in health decisions at an individual and at a community or population level improves health outcomes (3). Engaging the community in health programs and decision-making was a common theme identified in all PAR cycles. Community involvement in health decision-making was an important part of practice. In cycle three, staff identified their role as empowering community and individuals in health decision-making to improve health outcomes for now and for future generations. Community members need to be provided with information on individual indicators,

such as number of people who smoke, but also how health programs are improving health at a community or population level; for example, improvements to the social, cultural and environmental influences that contribute to why an individual smokes.

Outcomes of health promotion programs conducted in communities need to be evaluated and the findings shared with community members to inform future projects. Staff require the skills and supporting organisational systems, such as project planning and reporting templates, to evaluate their programs and to communicate their findings in ways that are understood by community members.

In cycle four, staff identified the types of skill development they preferred to access to support their health promotion practice. Staff valued content and advice that was transferable to working in a remote Indigenous setting. Advice to improve health promotion practice needs to consider the limited services and resources available in these settings, and how the target audience can be engaged in the approach.

8.4 Developing skills and knowledge in health promotion

The organisation identified that previous health promotion projects were often only evaluated to the requirements of the funding body (cycle two). These requirements focus on process measures, such as the types of activities conducted and the number of participants reached. Health promotion staff were not capturing the impacts of their programs such as changes in health behaviour, levels of knowledge and broader health environmental changes that occurred. They believed this was important for other staff in the organisation to know what works, and to expand understanding from activities just focusing on individuals to activities that support population level change.

Workforce training and mentoring was provided in cycle two to increase staff skills and knowledge to evaluate health promotion practice and to share their evaluation findings with others. The mentors assisted staff to apply the content covered in the training into their practice. To support new practice, organisational templates were developed and updated to capture process, impact and outcome measures of the health promotion programs. The mentors and the training facilitators had existing relationships with the organisation, such as other research roles, and their support to these staff was provided in-kind. Recognising that workforce support often relies on existing staff relationships,

a further priority was identified to explore how staff currently access skill development and expertise in health promotion to identify ways the organisation could strengthen workforce support for staff (cycle four).

Increasing staff capacity to evaluate their health promotion work enabled staff to share their findings with other colleagues, community members and peers through staff presentations, national conferences and in peer-reviewed journals. Sharing findings in health promotion practice is particularly important to inform policy-makers, decision-makers and other practitioners to understand what works or does not work and identify learnings to support future practice. It is crucial to increase publications about health promotion findings in peer-reviewed journals. A review of articles published in health promotion journals from 1996 to 2007 found that less than seven per cent of articles related to evaluation findings (4). Another way of disseminating findings is through the use of peer-reviewed blogs. Blogs such as Croaky (5) and the Conversation (6) are a way of communicating easily with other researchers, policy-makers, decision-makers and other practitioners in an interactive format (7). By disseminating findings in peer-reviewed journals or blogs, a wider audience is reached. Published health promotion program evaluations inform decision-makers and others working in similar areas of what works to improve health outcomes. To do this staff require the skills and capacity to communicate their findings with others.

In a recent study of characteristics that influence health promotion evaluation practice in Australia, a number of themes were identified consistent with those faced by this organisation. These characteristics included: funding constraints which reduce the ability to measure the longer term impacts of programs; varying workforce skill levels to evaluate health promotion programs; access to published program evaluations to provide guidance; and minimal reporting requirements that were not adequate for a comprehensive evaluation of the program (8). The current program of research conducted at Apunipima provides a case example of how health promotion workforce capacity can be increased under the same constraints, utilising existing and in-kind resources.

8.5 Leadership in health promotion

Over recent years there has been a lack of state and national leadership in health promotion and prevention practice (9, 10). The findings from this research show that leadership at a local level can influence an organisation's health promotion practice. Staff believed that the organisation was a leader in health promotion practice in the Cape York region and staff confidence in the organisation's ability to practise health promotion increased over the course of the research.

Leadership within this organisation was an enabler for health promotion practice. Experienced public health staff in the organisation were identified as being integral in shaping the way health promotion was practised in primary health care delivery. These staff members facilitated access to networks of external expertise that could assist staff and the organisation. If these staff members left the organisation, staff who replaced them would not necessarily have these skills based on the role descriptions of these positions. In this research project, the organisation was able to identify ways this expertise could be embedded in organisational systems and structures. This included detailing health promotion activities within work area plans and included in these plans were workforce training to ensure staff had the health promotion skills and support required.

8.6 Changes in workforce and organisational practice

There were a number of changes to health promotion workforce practice at Apunipima as a direct consequence of this research project. In summary, these included:

- an increase in skilled staff able to complete health promotion project evaluations;
- updated project planning and evaluation templates that captured process, impact and outcome measures and provided a consistent approach to project management;
- an increase in sharing health promotion project outcomes with staff, communities and with peers at national conferences;
- an increase in staff capacity to document work and disseminate findings in peer-reviewed journals;

- the development of new strategic documents for chronic conditions and family health with subsequent action plans detailing work across all areas of the health promotion framework (1) including training requirements; and
- the development of new organisational performance indicators to capture the impact of health promotion practice.

8.7 Strengths of the research

Recent research in Australia has explored how health promotion can be strengthened in primary health care settings. Since 2013, a number of studies have looked at workforce training and/or changes in organisational systems to support health promotion practice (11-14). The findings from these studies have highlighted the importance of building health promotion capacity within the organisation to improve how health promotion practice can be delivered from the primary health care setting. Consistent with this previous research, the findings presented in this PhD also highlight the importance of understanding the primary health care setting, in this case the ACCHS setting, to strengthen health promotion practice. This research adds important insights about how health promotion is practised in ACCHS, and how health promotion practice continued in this setting at a time of reduced investment and a lack of external leadership.

Unique study

Given the recent dramatic decrease in health promotion investment, particularly in Queensland and South Australia (10), the timing of this research was ideal. The research provided valuable insights into how health promotion continues to be practised, detail on how capacity can be enhanced, and highlighted the risk to health promotion practice if decision-makers are not informed of health promotion effectiveness. This researcher had a clear motivation to document and contribute findings to strengthen health promotion to a wider audience. The knowledge and past learnings from the impact of this dramatic loss in health promotion resources in Queensland has not been documented elsewhere. Past health promotion staff are not 'waiting in the wings' for health promotion investment to return. The impact on these staff is yet to be documented, but through conversations with past staff, most believe it will be many years, if not decades, before the size of the health promotion workforce is employed again in Queensland. Many past staff have retrained into other professions,

retired, changed careers or left the state to settle their families elsewhere. With a lack of attention to health promotion in Queensland, having a case example of health promotion practice from the largest ACCHS in Queensland provided valuable evidence of the resilience of health promotion in a resource-poor time period. This study also provided evidence of the value and commitment that ACCHS place on health promotion practice as part of comprehensive primary health care, particularly when the findings clearly showed that the scope of health promotion is not a funded requirement. As health promotion investment is unlikely to be increased in Queensland in the foreseeable future, this research identified how embedding health promotion work within an ACCHS allows this important work to continue.

This researcher had a unique opportunity to explore this area of interest as an outsider of the organisation, but with the opportunity to be based in the organisation, the researcher was also accepted within the organisation as an insider. This enabled an effective research partnership to form that examined the current health promotion practices occurring in the organisation. Having a researcher embedded in an ACCHS exploring organisational health promotion practice has not been reported in the literature previously. While 18 months can seem like a long time period to be working with an organisation in a voluntary researcher capacity, many staff, including the reference group members, discussed how the research focus could be maintained and recommended forming an ongoing advisory relationship with the researcher after the research project ceased. This suggestion highlights the positive relationship formed between the researcher and staff, and also demonstrates that organisational support required to continue to strengthen health promotion practice is not easily accessible elsewhere. The reality of providing ongoing support to the organisation in a voluntary capacity is not realistic in the long term.

The benefits of the PAR approach

This research was exploratory. To strengthen health promotion capacity in an ACCHS it was important to identify how health promotion was practised, and to understand the current opportunities to strengthen that practice. The PAR approach allowed this to occur. Staff identified the priorities that were explored. The actions to strengthen health promotion practice were based on knowledge of the current opportunities within the organisation. Each PAR cycle informed the subsequent PAR cycles. In this way, the

influences on health promotion practice were identified and explored further to advance understanding of how practice could be strengthened in an ACCHS setting. Previous research has used the PAR approach to inform how health promotion capacity can be strengthened in a primary health care setting (15). However, this current research is the first to apply this approach in an Indigenous primary health care setting.

Using PAR cycles provided practice-based evidence of how health promotion can be strengthened. Practice-based evidence as opposed to evidence-based practice, provides research findings that can be applied more readily to the real world context (16). The research is done within the workplace setting, rather than research being conducted in a controlled setting and then applied to the workplace. With the evidence generated from the workplace setting, practice-based evidence provided insights on what was achievable in the work environment (16). When research recommendations for health promotion practice are made without knowledge of the work context, the recommendations are often unable to be implemented as planned, which reduces the intended effect of those recommendations to improve health outcomes (17).

PAR was particularly beneficial in working in this Indigenous setting. The partnership approach of PAR allowed the ACCHS to participate in the research process rather than just being the subject of the study. Workforce insight was required to understand the health promotion context from the perspective of the practitioners, leading to a deeper understanding of how health promotion can be strengthened in this setting. By using PAR a culturally respectful research relationship was developed and maintained that demonstrated equality in the research process and resulted in findings that were of benefit to the organisation as well as a wider audience, for example other ACCHS.

Just the act of participating in the study heightened staff awareness of their health promotion practice. Reference group members provided anecdotal comments that they had noticed staff discussing and being more aware of the health promotion activities they were involved in, long after they had participated in the data collection during a PAR cycle. This reflective research process heightened staff awareness of health promotion within primary health care service delivery and extended the reflection process of the research beyond the structured PAR cycles.

The benefits of mixed methods

The mixed methods approach allowed the research to assess how health promotion is practised and to understand the context of that practice. Multiple data sources enabled triangulation of the findings, which increased the research credibility (18). These multiple data sources included the input from staff working in a variety of roles, and the collection of quantitative and qualitative data allowed validation and identified discrepancies in the findings.

For example, in cycle three, the interviews identified the staff belief that internal and external decision-makers were not aware of the breadth of health promotion activities staff delivered. The document analysis validated this finding that only health promotion activities targeting individuals were captured in reporting processes. The types of health promotion activities staff delivered were also captured in the baseline survey (cycle one), again validating the interview findings that more health promotion activities occurred than those reported.

The document analysis highlighted an inconsistency with the types of health promotion activities the organisation promotes in the guiding and strategic documents, and the lack of information provided to decision-makers on the breadth of health promotion work occurring in the organisation. How health promotion is discussed in the organisational documents along with the organisation's positive attitude towards health promotion practice in primary health care, assessed in cycle one, provided context of the work environment. The fact that only some health promotion activities are captured in reporting documents could be understood as an efficiency used to meet funding requirements, rather than an organisational lack of understanding of the scope of health promotion practice.

A mixed methods approach allowed the findings from multiple data sources, including other PAR cycles, to be combined to better understand the context of how health promotion is practised in this ACCHS.

8.8 Limitations of the research

Limitations of this research have been discussed in detail in each chapter. The main limitations are discussed below in summary.

This case study was chosen to represent a real world example in one ACCHS. As previously mentioned, there is limited published evidence on how health promotion is practised in this setting. By using a case study, the research offered new insights into how health promotion was practised and how it can be strengthened. A case study, while limited in its scope, was appropriate for the exploratory design of the research (19).

An organisation's ability to do health promotion work is influenced by workforce development, organisational development, resources, leadership and partnerships (20). These factors constantly change as staff, funding and organisational priorities change over time. This research identified how these factors influenced this organisation's health promotion capacity at the time of study. The research approach can be replicated, but other organisation's health promotion capacity will be different depending on their workforce, organisational structures, available resources, leadership and partnerships. Some of the priorities identified in this study may be similar, but staff in other ACCHS may identify different ways to strengthen health promotion practice based on their organisational context.

All work areas within the organisation were represented in the surveys, however not all staff participated in the surveys. Selection bias may be present, but was unavoidable. Staff more interested in the area of health promotion may have been more likely to complete the surveys (21). Staff with a greater interest in health promotion may be overly supportive or very critical of health promotion practice in the organisation. This in turn may have resulted in either an overestimate or underestimate (respectively) of the observed associations. Thus the survey results may not be an accurate reflection of all staff's experiences in the organisation. Every effort to encourage participation by all staff was made. Social desirability is another bias which may have been present in the survey responses and interviews (21). Staff knew that the organisation was being assessed on how health promotion was practiced and may have wanted to ensure the findings reflected positively on themselves and the organisation.

The surveys did not identify the office where staff were based. Given that approximately 20 per cent of staff are community based (22), it is not possible to know if staff responses differed based on their location.

To reduce response bias the researcher put posters up on staff notice boards, emailed all staff and attended team meetings, in person or via teleconference, to discuss the purpose of the research. Team leaders and key staff in all offices were recruited to remind and encourage staff to complete the surveys in work time. After the survey was completed, the findings were shared with all staff and discussed with key staff, allowing an opportunity for further comments to be made and to try to determine whether the findings accurately reflected health promotion practice in this organisation.

To assure anonymity, survey participants were not individually identified. This was recommended by the organisation to encourage staff participation in the surveys. However, while it may have increased the response rate, this approach prohibited comparisons of the same individual's practice and attitude towards health promotion over time. Instead, changes were assessed at the group level.

All staff were invited and encouraged to be involved in the research project. Each time a PAR cycle commenced, staff on the reference group reviewed what would be explored through the surveys, interview questions and document analysis. All staff were invited to facilitate the interviews and focus groups, and participate in the analysis of the findings. However, only three staff actively participated in data collection and analysis. Staff were sent summaries of the data findings after each PAR cycle for comment and to identify priorities to action. Those staff on the reference group provided the majority of feedback and were more actively involved in all stages of the PAR approach. While every effort was made to include a wide variety of staff in the analysis and understanding of the research findings, the reference group members who had a known interest in strengthening the health promotion capacity of the organisation were the dominant voice in this research project.

Hence, the findings of this research should be interpreted in the context of these limitations.

8.9 Challenges and lessons learned

During this research, a number of key learnings have been identified. These learnings are useful to note and guide future research in the area.

Allowing the time to work at the pace of the organisation was important. Being flexible in approaches and checking in regularly with key staff, through the reference group, aligned a common understanding of the priorities identified through the PAR cycles. This also allowed review of any priorities initially identified, to check that they remained a priority months later. In checking in regularly with the reference group the researcher and staff members were able to constantly monitor organisational changes that may provide new opportunities to address identified priorities or highlight where further action was needed to support actions already in place.

Building the capacity of others is important to sustain health promotion impacts over time (23). Often health promotion practitioners place themselves in the background and encourage others to take ownership of project deliverables and outcomes (24). This practitioner was working hard in the background to make these relationships work, ensuring tasks and milestones were being met. In health promotion programs a sign of success can be that the health promotion practitioner is seen as just one of a group of many that achieved the outcomes as planned and others gain credit for program success. This is detrimental to the profile of the health promotion workforce, and perhaps one reason why, in Queensland, staff were identified as 'not frontline service provision' (25). It was also a challenge in this research relationship. Documenting the effects of change in the organisation and contributing that change to the research process does not sit comfortably with health promotion practice. Taking ownership on the influence of the research process is important to build the health promotion evidence base, without overstating the research effect.

After the data collection period had ended, a number of staff reflected with the researcher on the change they had seen in the organisation and the change they had observed in other staff, as a direct result of involvement in this research. On reflection, it would have been useful to gather, through a structured process, staff's reflections on the project from a variety of staff with differing levels of involvement over the research period, to assess more formally the impact of the research on organisational practice.

Other research techniques could have been used to describe the changes in health promotion practice over time. For example, the researcher could have collected a series of narrative stories from various staff in the organisation exploring how they view health promotion practice in the organisation and exploring what health promotion

means to different staff roles. This narrative inquiry technique could provide a social and cultural context of how different staff view health promotion practice and responses would not be limited by structured survey questions (19).

The researcher was based in the organisation and observed how health promotion was viewed and practised. Diary notes captured the detail of what was occurring in the organisation. This detail was used to guide the research priorities and identify opportunities to influence organisational or workforce changes. However, the observational data, once analysed, could have been used as another way to describe health promotion changes over the research period.

8.10 Implications and recommendations

This research identifies a number of implications and future recommendations for research, policy and primary health care practice. These recommendations are either derived from or inspired by the findings presented in this thesis.

Implications for research

Documenting how an ACCHS practised health promotion and what influenced their health promotion practice provided new insights useful for other research focused on improving health outcomes in Aboriginal and Torres Strait Islander populations. With the higher rates of chronic disease experienced in Aboriginal and Torres Strait Islander populations, there needs to be an ongoing focus on increasing the evidence-base of how these rates can be reduced. This research provided an organisational context of how health promotion approaches were being delivered as well as providing an understanding of what influences health promotion practice in this ACCHS. By having an understanding of the ACCHS workplace setting, future health promotion research can apply this knowledge to tailor interventions suited to how health promotion is practised, to address the influences of organisational health promotion capacity and to target the gaps that can improve the effectiveness of health promotion approaches.

The changes made to workplace practice were identified as areas that could strengthen health promotion practice in this organisation. However, the effect of these changes has not been captured in this research project. In this organisation, it would be useful to

monitor over a longer time period the sustainable effects of the organisational changes made.

This research documented health promotion practice at a time when there were recent cuts to funding and a loss of external leadership in health promotion and prevention approaches. It would be useful to add further to the evidence about how health promotion practice can be strengthened in Aboriginal health organisations, particularly when the external environments have greater available resources, leadership and stronger direction in health promotion and prevention approaches.

Recommendations for research

1. Health promotion research in ACCHS should consider the organisational and workforce influences on health promotion practice and design research interventions that will enhance the strengths and address the barriers that will hinder effective practice.
2. Design future research projects that will assess, over a longer time period, how workplace changes impact health promotion practice.
3. Document health promotion practice in other Aboriginal health organisations and increase the evidence as to how health promotion can be strengthened using examples from multiple organisations. This will allow a deeper understanding of the commonalities and differences of how health promotion capacity can be increased in this setting.

Implications for policy

The research identified that health promotion work is occurring in this ACCHS, yet there were a number of barriers that could be addressed through stronger policy and leadership support. Policy change can influence the way in which health promotion is practised, target the barriers that hinder practice, and leverage the enablers to increase the health promotion capacity of organisations. Recent Australian policy documents state the need to increase investment in health promotion and prevention to reduce the burden of ill health (26). At the same time, Australia's investment has decreased in recent years, and is almost a third of what other similar OECD countries allocate to prevention and public health (27). Re-investing in health promotion at a state and national level is desperately needed to coordinate strategies and approaches required to

improve health outcomes. Increasing investment in parity with that of Canada and New Zealand would be consistent with current Australian Health Promotion Association's advocacy efforts (28).

The findings highlighted the lack of information that is being reported and requested by decision-makers in ACCHS. All ACCHS have 21 common national key performance indicators (nKPIs) which are reported to the Australian Government (29). At an organisational level Apunipima provides nKPI progress reports for each community in its region. These prescribed nKPIs do not effectively capture health promotion efforts. For local and national decision-makers to understand how health promotion is improving health outcomes, specific nKPIs need to be developed. These new nKPIs need to be developed in conjunction with ACCHS and health promotion experts.

Supporting health promotion practice through stronger leadership and investment, and measuring the effects of this investment, will increase the capacity and capability of health promotion efforts, which in turn will improve health outcomes.

Recommendations for policy

4. At a national level, re-invest in health promotion and prevention to a level that is consistent with other OECD countries.
5. Re-establish a national leadership body equivalent to the Australian National Preventive Health Agency that will work across government and non-government health organisations to set direction, support the advancement of research into health promotion outcomes, and have bi-partisan support for ongoing leadership in health promotion practice to reduce the burden of ill health in Australia.
6. Develop and adopt nKPIs for ACCHS that capture health promotion impact and outcome measures.

Implications for practice

This research engaged staff in a reflective approach to identify, understand and implement action to strengthen health promotion practice in the organisation. By adopting this approach, staff throughout the organisation had a greater awareness of the current influences on health promotion practice. This awareness of internal and external

influences enabled targeted workforce and organisational practice to change. The reflective approach is consistent with continuous quality improvement (CQI) processes. A number of Indigenous primary health care services in northern Australia have utilised CQI processes, through the One21seventy audit tool, to improve the delivery of health promotion practice (30). Research has found that if there is a sufficient level of resource commitment, including staff and organisational commitment, CQI will increase the health promotion capacity of primary health care practice (14). However, access to previous external support to adopt and sustain these CQI practices has ceased with the closure of One21seventy support in October 2016 (31). Reflective processes involving a variety of staff in ACCHS are needed to identify and adapt to the changing internal and external influences on health promotion practice.

Primary health care settings are important providers of health promotion approaches. Their comprehensive approach to health service delivery allows a holistic approach to strengthen protective factors and target risk factors that contribute towards ill health. This ACCHS delivers health promotion activities at both an individual and a population level. However, some activities, such as those at the individual level, receive greater attention than those at the population level. This research identified a number of ways the workforce can be supported to improve the overall organisation's health promotion practice. This included access to skill development and health promotion expertise, embedding change into organisational systems and improving health promotion measures to better inform decision-makers in the organisation.

Health promotion practice is an important part of comprehensive primary health care. These final recommendations provide direction on changes for practice that will strengthen the profile of health promotion in primary health care settings.

Recommendations for practice

7. Health services should adopt CQI processes that focus on how health promotion practice can be strengthened through workforce and organisational practices and to do this, health promotion expertise needs to be provided as a resource to assist this commitment to a new way of working.

8. Support health promotion approaches that target population change as well as individual change and develop appropriate measures that will capture all health promotion activity.
9. Formalise health promotion practice through continued professional development processes for all primary health care staff.
10. Support comprehensive primary health care by embedding health promotion practice within staff roles to ensure health promotion practice and clinical care are complementary rather than competing for workforce attention.

The above ten recommendations provide directions for how health promotion practice can be strengthened through future research, policy change and primary health care practice.

8.11 Conclusion

The objectives of this exploratory research were to identify current practices, enablers and barriers for health promotion in an ACCHS; document the health promotion approach within an ACCHS; and to use participatory action research as a tool for strengthening health promotion and research practice within this ACCHS.

In chapter one, the literature review provided a summary of the known enablers and barriers to building health promotion capacity in health organisations. The literature review highlighted that there is a gap in in the literature on how Aboriginal health organisations build health promotion capacity.

Chapter two included an article which outlined how the research partnership was established and maintained between a non-Indigenous PhD candidate and an Aboriginal health organisation. The steps in establishing and maintaining the research partnership provide detail for future researchers and Aboriginal health organisations to consider.

Chapter three provided insight to how the workforce at an Aboriginal health organisation practised health promotion. This paper provided insight from the workforce on the enablers and barriers to deliver health promotion approaches. The findings from this research were used to identify priorities to strengthen health promotion practice in the ACCHS.

Chapter four demonstrated how workforce capacity can be strengthened to evaluate and share health promotion findings with internal and external peers. The findings from this research highlighted how targeted training, reviewing and updating health promotion processes in the organisation, and providing mentoring support to staff can result in knowledge sharing between staff, presenting work to colleagues at a national conference and writing for publication.

Chapter five identified how health promotion practice was captured and reported to decision-makers. The breadth of health promotion activities and their contribution to improving health outcomes was not being captured or reported. The findings from this research identify a need for new measures to be developed and adopted to capture population level change.

Chapter six provided insights into how primary health care staff who work in remote areas access health promotion skill development and expertise. This study increased understanding of the creative ways staff in this ACCHS engage with others to support their health promotion learning. The findings from this study enabled the organisation to identify ways support could be formalised to reduce reliance on interpersonal relationships.

Chapter seven demonstrated how an ACCHS can identify and increase their capacity to deliver health promotion through active involvement in research. The PAR approach provided practice-based evidence on what influenced the organisation's capacity to deliver health promotion and identified appropriate actions to strengthen health promotion practice in an Indigenous primary health care setting.

This novel and significant research contributes to the evidence base to understand how health promotion is practised and how it can be strengthened in an Indigenous health setting. The research was conducted within an ACCHS over a period of time with a focus solely on understanding how health promotion can be strengthened in the organisational setting. There have been no other studies where the researcher has worked alongside staff in an ACCHS for an extended period of time. The participatory action research approach was specifically chosen to facilitate practitioner insights into how health promotion practice may be strengthened, and to involve staff in identifying actions applicable to the work environment. This approach provided practice-based evidence of how health promotion can be strengthened in an ACCHS. This research is

timely and provides insights into the constraints of reduced national and state government investment in health promotion for an ACCHS. It highlights that ACCHS are committed to health promotion practice as part of comprehensive primary health care even when additional funds for health promotion programs are scarce. Health promotion approaches are needed to improve health outcomes particularly for Aboriginal and Torres Strait Islander populations.

This research is the first study of its kind and provided practice-based learning and insights into how health promotion capacity can be strengthened in an ACCHS. The research aligns with current national policies that identify a need to increase health promotion and prevention approaches in primary health care. A number of recommendations for future research, policy and practice have been made that will increase health promotion practice in Indigenous primary health care settings.

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Appendices

Appendices **167**

Appendix A: Human Research Ethics Committee approval **168**

Appendix B: Memorandum of Understanding for the research collaboration Between James Cook University and Apunipima Cape York Health Council **169**

Appendix C: Information sheet **177**

Appendix D: Consent form **179**

Appendix E: Letters of support to publish in peer reviewed journals **180**

Appendix F: Survey (pre-test) **185**

Appendix G: Documents included for analysis **197**

Appendix H: Interview questions: Capturing and reporting Health Promotion practice **200**

Appendix I: Summary report provided to staff of the themes: Capturing and reporting Health Promotion practice **203**

Appendix J: Interview questions: How staff access skill development and health promotion expertise **207**

Appendix K: Summary report provided to staff of the themes: How staff access skill development and health promotion expertise **208**

Appendix L: Survey (post-test) **214**

Appendix M: Conference abstract submitted to the Population Health Congress, Hobart 6-9 September 2015 ..... **230**

Appendix N: Conference abstract submitted to the Primary Health Care Research Symposium, Adelaide 29-31 July 2015 ..... **231**

Appendix O: Poster presented at the Primary Health Care Research Symposium, 2015; and the Population Health Congress, 2015 ..... **232**

Appendix P: Publication co-authored by candidate during the thesis **233**

Appendix Q: Journal copyright permissions **244**

Appendix A: Human Research Ethics Committee approval

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Appendix B: Memorandum of Understanding for the research collaboration Between James Cook University and Apunipima Cape York Health Council

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Appendix C: Information sheet

INFORMATION SHEET

PROJECT TITLE: **Strengthening organisational capacity to use health promotion approaches to address the determinants of health [H5787]**

Background
Health promotion helps people to increase control over their health. It does this by strengthening the skills and capabilities of individuals, groups and the broader population to live a healthy life. Health promotion influences the determinants of health – factors such as education, socioeconomic status, physical environments, and access to health services, all of which can affect health status. Health promotion also addresses risk factors such as poor nutrition, lack of physical activity, smoking, and high alcohol consumption, that leads to ill health. It also addresses protective factors such as good maternal and child health, stress management, sun safe practices etc. In short, health promotion aims to make the healthy choice the easy choice.

For organisations to deliver effective health promotion, their staff need sufficient capacity and support. NSW Health has identified five areas which will help organisations build their capacity to deliver health promotion: organisational development, workforce development, resource allocation, leadership, and partnerships.

The focus of this research project is to document the capacity of and support within an organisation for health promotion delivery. The project will also identify the challenges to implementing health promotion. The organisation involved in this research is Apunipima Cape York Health Council.

The Research Process
You are invited to take part in this research project, which will focus on the factors that support or prevent a community controlled health service to improve its capacity to deliver health promotion. As a result of the research, there will be a greater understanding of how organisations can build their health promotion capacity.

The study is being conducted by **Kath McFarlane** and will contribute to her Doctorate of Public Health research at James Cook University.

If you agree to be involved in the study, you will be invited to participate in the following research processes:

1. Questionnaires
A questionnaire will be sent to you via email, which asks you about your perceptions of organisational capacity, and your knowledge, skills and confidence in planning, implementing and evaluating health promotion programs. The questionnaire should only take 30 minutes to complete. The survey will be sent at the beginning and at the end of the research, so that any changes can be monitored.
Questions will include:
- Knowledge and understanding of health promotion
- Formal training and work experience in health promotion
- Skills and confidence in planning, implementing and evaluating health promotion programs
- Rating of the importance of health promotion in primary health care practice
- Perceived barriers and enablers to the delivery of health promotion
- Perceived organizational support for health promotion

2. Focus groups
Each focus group, with your consent, will be digitally recorded, and should take approximately 60-90 minutes of your time. The focus groups will explore barriers and enablers to health promotion practice and will be conducted at Apunipima Cape York Health Council. The focus groups will occur during the research project.
Questions will include:
- What are the barriers and enablers for health promotion in this organisation?

3. Interviews
Each interview, with your consent, will be digitally recorded, and should take approximately 30-60 minutes of your time. The interviews will be conducted one-on-one to explore barriers and enablers to health promotion practice and will be conducted at Apunipima Cape York Health Council. The interviews will occur during the research project.
Questions will explore:
- Perceived barriers and enablers to the delivery of health promotion in this organisation

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CRICOS Provider Code 00117J

4. Participatory Action Research

Participatory action research is a process of collective, self-reflective inquiry that both researchers and participants undertake to understand and improve practice. As a participant, you will be invited to analyse with the researcher the data that will be collected. Training in the analysis of qualitative data will be provided for staff interested in being involved in the research. Interested staff will have access to de-identified transcripts and the analysis will be facilitated by the Principal Investigator in a set group session. The transcripts will not be shared or available outside of the session. Analysed data and themes will be shared with all staff so that this information can be used at a planning meeting to discuss and prioritise areas for action.

Apunipima Cape York Health Council supports this research, but does not require staff to participate. Taking part in this study is completely voluntary and you can stop taking part in the study at any time without explanation or prejudice.

All data will be de-identified to preserve anonymity. However, due to the closeness of participants within the organisation, confidentiality or anonymity cannot be assured. The data from the study will be used in research publications and reports. You will not be identified in any way in these publications.

If you have any questions about the study, please contact Kath McFarlane or Dr Kerrianne Watt.

Principal Investigator:
Kath McFarlane
College of Public Health, Medical and Veterinary Sciences
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Phone:
Email: Kathryn.McFarlane@my.jcu.edu.au

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If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

Appendix D: Consent form

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Appendix E: Letters of support to publish in peer reviewed journals

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Appendix F: Survey (pre-test)

About the questionnaire

Background
Health promotion is the "process of enabling people to increase control over their health and its determinants, and thereby improve their health" (WHO, 1986). Health promotion approaches are designed to both strengthen the skills and capabilities of individuals, groups and the broader population and also to influence the social, environmental and economic determinants of health. Health promotion approaches target the protective and risk factors of ill-health to make the healthy choice the easy choice.

For organisations to deliver effective health promotion programs and strategies, there needs to be capacity of the staff and the organisational system to support these approaches. The focus of this research project is to document the capacity and supports that are in place that strengthen health promotion program delivery at Apunipima Cape York Health Council.

Questionnaire
The following questionnaire will gather your insights into how health promotion approaches and programs fit within Apunipima. The questionnaire should take no longer than 30 minutes to complete.
Questions will include:
- Knowledge and understanding of health promotion
- Formal training and work experience in health promotion
- Skills and confidence in planning, implementing and evaluating health promotion programs
- Rating of the importance of health promotion in primary health care practice
- Perceived barriers and enablers to the delivery of health promotion
- Perceived organisational support for health promotion

Consent
By selecting 'next', you are consenting to participate in this questionnaire, and acknowledge that:
- you understand the aim of this research study which is to understand and document how health promotion programs and approaches are currently being undertaken and to identify how health promotion capacity can be strengthened within Apunipima;
- you understand that your participation will involve completing the following questionnaire. All data will be de-identified to maintain confidentiality and to preserve anonymity;
- taking part in this study is voluntary and that you are aware that you can stop taking part in it at any time without explanation or prejudice and to withdraw any unprocessed data you have provided;
- you understand that your participation in this research is voluntary and not a requirement of Apunipima Cape York Health Service;
- you agree that the researcher may use the results in research publications and reports. You will not be identified in any way in these publications;
- no names will be used to identify you with this study without your approval.

For further information
If you have any questions about the study, please contact Kath McFarlane on 4232 1614, kathryn.mcfarlane@jcu.edu.au or Dr Kerrianne Watt, Principal Advisor kerrianne.watt@jcu.edu.au

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Your experiences

1. Which of the following are you involved with and how often (approximately)?

	weekly	monthly	yearly	never
Screening or individual risk assessment (e.g. Adult health check, Pit Stop)	○	○	○	○
Immunization	○	○	○	○
Providing health information (e.g. brochures, pamphlets, fact sheets)	○	○	○	○
Delivering health education (e.g. Core of life)	○	○	○	○
Conducting health counseling (e.g. brief interventions)	○	○	○	○
Delivering skill development (e.g. cooking classes, parenting courses)	○	○	○	○
Social marketing (e.g. radio interviews or announcements; health messages for billboards or tv; branded material to support campaigns - pens, water bottles, hats, t-shirts)	○	○	○	○
Community action and community participation (e.g. setting up mothers groups; supporting mens/womens groups; community walking groups)	○	○	○	○
Advocating for the implementation of structural changes for supportive environments (e.g. advocating for shade over playground equipment, more footpaths, condom vending machines)	○	○	○	○
Policy development and review (e.g. smoke free policies, healthy canteen policy, catering guidelines)	○	○	○	○

	weekly	monthly	yearly	never
Economic and regulatory activities (e.g. decreasing cost of fruit and vegetables, liquor licensing laws, ban on soft drinks)	○	○	○	○

Prev Next

2. Please provide examples of the types of health promotion or prevention work you have been involved in. Describe the program or activity and include, where possible, the name of the program or activity:

Prev Next

3. How important is it that Apunipima delivers / leads the following activities?

	Not at all important(1)	Unsure(2)	Somewhat important(3)	Extremely important(4)
Screening or individual risk assessment (e.g. Adult health check, Pit Stop)	○	○	○	○
Immunization	○	○	○	○
Providing health information (e.g. brochures, pamphlets, fact sheets)	○	○	○	○
Delivering health education	○	○	○	○
Conducting health counseling (e.g. brief interventions)	○	○	○	○

	Not at all important(1)	Unsure(2)	Somewhat important(3)	Extremely important(4)
Delivering skill development (e.g. cooking classes, parenting courses)	○	○	○	○
Social marketing (e.g. radio interviews or announcements; health messages for billboards or tv; branded material to support campaigns - pens, water bottles, hats, t-shirts)	○	○	○	○
Community action and community participation (e.g. setting up mothers groups; supporting mens/womens groups; community walking groups)	○	○	○	○
Advocating for the implementation of structural changes for supportive environments (e.g. advocating for shade over playground equipment, more footpaths, condom vending machines)	○	○	○	○
Policy development and review (e.g. smoke free policies, healthy canteen policy, catering guidelines)	○	○	○	○
Economic and regulatory activities (e.g. decreasing cost of fruit and vegetables, liquor licensing laws, ban on soft drinks)	○	○	○	○

4. Any comments?

Prev Next

5. Please rate YOUR confidence to undertake the following activities

	Not at all confident (1)	(2)	Neutral (3)	(4)	Very confident (5)	N/A to my role
If you were asked to justify to your organisation why it should take on a greater role in health promotion, would you feel confident of being able to present a good argument?						
How confident do you feel to assess the needs of the community and plan a health promotion program based on this?						
How confident do you feel to contribute to the design and implementation of a health promotion initiative?						
How confident are you that you can identify appropriate strategies for a health promotion program that your organisation may wish to implement?						
How confident are you that you can evaluate a health promotion program that your organisation has implemented?						
How confident do you feel to work collaboratively with the community?						
How confident do you feel to work collaboratively with other key organisations?						
How confident are you in giving presentations and facilitating meetings?						

	Not at all confident (1)	(2)	Neutral (3)	(4)	Very confident (5)	N/A to my role
How confident are you in writing program plans and program completion reports?	○	○	○	○	○	○
How confident are you in using a computer and the internet as a work tool?	○	○	○	○	○	○
How confident are you to explain to others what health promotion is and the action areas of the Ottawa Charter for health promotion?	○	○	○	○	○	○

Other comments

Prev Next

About Apunipima

6. Please rate how well Apunipima does the following:

	Does not do this well (1)	(2)	Unsure (3)	(4)	Does this really well (5)	N/A to the organisation
Assessing and understanding the needs of the community	○	○	○	○	○	○
Planning a health promotion program	○	○	○	○	○	○
Using evidence-based strategies in health promotion and prevention programs	○	○	○	○	○	○
Evaluating health promotion or prevention programs	○	○	○	○	○	○
Working in partnership with the community on the planning and implementation of a health promotion program	○	○	○	○	○	○
Working in partnership with other key organisations in the planning of a health promotion program	○	○	○	○	○	○
Working in partnership with other key organisations in the implementation of a health promotion program	○	○	○	○	○	○
Giving presentations and facilitating meetings	○	○	○	○	○	○
Writing program plans and completion reports	○	○	○	○	○	○
Explaining to others what health promotion is and the action areas of the Ottawa Charter for health promotion	○	○	○	○	○	○

Any further comments

Prev Next

The supports and enablers

54%

7. Please select which of the following you see are the most important enablers or things that support health promotion delivery: (more than one response allowed)

- ☐ Funding for health promotion programs
- ☐ Funding for positions
- ☐ Access to resources
- ☐ Staff skilled in health promotion
- ☐ Evaluation and sharing lessons learnt from previous programs
- ☐ Management support
- ☐ Health promotion is a priority in the organisation
- ☐ Health promotion leadership in the organisation
- ☐ Communities are keen to work with us to address health issues
- ☐ Other organisations are keen to work with us to address health issues

8. Any other enablers for health promotion?

Prev Next

62%

9. At Apunipima the top three (3) things that support health promotion practice are:

1.

2.

3.

Prev Next

The barriers or challenges

10. Please select which of the following factors you see are the main barriers or challenges for health promotion delivery: (more than one response allowed)

- [ ] Lack of funding for health promotion programs
- [ ] Lack of funding for health promotion positions
- [ ] Staff lack skills or confidence in health promotion
- [ ] Lack of management support
- [ ] Health promotion is not a priority in the organisation
- [ ] Clinical priorities are more important
- [ ] Lack of understanding of health promotion practice
- [ ] Limited ability to apply a broad mix of health promotion strategies in practice
- [ ] Lack of leadership in health promotion
- [ ] Lack of time to deliver effective health promotion programs
- [ ] Communities can be difficult to work with to address health issues
- [ ] Other organisations are difficult to work with to address health issues

11. Any other barriers for health promotion?

Prev Next

12. At apunipima the top three (3) things that are a barrier to health promotion practice are:

1.

2.

3.

Prev Next

13. How does your management team support health promotion practice?

14. Are there any specific policies or workplace guidelines that you are aware of that encourage you to do prevention or health promotion work? If yes, please name or describe them:

Prev Next

92%

15. Please rate your agreeement with the following statements:

	Strongly disagree (1)	(2)	Neither agree/disagree (3)	(4)	Strongly agree (5)
Clinical staff and community staff have a role to play in health promotion	○	○	○	○	○
Only the Health Promotion Team is responsible for the delivery of health promotion programs	○	○	○	○	○
Health promotion is separate to primary health care delivery	○	○	○	○	○
Health promotion is necessary to improve the health in our communities	○	○	○	○	○

Prev Next

Tell me more about you

100%

16. How many years have you been involved in delivering health promotion or prevention programs?

- I have never been involved in deliverying health promotion programs
- Less than 12 months
- 1-3 years
- 4-5 years
- 6-10 years
- 11 or more years

17. Have you attended training in health promotion? (tick all that apply)

- I have not attended training in health promotion
- I have completed a workshop/short course in health promotion
- I have completed health promotion subjects at TAFE level
- I have completed health promotion subjects at undergraduate level at university
- I have completed health promotion subjects at postgraduate levels at university
- I have a health promotion qualification from a university

Other (please specify)

18. Which work team do you belong to?

- Healthy Lifestyles
- Family Health
- Men's Health
- Social and Emotional Well Being
- Clinical Services
- Primary Health Centre Managers
- Corporate support services

Other (please specify)

19. Do you line manage other staff?

- Yes
- No

20. Do you have any further comments?

Thank you for completing the questionnaire. Your assistance in this study is greatly appreciated.

Prev Done

Appendix G: Documents included for analysis

Name of document	Document version assessed	Purpose
Apunipima Model of Care	v2.0	Outlines the Model of Care of the organisation.
Apunipima Primary Health Care Business Plan	current at July 2016	Identify work focus for 2016
Apunipima Strategic plan 2014-2019	current at July 2016	States mission, values, vision and five strategic objectives
Social and Emotional Wellbeing summary document	current at July 2016	Internal and external promotional document stating SEWB work approach
Activity evaluation sheet	current at Dec 2015	Captures feedback from target audience after attending a health promotion program, or Apunipima event
Adult Health Check form	v48 current at Jan 2016	Captures health risk factors of clients
Health promotion activities planning and reporting process. Ref: 1815 PHC	v3.0 last updated Nov 2014	Provides a description for all staff on how to use the health promotion planning and evaluation registers
Community health plan - Aurukun as example	Oct-15	Provides a clear plan between community priorities and Apunipima's role in addressing those priorities. Shared planning
Deed of commitment	current	States the role of the organisation
Apunipima operational plan 2014-15	v1.0	Provides direction and accountability for Apunipima staff and enables the Senior Management Team to monitor the implementation of the Apunipima strategic plan
Constitution of ACYHC	current from 28 Nov 2014	Defines the business of ACYHC
Health promotion strategy 2013-2015	v5.0	Guides the efforts of all Apunipima staff working in health promotion
Maternal Child Health group work (register)	current	Captures group work, what is discussed, number of participants, where etc
Men's health group work (register)	current	Captures group work, what is discussed, number of participants, where etc
Healthy lifestyles group work (register)	current	Captures group work, what is discussed, number of participants, where etc

Quality Standards		
APU 1763	current from April 2016	Patients are able to make informed decisions about their health care through information obtained in health promotional and disease prevention material, and talking to health staff.
APU 1784	current May 2016	To ensure research is conducted respectfully, appropriately, approved through the correct channels and that the research is mutually beneficial to participants and health care consumers
1740 PHC	current at January 2015	To ensure staff have access to information about local health, disability, community services and their costs
Apunipima Key Performance Indicators		
AKPI 24	current at July 2016	Number and type of health promotion and education activities, programs planned and implemented
AKPI 25	current at July 2016	Number and type of collaborative meetings held with community
AKPI 28	current at July 2016	Reduced smoking during pregnancy
AKPI 29	current at July 2016	Reduced smoking in clients with chronic disease
AKPI 43	current at July 2016	Number of BMI results for children 2-18 years
National Key Performance Indicators		
NKPI 01	current at July 2016	Number and proportion of Indigenous babies born within previous 12 months whose birth weight has been recorded
NKPI 02	current at July 2016	Number and proportion of Indigenous babies born within previous 12 months whose birth weight results were low, normal or high
NKPI 03	current at July 2016	Number and proportion of regular clients who receive an MBS health assessment
NKPI 04	current at July 2016	Number and proportion of Indigenous children who are fully immunised
NKPI 09	current at July 2016	Number and proportion of regular clients whose smoking status has been recorded
NKPI 10	current at July 2016	Number and proportion of regular clients who are current smokers
NKPI 11	current at July 2016	Number and proportion of women smoking during pregnancy

NKPI 12	current at July 2016	Number and proportion of regular clients who are classified as overweight or obese
NKPI 14	current at July 2016	Number and proportion of regular clients aged 50 years and over who are immunised against influenza
NKPI 15	current at July 2016	Number of regular female clients with Type 2 diabetes who are immunised against influenza
NKPI 16	current at July 2016	Number and proportion of regular clients whose alcohol consumption status has been recorded
NKPI 22	current at July 2016	Number of regular female clients aged 20-69 years who have had a cervical screening

Appendix H: Interview questions: Capturing and reporting Health Promotion practice

I am interested in the reporting of health promotion and prevention work. This includes a) wellbeing indicators of Apunipima clients and b) organisational activities that enhance/promote wellbeing in communities.

a) Types of wellbeing indicators of Apunipima clients:
   - Physical activity levels
   - Alcohol consumption
   - Smoking status
   - Fruit and vegetable consumption
   - Social and emotional wellbeing indicators
   - BMI or waist measurement

b) Types of organisational activities that enhance/promote wellbeing in communities:
   - Screening for ill health
   - Immunisation
   - Health education
   - Health information and social marketing activities
   - Working in partnership with community members to be involved in community health activities
   - Working in partnership/building capacity of key stakeholders to assist in addressing the causes of ill health (housing, education, local government, etc)
   - Advocating at a community, regional, state or national level for policy or legislation change that supports health in communities.

Questions for staff

Firstly, are you involved in reporting activity related to the wellbeing indicators (section a), which ones?

How do you capture this activity?

When working with clients?

Do you record this on Apunipima databases? (which ones?)

Looking at the organisational activities (section b) what activities are you involved with?

Do you report these activities, which ones? And,

How? (i.e. verbally to line manager; through particular databases; for specific reports?)

Do you think there is a need to capture and report the activities listed? (ask separately for section a) and for section b))

Who is this useful for? Or who do you think uses this information?

If not useful, is there additional information required? What information?

If activities aren't been reported…

Do you think, any of the activities not reported, should be? And who could use this information? For what purposes?

Questions for staff compiling reports

Thinking about both internal and external reports you are involved in compiling.

Are there any reports you compile that request information on any of these types of areas (section a and b)?

Which ones (type of activity and report for whom)?

How/where do you access the information (source)?

Is the information available in a way that is easy for you to compile in the report? Or how would you prefer to have the information?

Who (internal and external) do you think is interested in this type of information?

What enables you to provide them with information that you think they are interested in?

What type of format do they prefer or is useful – numbers? Case studies? Other?

The health promotion and prevention activities listed in b) are undertaken by many if not all staff who work in community.

How is this work captured?

What are the challenges you see in compiling/capturing health promotion and prevention activities and outcomes?

I am aware of some ways that the organisation is being proactive in capturing health promotion and prevention work – development of specific KPIs, meeting register, health promotion register.

Are there any others?

Would you use this information in your reports? Which ones and in which reports?

Do you have any ideas on other ways Apunipima can be proactive in reporting/capturing health promotion and prevention work?

Appendix I: Summary report provided to staff of the themes: Capturing and reporting Health Promotion practice

BACKGROUND

A series of small group and one-on-one interviews were conducted with staff to discuss how health promotion work was being captured and the challenges they identified when reporting health promotion work. Staff were from the Health Promotion, Nutrition, Family Health, Men's Health/SEWB, Allied Health and Corporate support teams and included managers, team leaders, staff who compile reports for funding organisations and on the ground staff (n=12).

The purpose of the interviews were to:

- Understand how health promotion and prevention activities are being reported within the organisation
- Identify and begin to explore ways that health promotion and prevention work can be better captured to be useful for reporting, monitoring and decision making.

MAIN THEMES

The following headings are the main themes that emerged from the interviews.

Difficulties in reporting health promotion

Inconsistencies with systems

- Language used to describe the relationship between strategic and reporting documents is confusing and as staff have not been involved in writing the plans, this contributes to the confusion of how the documents link.
- Plans reflect funding requirements rather than service planning.

Unsure of what information is wanted by decision makers

- On the ground staff are sometimes unaware of what funders want to know until the report is due.

Focus on KPIs

- The organisation's view of health promotion is influenced by having only one KPI for health promotion 'number and type of health promotion activities'.
- Reporting involves monitoring rather than evaluating outcomes of work efforts.
- Notice that teams work in silos and feel this is influenced by reporting requirements.

Time spent reporting

- Health promotion reporting needs to be improved, however time spent on reporting should be minimal – simple not onerous.

Report in the context of challenges

- Know there is a risk that funding and positions are reduced if can't show their work is having an effect.

Difficulties in capturing health promotion work

Lifestyle factors

- Staff are sometimes uncomfortable to ask clients about health behaviours or don't believe their responses, 'as they say what you to hear' (smoking, alcohol, exercise, etc.).
- The organisation has templates to capture lifestyle behaviours - fruit and vegetable intake, physical activity levels, social and emotional wellbeing, but information is not always recorded by staff.

Where and what to capture?

- Unsure what funders really want.
- Time poor.
- Staff recognised that Apunipima doesn't capture a lot of the good work they are doing.
- Nowhere to capture broader health promotion activities such as advocating for change etc.

Strengths of Apunipima in reporting

- Confident to negotiate with external funders around funding and reporting measures.
- Reporting should firstly be useful to organisation, and where possible use them to inform other areas.
- Good relationships with funding bodies.
- Are proactive in seeking funding and realise that data to back up requests is a strength.
- Share work between teams. Other teams are interested in what's working not just line managers.
- The organisation has a good understanding of the health promotion and prevention work that occurs.
- Staff have noticed the organisation is pushing to document its direction through guiding documents, particularly over the last 5 years.
- Strong advocacy in the organisation, but recognise that senior positions would find it difficult to explain the work that teams do as there is no way for them to know.

National and state cuts in prevention has impacted on the organisation

Leadership

- Lack of external leadership. No longer doing the on the ground role, but have to think more strategically to address issues, as state and national leadership is missing.
- Reduced capacity from other partners who used to work in prevention means that Apunipima's work is not supported, and capacity to make a difference is greatly reduced.

Vulnerable workforce

- Health promotion and prevention workers are vulnerable.
- Impacts on what is captured as there is a need to capture everything to justify the work.

Funding

- Funders used to have a relationship with staff and knew the work area, but now just contract managers ticking boxes. Reduced positions in Department of Health (state) means no capacity to provide feedback.
- Staff feel that reduced funding to the organisation has a direct impact on KPI outcomes.

Challenges in doing health promotion work (related to reporting)

Understanding of health promotion in the organisation

- The breadth of health promotion work is not well understood. Often interpreted as getting people into the clinic or delivering healthy lifestyle programs

Funding

- Lose positions when funding is year by year. People look for other work when their contract is getting close to expiring. We commonly do get refunded, but too late and need to recruit again.

Engaging community is difficult

- Getting community members to health promotion programs is challenging. They have so much going on.

Consistency with programs

- Staff get excited about health promotion programs and then the focus changes to something else without finishing.

Difficult work

- Health promotion is seen as difficult/hard to have an impact on health outcomes. For example, telling people to reduce sugar consumption, against Coca cola / multi nationals.
- Behaviours take time to change and more time to then show an impact on health.
- Planning and preparing health promotion work takes time.

Identified risk

There is a disparity between the long term measures (NKPIs) and ability to report on health behaviour changes – skills, knowledge, values, practice and attitudes. This results in both internal and external decision makers not getting the whole picture of the impact that health promotion work is having in Cape York.

Changes staff would like to see

Leadership

- Primary health care experts in the organisation should drive the health planning.
- Consult with team leaders on guiding documents.
- Would like senior staff to be more interested in the outcomes of projects – did it work, what were the lessons learnt?
- Inform senior positions and the Board on the different things that are happening in health promotion and prevention (note that written reports are not shared or read and verbal updates are well received).

Organisational culture

- Increase the organisations understanding of what health promotion work is, as that has implications for guiding and reporting on work.
- Need to improve the evaluation and monitoring culture in the organisation.

Access to decision makers

- Staff want to be able to update decision makers in the organisation about work that is happening.
- Would like to know what funding bodies want to know prior to commencing a project to adjust templates to capture that information better.
- More feedback to staff on how the information they collect is informing decisions and contributing to funding success.
- Invite funding representatives to see for themselves how work is occurring in community.
- Increase the profile of prevention work in the organisation to senior positions.

Celebrate success with others

- Annual report for the organisation detailing achievements across the teams.
- Sharing program successes within the organisation (noting that Yarning updates are too brief).
- Provide more detail to communities in community feedback. More than just a comment beside NKPI data.
- Share what is happening between teams through community cluster meetings.

Templates that capture reporting

- Templates help capture work, but need to detail information required that is seen by staff as relevant to record.
- Share templates across teams doing similar work, e.g. project management templates.
- Provide summary documents for community to share health promotion work.
- Detail staff and teams contribution to a project or strategy and monitor to assess progress in achieving better health outcomes.
- Align team planning documents to strategic/funding documents.

HOW THIS INFORMATION WILL BE USED

The main themes from the interviews have been shared with the research reference group at Apunipima, staff who participated in the interviews, all staff forum (Journal Club 4th Nov 2016) and with Primary Health Care Managers. The findings from these interviews will be used as part of the *Strengthening Health Promotion and Research in Practice* research project, which is being undertaken by Kath McFarlane as part of her PhD studies with James Cook University.

If you have any questions about the research please contact Kath McFarlane, email kathryn.mcfarlane@my.jcu.edu.au

9/12/16

Appendix J: Interview questions: How staff access skill development and health promotion expertise

Questions:

How do you currently access external expertise in health promotion?

What are the types of skills or knowledge you are looking for?

Previous studies have used workforce training and access to external staff to deliver the training, skill development. What do you see are the benefits to that? or negatives to that?

What skills currently exist in the organisation for health promotion specialist support? (what skills, who, in what teams?)

What ways can the organisation build on these existing skills?

If resources were not a barrier how would you like to access support for health promotion? What model would best suit your working needs?

What is needed for this to happen? Is this likely at the organisation?

> If specialist role/s, where might you find them? how could you link them to the organisation?

What would be the challenges in sustaining the preferred model/s?

Appendix K: Summary report provided to staff of the themes: How staff access skill development and health promotion expertise

BACKGROUND

A series of small group and one-on-one interviews were conducted to explore how staff seek support for the work they do in health promotion and prevention, what works well and what could work in the future. Staff were from the Health Promotion, Nutrition and Family Health teams. Team leaders and on-the-ground staff were interviewed separately (n=9).

MAIN THEMES

The following headings are the main themes that emerged from the interviews.

Knowing the work context is paramount

Type of training/conferences

- Look for facilitators that have experience in working in Aboriginal and Torres Strait Island context and will seek recommendations from others who have seen that facilitator present to ensure it will be relevant and culturally appropriate.
- Prefer to attend conferences that promote an Indigenous or remote focus.
- Workshops that are Indigenous related and in remote settings are more appealing.
- The training needs to be relevant and tailored to the Cape York context.
- Staff are interested in learning from other similar communities who share what worked for them.

Benefits of workplace training

- When training is put on by Apunipima it is organised so that the facilitator knows the context and makes the training applicable and relevant.
- Internal workshops are really useful as everybody gets the same information.

Negatives to attending training

- Information is just an overview and it can be too short to get into detail that is useful.
- There are many ways to do the same thing. One version of training may not be the best way for Apunipima.
- Some staff mentioned they get frustrated when the organisation doesn't support them to attend training.

Conferences

- Staff like presenting their own work at conferences or workshops, as they find it a good reflection process.
- Staff value seeing presentations at conferences.
- Conferences are good, but having the organisation cover conference costs is not realistic in the current funding environment.
- Staff are less interested in hearing about programs that work in urban/city environment as they are too different from the setting they work in.

External relationships are important

Staff nurture external relationships to assist their practice

- Keep in touch with other staff that they have met at conferences and workshops that work in similar areas, e.g. NT.
- Relationships with existing partners are important to use.
- Link with experts that staff have worked with previously.
- Being on a special interest group for a professional association or participate in 'community of practice' groups is a useful way to mix with others in the field.
- Staff share contacts/networks within their team.
- Two-way relationship with external support. Both Apunipma staff and external staff support each other.

Apunipima is a respected organisation

- Staff see that the organisation is well respected to attract collaborations with outside specialists.
- People seek relationships with Apunipima to work on projects.

Types of external support sort

- Assistance from others to 'chase money'.
- Invite external advisors to be on steering groups for a project.
- Peer support from network colleagues.

Staff support each other

- Staff support each other and see this as part of their role and part of organisations role to foster shared learning as they work in a unique environment and staff are dispersed throughout a large geographical area.
- Staff recognise that there is a lot of expertise in the organisation, but know everyone is busy.
- Staff share contacts and work together on projects.
- Mentoring within the organisation was seen as positive, but needs an agreed structure for both participants that supports equal sharing of knowledge and skills, as both participants have expertise.
- Informal support from other staff is useful, but staff don't see a lot of each other and travel hinders informal catch ups with staff in other teams.
- Some teams work well together on shared projects and support across the teams.

Why staff value health promotion specialist support

- Having access to expertise in health promotion is vital for supporting prevention work.
- Individuals to bounce ideas off that understand the context of work in the Cape.
- Having a second opinion is really useful.

Other sources of health promotion specialist information

- Online, websites e.g. Australian Indigenous Health Infonet, Department of Health, Indigenous Allied Health Association, national campaigns.
- Email groups and list servers.
- Professional associations.
- Journal subscriptions or open access.
- Study tours.

Topics/areas of interest (when interviewed June 2016)

- Motivational interviewing/brief intervention.
- Programs to assist in reporting/evaluation.
- Turning point clickers.
- Dealing with difficult conversations.
- Negotiating partnerships/ buy in from stakeholders to the project.
- Emerging issues, such as the social marketing and media training.

Challenges for continual up skilling

- Staff feel they miss out on professional development if put on by a team and they are not part of that team.
- Programs stop and start, and focus changes.
- Staff attend training and want to adopt that new approach, but don't realise other staff have already been using that approach to address an issue.
- Challenging to set training for all staff in the team to meet all needs, as team members can range from novice to very experienced and have different clinical skill sets. But training together as a team was seen as very beneficial.
- Staff recognised that structures exist to support clinical staff (e.g. medical research, PHC educators with focus on clinical needs and accreditation requirements), but nothing exists formally to support health promotion and prevention work needs.

Reduced external support and leadership

Lost resources in recent years

- The health promotion team used to work closely with the health promotion team at Queensland Health. This had a two-way benefit as Queensland Health could provide health promotion expertise and access to local professional development. While Apunipima provided an opening into Cape communities.
- Staff previously worked closely with QAIHC, but their health promotion and prevention positions were also lost in the funding cuts.
- Staff feel there are very few external health experts that understand the Cape York context.

Challenges for internal support

- Health Workers have theoretical training in health promotion and prevention but have not applied their training and need support to do so.
- Health promotion staff see they have a role in supporting other teams, but finding the time to do so when they have their own work priorities is difficult.
- Team leaders mentioned being time poor to provide expertise to their own staff.
- The right type of support is needed, and for this staff need a broad understanding of health promotion and its importance in the organisation.
- To support remote-based staff, training has been delivered in community rather than staff coming to Cairns. This allows other partner organisations to attend which can result in greater capacity locally.
- Primary Health Care Managers based in community need both the clinical and prevention expertise as they cover all things in the primary health care approach.

Creative around support with limited resources

- Staff make the most of external relationships by inviting experts onto steering committees and seeking advice/input on work.
- Funding received from student placements is used to address the teams' professional development needs.
- Professional development has been factored into project funding submissions.
- Staff utilise professional networks for free advice.
- Staff take a lead on a health issue/approach for the team and then provide the support to others in the team on that health issue/approach.
- Staff apply and are encouraged to apply for conference scholarships.
- Conference cost is a limitation and can prevent attendance. Sometimes staff share a registration for local conferences to attend some of the sessions.

Future support should consider

<u>Organisational focus</u>

- Staff identified the need for an overarching health promotion workforce plan to better deliver health promotion, as part of comprehensive primary health care, across the organisation. From this, identify what staff professional development needs are to achieve organisational outcomes, rather than just individual or team up skilling without reference to the organisations' vision.
- Useful to have a clear agreed focus over a set period of time.
- Conduct a training needs analysis to identify gaps, how it fits with the scope of role and in line with KPIs and outcomes.
- Strategies such as the Chronic Conditions Strategy could be used to guide priorities in prevention and will help drive where the training needs are.
- Improve communication within the organisation as teams have subscriptions to professional associations but this is not streamlined or known by all relevant staff.
- The reduced focus and leadership in health promotion at a state wide and national level has been felt. Staff and the organisation need to continue to be creative to link with health promotion expertise.
- There's a lot of opportunity for staff-to-staff support in the organisation but it is at risk because it is dependent on informal relationships. Needs to be formalised.

<u>Leadership</u>

- Senior staff are important to facilitate relationships with external and internal experts.
- Need senior staff, from team leaders up, to be working on relationships that can influence the social determinants of health.
- Apunipima needs to define its own solutions as a unique AMS.
- The executive level need to build their capacity in health promotion and be supported in this as decisions for prevention and health promotion work is made at that level. Without a broad understanding this becomes disjointed.

Staff roles

- Staff who are not in the health promotion team would like detail on their role health promotion.
- There is an opportunity to utilise the new Primary Health Care Educator positions in the future to focus on staff health promotion needs.
- Build on the idea that it is part of staff's role to build the capacity of other staff and formalise this in job descriptions.

Mentoring

- Some staff identified that with their level of experience, they could mentor other staff.
- QAIHC produced a mentoring resource kit, but unaware what happened with it.
- Mentoring/buddying staff needs to be formalised, so everyone knows their responsibilities in the relationship.
- Mentoring/buddying should be extended for staff to learn from community members.
- Identifying a mentor is important for lifelong learning. Some people will be connected through past relationships but others will need support to identify a mentor.
- There are advantages of an external mentor. They provide a fresh perspective, but may not understand context.
- Staff can get trained in prevention and learn theory and knowledge, but they need support to get out and do it. Need to plan that side by side support.
- Pairing staff to learn from each other rather than mentor/mentee relationship as both staff have expertise to share.
- Mentoring was seen as a good option to support staff who work in different locations.

Sharing information/linking internally

- Staff like:
  - attending journal club as they are exposed to broader topics
  - sharing stories and experiences of what has worked with other staff in the organisation, and
  - receiving interesting links sent out by other staff.
- Staff need to be supported and encouraged to link with one another.
- Between teams it is useful for staff to pair up on work. They have different skill sets and working together facilitates learning and support.

Training

- Training needs to be in line with what is possible in the workplace. For example a new tool or way of working won't be implemented if it isn't supported by the line manager.
- There are benefits for staff to attend training together as they can then support each other when applying their learnings.
- While it is useful to plan training, it is also important to look for training opportunities as they come up.

Staff examples of other successful models

- Community brokering positions used in the Northern Territory. Aboriginal community workers who live in community and work for the health service to assist work outside of the clinic. They lived in that community, knew the language and people to assist health projects.
- Expert hubs - Victorian example used 15 years ago (no longer operating) Expertise hubs, where you could access resources, like a library and drop in and speak to others and workshop ideas. This could be a role for Primary Health Networks as other health services would be missing health promotion support as well. Or NATSIHAA could support northern ACCHOs in health promotion like VACCHO does in Victoria.

HOW THIS INFORMATION WILL BE USED

The main themes from the interviews have been shared with the research reference group at Apunipima, staff who participated in the interviews, all staff forum (Journal Club 4th Nov 2016) and with Primary Health Care Managers. The findings from these interviews will be used as part of the *Strengthening Health Promotion and Research in Practice* research project, which is being undertaken by Kath McFarlane as part of her PhD studies with James Cook University.

If you have any questions about the research please contact Kath McFarlane, email kathryn.mcfarlane@my.jcu.edu.au

9/12/16

Appendix L: Survey (post-test)

Apunipima All Staff Survey 2016

About the survey

Background
Health promotion is the "process of enabling people to increase control over their health and its determinants, and thereby improve their health" (WHO, 1986). Health promotion approaches are designed to both strengthen the skills and capabilities of individuals, groups and the broader population and also to influence the social, environmental and economic determinants of health. Health promotion approaches target the protective and risk factors of ill-health to make the healthy choice the easy choice.

For organisations to deliver effective health promotion programs and strategies, there needs to be capacity of the staff and the organisational system to support these approaches. The focus of this research project is to document the capacity and supports that are in place that strengthen health promotion program delivery at Apunipima Cape York Health Council.

The results from this survey will be compared to the survey findings collected approximately 12 months ago, to determine differences and consistencies. The results also build on information collected through specific staff interviews and focus groups.

Survey
The following survey will gather your insights into how health promotion approaches and programs are practiced at Apunipima. The questionnaire should take no longer than 30 minutes to complete.
Questions will include:
- Current health promotion practice
- Confidence in planning, implementing and evaluating health promotion programs
- Perceived barriers and enablers to the delivery of health promotion
- Perceived organisational support for health promotion
- Rating of the importance of health promotion in primary health care practice
- Some details about you (e.g. years of experience in health promotion, work team, etc)

Consent
By selecting 'next', you are consenting to participate in this survey, and acknowledge that:
- you understand the aim of this research study which is to understand and document how health promotion programs and approaches are currently being undertaken and to identify how health promotion capacity can be strengthened within Apunipima;
- your participation will involve completing the following survey. All data will be de-identified to maintain confidentiality and to preserve anonymity;
- taking part in this study is voluntary and that you are aware that you can stop taking part in it at any time without explanation or prejudice and to withdraw any unprocessed data you have provided;
- your participation in this research is voluntary and not a requirement of Apunipima Cape York Health Council;
- you agree that the researcher may use the results in research publications and reports. You will not be identified in any way in these publications;
- no names will be used to identify you with this study without your approval.

For further information
If you have any questions about the study, please contact Kath McFarlane on 4232 1614, kathryn.mcfarlane@my.jcu.edu.au or Dr Kerrianne Watt, Principal Advisor kerrianne.watt@jcu.edu.au

Apunipima All Staff Survey 2016

Your experiences

1. Which of the following are you involved with and how often (approximately)?

	weekly	monthly	yearly	never
Screening or individual risk assessment (e.g. Adult health check)	○	○	○	○
Immunization	○	○	○	○
Providing health information (e.g. brochures, pamphlets, fact sheets)	○	○	○	○
Delivering health education (e.g. Core of life)	○	○	○	○
Conducting health counseling (e.g. brief interventions)	○	○	○	○
Delivering skill development (e.g. cooking classes, parenting courses)	○	○	○	○
Social marketing (e.g. radio interviews or announcements; health messages; branded material to support campaigns - pens, water bottles, hats)	○	○	○	○
Community action and community participation (e.g. setting up or supporting mens/womens groups, community walking groups)	○	○	○	○
Advocating for the implementation of structural changes for supportive environments (e.g. shade over playground equipment, more footpaths, condom vending machines)	○	○	○	○

	weekly	monthly	yearly	never
Policy development and review (e.g. smoke free policies, healthy canteen policy, catering guidelines)	◯	◯	◯	◯
Economic and regulatory activities (e.g decreasing cost of fruit and vegetables, liquor licensing laws, ban on soft drinks)	◯	◯	◯	◯

2. Please provide examples of the types of health promotion or prevention work you have been involved in. Describe the program or activity and include, where possible, the name of the program or activity:

Apunipima All Staff Survey 2016

3. How important is it that Apunipima delivers / leads the following activities?

	Not at all important(1)	Unsure(2)	Somewhat important(3)	Extremely important(4)
Screening or individual risk assessment (e.g. Adult health check)	○	○	○	○
Immunization	○	○	○	○
Providing health information (e.g. brochures, pamphlets, fact sheets)	○	○	○	○
Delivering health education	○	○	○	○
Conducting health counseling (e.g. brief interventions)	○	○	○	○
Delivering skill development (e.g. cooking classes, parenting courses)	○	○	○	○
Social marketing (e.g. radio interviews or announcements; health messages; branded material to support campaigns - pens, water bottles, hats)	○	○	○	○
Community action and community participation (e.g. setting up or supporting mens/womens groups, community walking groups)	○	○	○	○
Advocating for the implementation of structural changes for supportive environments (e.g. shade over playground equipment, more footpaths, condom vending machines)	○	○	○	○

	Not at all important(1)	Unsure(2)	Somewhat important(3)	Extremely important(4)
Policy development and review (e.g. smoke free policies, healthy canteen policy, catering guidelines)	○	○	○	○
Economic and regulatory activities (e.g. decreasing cost of fruit and vegetables, liquor licensing laws, ban on soft drinks)	○	○	○	○

4. Any comments?

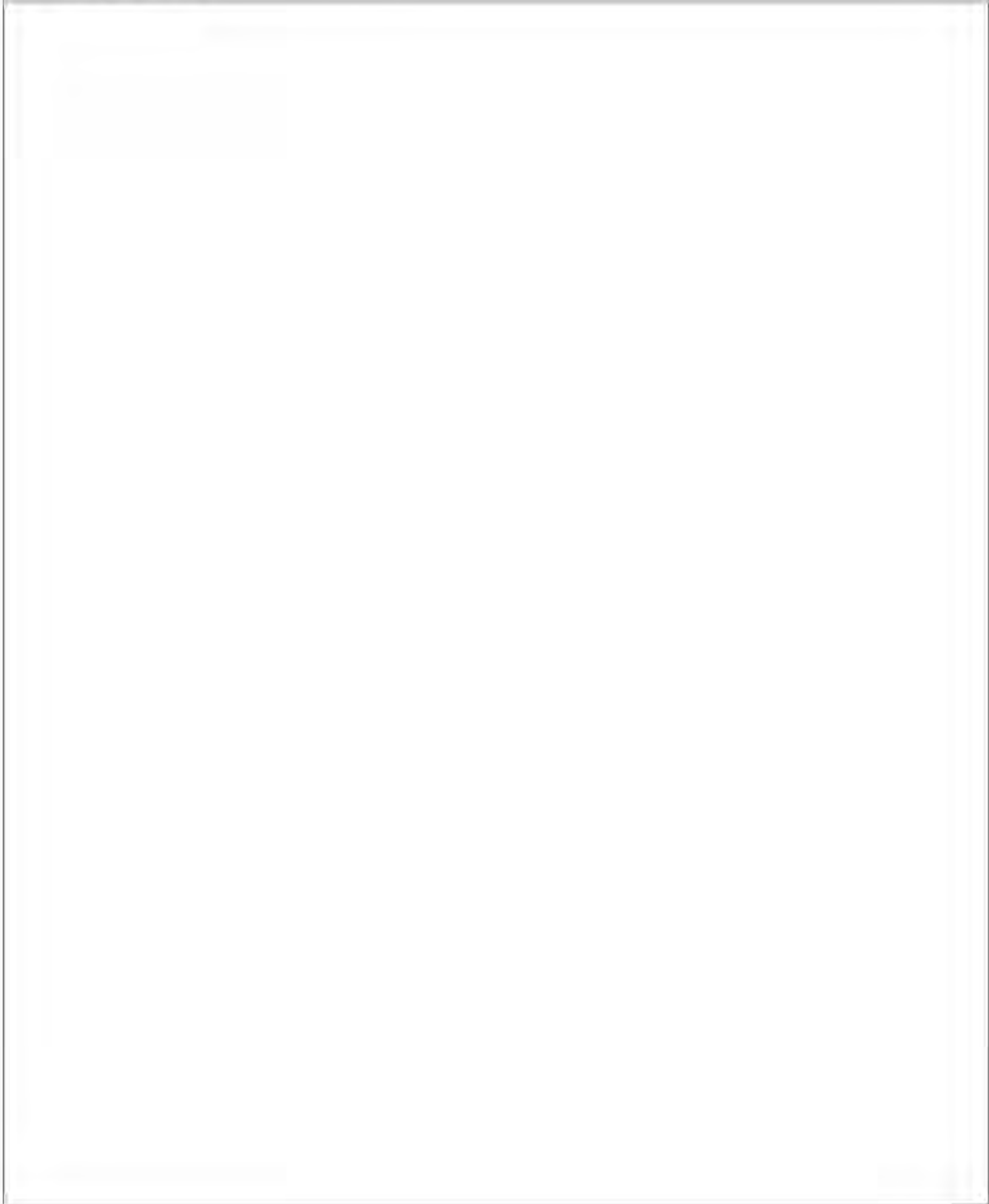
Apunipima All Staff Survey 2016

5. Please rate YOUR confidence to undertake the following activities

	Not at all confident (1)	(2)	Neutral (3)	(4)	Very confident (5)	N/A to my role
If you were asked to justify to your organisation why it should take on a greater role in health promotion, would you feel confident of being able to present a good argument?	○	○	○	○	○	○
How confident do you feel to assess the needs of the community and plan a health promotion program based on this?	○	○	○	○	○	○
How confident do you feel to contribute to the design and implementation of a health promotion initiative?	○	○	○	○	○	○
How confident are you that you can identify appropriate strategies for a health promotion program that your organisation may wish to implement?	○	○	○	○	○	○
How confident are you that you can evaluate a health promotion program that your organisation has implemented?	○	○	○	○	○	○
How confident do you feel to work collaboratively with the community?	○	○	○	○	○	○
How confident do you feel to work collaboratively with other key organisations?	○	○	○	○	○	○

	Not at all confident (1)	(2)	Neutral (3)	(4)	Very confident (5)	N/A to my role
How confident are you in giving presentations and facilitating meetings?	○	○	○	○	○	○
How confident are you in writing program plans and program completion reports?	○	○	○	○	○	○
How confident are you in using a computer and the internet as a work tool?	○	○	○	○	○	○
How confident are you to explain to others what health promotion is and the action areas of the Ottawa Charter for health promotion?	○	○	○	○	○	○

Other comments


Apunipima All Staff Survey 2016
About Apunipima

6. Please rate how well Apunipima does the following:

	Does not do this well (1)	(2)	Unsure (3)	(4)	Does this really well (5)	N/A to the organisation
Assessing and understanding the needs of the community	○	○	○	○	○	○
Planning a health promotion program	○	○	○	○	○	○
Using evidence-based strategies in health promotion and prevention programs	○	○	○	○	○	○
Evaluating health promotion or prevention programs	○	○	○	○	○	○
Working in partnership with the community on the planning and implementation of a health promotion program	○	○	○	○	○	○
Working in partnership with other key organisations in the planning of a health promotion program	○	○	○	○	○	○
Working in partnership with other key organisations in the implementation of a health promotion program	○	○	○	○	○	○
Giving presentations and facilitating meetings	○	○	○	○	○	○
Writing program plans and completion reports	○	○	○	○	○	○
Explaining to others what health promotion is and the action areas of the Ottawa Charter for health promotion	○	○	○	○	○	○

Any further comments

Apunipima All Staff Survey 2016

Enablers and barriers to health promotion

7. At Apunipima the top three (3) things that support health promotion practice are:

1.

2.

3.

8. At apunipima the top three (3) things that are a barrier to health promotion practice are:

1.

2.

3.

Apunipima All Staff Survey 2016

Organisation Support

9. In what way does your line manager or the management team support health promotion practice?

10. Are there any specific *reporting* or *planning documents* that support health promotion practice? If yes, please identify any you know of and if you have used them:

11. Are there any *policy documents* you are aware of that support health promotion and prevention practice? (Please name them if known)

12. What if anything, has changed in health promotion practice over the last year?

Apunipima All Staff Survey 2016

Please move to the next page if these questions don't apply to you

13. Some staff have worked more closely with Kath than others. If you have linked with Kath directly, what type of support has she provided?

14. How has this supported or influenced your work?

Apunipima All Staff Survey 2016

Health promotion and primary health care

15. Please rate your agreeement with the following statements:

	Strongly disagree (1)	(2)	Neither agree/disagree (3)	(4)	Strongly agree (5)
Clinical staff and community staff have a role to play in health promotion	○	○	○	○	○
Only the Health Promotion Team is responsible for the delivery of health promotion programs	○	○	○	○	○
Health promotion is separate to primary health care delivery	○	○	○	○	○
Health promotion is necessary to improve the health in our communities	○	○	○	○	○

Apunipima All Staff Survey 2016

Tell me more about you

16. Do you identify as Aboriginal and / or Torres Strait Islander?

- ◯ Yes
- ◯ No

17. How many years have you been involved in delivering health promotion or prevention programs?

- ◯ I have never been involved in deliverying health promotion programs
- ◯ Less than 12 months
- ◯ 1-3 years
- ◯ 4-5 years
- ◯ 6-10 years
- ◯ 11 or more years

18. Have you attended training in health promotion? (tick all that apply)

- ☐ I have not attended training in health promotion
- ☐ I have completed a workshop/short course in health promotion
- ☐ I have completed health promotion subjects at TAFE level
- ☐ I have completed health promotion subjects at undergraduate level at university
- ☐ I have completed health promotion subjects at postgraduate levels at university
- ☐ I have a health promotion qualification from a university

Other (please specify)

19. Which work team do you belong to? (if not clear please select 'other')

- ◯ Healthy Lifestyles
- ◯ Family Health
- ◯ Social and Emotional Well Being / Men's Health
- ◯ Doctor/ Medical Services
- ◯ Primary Health Centre Managers / Coordinators
- ◯ Business Services
- ◯ Organisational Development

Other (please specify)

20. Do you line manage other staff?

- ◯ Yes
- ◯ No

21. Do you have any further comments?

On the next page is a link to the random draw or just press 'Next' and 'Done' to submit.

Apunipima All Staff Survey 2016

Thank you for completing the questionnaire. Your assistance in this study is greatly appreciated.

If you would like to go into the draw to win 1 of 5 $20 coles/myer gift cards, please select the following link.
You will be redirected to an external survey and your name will not be linked to the responses given in this survey.

Random draw

Appendix M: Conference abstract submitted to the Population Health Congress, Hobart 6-9 September 2015

Conference Paper Abstract Submitted to the Population Health Congress, Hobart 6-9 September 2015

Title: Translating research into practice: Increasing health promotion capacity within an Aboriginal Community Controlled Health Organisation

Aim and Rationale:

Recent political changes in Australia has resulted in major funding cuts to health promotion and prevention activities. However health promotion approaches are extremely important to reduce the burden of chronic disease which disproportionally affects Aboriginal and Torres Strait Islander populations. Apunipima Cape York Health Council commenced a Participatory Action Research (PAR) process in February 2015 to identify and prioritise the organisations' strengths and barriers in health promotion practice and to translate identified action areas into practice.

Methods:

PAR is a cyclical process where the researcher acts in full collaboration with the Apunipima workforce for the purposes of achieving some kind of change. Quantitative and qualitative data will be collected via questionnaires, focus groups, interviews and document analysis.

Findings:

Results of the PAR cycles to date will be presented and will include analysis of perceived enablers and barriers to practice and, an overview of organisational systems that support health promotion practice. Descriptions of the PAR cycle/s, including priorities identified and actioned, will demonstrate how the workforce has been actively involved in the research process.

Relevance to policy, research and or practice:

Health promotion approaches can be strengthened utilising existing resources. The active involvement of the workforce in the research process builds their insight into the challenges of delivering effective health promotion approaches and allows them to identify and reflect on ways to increase health promotion capacity.

Appendix N: Conference abstract submitted to the Primary Health Care Research Symposium, Adelaide 29-31 July 2015

Translating research into practice: Increasing health promotion capacity within an Aboriginal Community Controlled Health Organisation

Introduction/background/issues

How Aboriginal primary health care organisations deliver effective health promotion approaches remains undocumented. Apunipima Cape York Health Council commenced a Participatory Action Research (PAR) process in February 2015 to identify and prioritise the organisations' strengths and barriers in health promotion practice and to translate identified action areas into practice.

Methods

PAR is a cyclical process where the researcher acts in full collaboration with the Apunipima workforce for the purposes of achieving some kind of change. Quantitative and qualitative data will be collected via questionnaires, focus groups, interviews and document analysis.

Results/discussions

Results of the PAR cycles to date will be presented and will include analysis of perceived enablers and barriers to practice; and, an overview of organisational systems that support health promotion practice. Descriptions of the PAR cycle/s, including priorities identified and actioned, will demonstrate how the workforce has been actively involved in the research process.

Conclusions/implications

PAR allows the collection of evidence to inform organisational policy and practice and reflect on the effectiveness of changes made. The engagement of the workforce in the research process builds their insight into the challenges of delivering health promotion approaches and allows them to identify and reflect on ways to increase health promotion capacity.

Key message

Health promotion capacity can be increased through PAR. The active involvement of the workforce in the research experience will be of interest to both Aboriginal and mainstream primary health care organisations.

Appendix O: Poster presented at the Primary Health Care Research Symposium, 2015; and the Population Health Congress, 2015

Translating research into practice: Increasing health promotion capacity within an Aboriginal Community Controlled Health Organisation

Kathryn McFarlane[I], Kerrianne Watt[I], Jenni Judd[II], Sue Devine[I], Aletia Twist[II], Melinda Hammond[III], Nina Nichols[III], Rachael Ham[III], Priscilla Gibson[III]

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[I] Division of Tropical Health and Medicine, James Cook University

[II] Apunipima Cape York Health Council

What is health promotion?

Health promotion is "the process of enabling people to increase control over their health and its determinants, and thereby improve their health"[1], and plays an important role in maintaining and improving the overall health of the population.

By specifically improving diet, physical activity levels and eliminating tobacco smoking, at least 80% of all heart disease, stroke and Type 2 diabetes and over 40% of cancer would be prevented[2].

Why is health promotion important in Primary Health Care?

At both a state and national level there have been major funding cuts to health promotion resources including: staffing, program funding, loss of national leadership and research in preventive health areas.

The need for primary health care organisations to continue to improve population health outcomes remains. This is particularly so for Aboriginal Community Controlled Health Services when the burden of chronic disease disproportionately affects Aboriginal and Torres Strait Islander populations[3].

Method

Apunipima Cape York Health Council commenced a Participatory Action Research (PAR) process in February 2015 to identify and prioritise the organisation's strengths and barriers in health promotion practice and to use these findings to identify action areas to focus on.

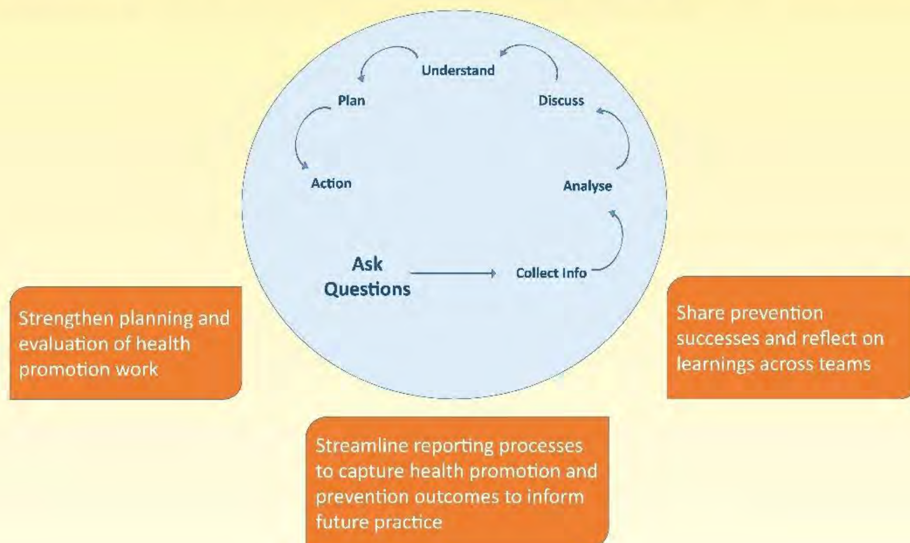
PAR is a cyclical process where the researcher acts in full collaboration with the workforce for the purposes of achieving change. The PAR process is an empowering process. By engaging participants in the process of inquiry it acknowledges their competence and worth and develops a productive relationship that builds trust and understanding[4]. Through a prioritisation process with the Reference group at Apunipima, three priorities have been identified to date.

Conclusion

Health promotion approaches can be strengthened utilising existing resources[5].

The active involvement of the workforce in the research process:

- builds understanding of the challenges of delivering health promotion approaches
- allows the workforce to identify and reflect on ways to increase health promotion capacity.



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Appendix P: Publication co-authored by candidate during the thesis

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Working From the Inside Out: A Case Study of Mackay Safe Community

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Abstract

Mackay Whitsunday Safe Community (MWSC) was established in 2000 in response to high rates of injury observed in the region. MWSC assumed an ecological perspective, incorporating targeted safety promotion campaigns reinforced by supportive environments and policy. By involving the community in finding its own solutions, MWSC attempted to catalyze structural, social, and political changes that empowered the community and, ultimately, individuals within the community, to modify their environment and their behavior to reduce the risk of injury. A community network consisting of 118 members and an external support network of 50 members was established. A social network analysis conducted in 2000 and 2004 indicated that the network doubled its cohesiveness, thereby strengthening its ability to collaborate for mutual benefit. However, while MWSC was rich in social resources, human and financial resources were largely controlled by external agencies. The bridging and linking relationships that connected MWSC to its external support network were the social mechanism MWSC used to access the resources it required to run programs. These boundary-spanning relationships accessed an estimated 6.5 full-time equivalents of human resources and US$750,000 in 2004 that it used to deliver a suite of injury control and safety promotion activities, associated with a 33% reduction in injury deaths over the period 2002 to 2010. MWSC can only be understood in its ecological context. The productivity of MWSC was vulnerable to the changing policy priorities of external sponsoring agents and critically dependent on the advocacy skills of its leaders.

Keywords

injury prevention, international safe communities, safety promotion, social ecological model, social network analysis, sustainability

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