Reorienting health services with capacity building: a case study of the Core Skills in Health Promotion Project

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SUMMARY

This paper presents a case study of the application of a framework for capacity building [Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B. (2000) Indicators to Help with Capacity Building in Health Promotion. *NSW Health, Sydney] to describe actions aimed at building organizational support for health promotion within an area health service in New South Wales, Australia. The Core Skills in Health Promotion Project (CSHPP) arose from an investigation which reported that participants of a health promotion training course had increased health promotion skills but that they lacked the support to apply their skills in the workplace. The project was action-research based. It investigated and facilitated the implementation of a range of initiatives to support community health staff to apply a more preventive approach in their practice and it contributed to the establishment of new organizational structures for health promotion. An evaluation was undertaken 4 years after the CSHPP was established, and 2 years after it had submitted its final report. Interviews with senior managers, document analysis of written reports, and focus groups with middle managers and service delivery staff were undertaken. Change was achieved in the three dimensions of health infrastructure, program maintenance and problem solving capacity of the organization. It was identified that the critically important elements in achieving the aims of the project—partnership, leadership and commitment—were also key elements of the capacity building framework. This case study provides a practical example of the usefulness of the capacity building framework in orienting health services to be supportive of health promotion.*

Key words: capacity building; leadership; partnership; reorienting health services

INTRODUCTION

Reorientation of health services to be more supportive of health promotion requires an increase in the capacity of the health service staff themselves and of the organization. Hawe and colleagues developed a framework on capacity building in the field of health promotion that identifies indicators for success at the individual, program and organizational levels (Hawe *et al.*, 1997). Informal learning and the provision of management support for staff to be involved were identified as critically important in supporting individual action. Changes within an organization may be resisted by staff because of increased workload or a change in work focus (Nirenberg, 1991). Such potential for resistance can be addressed through involving staff in activities that facilitate the change process (Goldstein, 1988). Staff involvement in the process has been identified as critical in assisting staff to recognize the need for change and to develop a sense of ownership of the proposed change (Pettigrew *et al.*, 1988; Nirenberg, 1991). In addition, fear of change can be reduced through better communication (More, 1991).

The capacity building framework also incorporates recognition of the need to embed health

promotion programs within an organization. Hawe *et al.* believe that health promotion must be integrated with other health service roles and provided with recognition and support to enable the build-up of organizational knowledge, ideas and resources for effective health promotion action (Hawe *et al.*, 1997). At the organizational level, support for health promotion needs to be integrated into the policies and procedures of the organization. Knowledge and skills gained from one health promotion initiative should contribute to the organization's capacity to take on new and different initiatives in the future.

Reorientation of health services to health promotion is a core element of a comprehensive approach to maximize the health capacity of a community [World Health Organization (WHO), 1986; Lopez-Acuna *et al.*, 2000]. Formal training of health service staff in relevant health promotion knowledge and skills is not sufficient to achieve long-lasting changes. Supportive organizational structures are required to reinforce knowledge and skills gained during staff training and enable them to be applied (Tunny, 1996). The work environment needs to encourage or require staff to incorporate health promotion initiatives into their work practices (NSW Health, 2001b; Australian Centre for Health Promotion, 2002). The organization also needs to manage competing demands on staff to address state and local health priorities as well as deal with wider issues brought about by limited public health budgets and limited staffing combined with an increasing demand for direct service provision.

This paper describes the long-term outcomes of a project that facilitated and investigated the implementation of a range of organizational 'support' structures to enable community health staff to reorient their work to a more preventive approach. The key contributions of this project provide an important case study of the application of the capacity building framework to the health promotion strategy of reorientation of health services to be supportive of health promotion.

HEALTH SERVICES IN NEW SOUTH WALES, AUSTRALIA

Within the state of New South Wales, Australia, public health services are organized on an area basis. State funding is provided to local area health services to provide all primary, secondary and tertiary services. Hospital and community services are independent. The primary health care services provided by community health are free and include generalist community nursing, school nursing, maternal and child health, counselling, health promotion and specialist services (e.g. drug and alcohol, youth, aged care and multicultural). Community-based health professionals include nurses, dietitians, physiotherapists, social workers and psychologists. Health professionals (e.g. nurses, dietitians, physiotherapists) in Australia have the same basic pre-service training whether they work in hospital or community health services. However, community health staff are, on average, required to devote 10% of their time to health promotion initiatives, addressing local needs or contributing to state-wide initiatives. The Core Skills in Health Promotion training program was developed to assist community health staff in this health promotion role.

Also located within the area health services is an area-wide health promotion unit/service. This unit provides specialist health promotion services and programs and it is responsible for the implementation, in the western Sydney area, of state-wide health promotion programs, for example, falls prevention in the home and promotion of fruit and vegetable consumption (NSW Health, 2001a). This health promotion unit links with the community health services as the implementation of state-initiated health promotion programs usually relied significantly on the involvement of local community health staff. This has resulted in community health staff needing to balance their attention to key local health promotion issues while also attending to state-wide priorities. Examples of locally relevant health promotion priorities include personal safety issues and parenting issues in a new housing development. Community health staff had a preference for undertaking health promotion activities with which they were familiar, for example providing health information booths at local shopping centres. Health promotion funding was available for initiatives that addressed state-wide priorities but was not necessarily for the local health issues.

The organization of the health services resulted in pressure on community health staff in their health promotion role. They were torn between staying within their limited area of health promotion expertise and addressing local health issues without additional resources, and being co-opted into state-wide initiatives that they felt may not be high priorities in their local area.

Such tension was amplified by limited budgets, competing demands for service provision and lack of management support for staff to undertake health promotion initiatives.

THE CORE SKILLS IN HEALTH PROMOTION PROJECT

The Core Skills in Health Promotion Project (CSHPP) was initiated to develop and pilot management strategies that would assist workers undertake health promotion within their work role. The CSHPP was based on the evaluation findings of the health promotion training program that had been offered to all new community health staff in the area health service (Nove, 1994; Nove and Heslep, 1994; Tunny,

1996). The six objectives of the CSHPP are listed in Table 1.

The need for organizational support for health promotion was identified at the beginning of the project. Specific strategies were developed through the actions of an area-wide Reference Committee. This committee adopted an iterative communication strategy involving staff and managers from throughout the community health services (Bohr and Nove, 1997; Nove and Yeatman, 1998). The Reference Committee developed recommendations based around seven themes, some of which addressed staff needs while others identified requirements for management and organizational support (Table 2).

The CSHPP was undertaken at the same time as two other health promotion projects within the same community health services, one examining

Table 1: CSHPP objectives

Objective 1	To inform community health staff of the findings of the evaluation of the health promotion training program
Objective 2	To access community health staff responses to the data
Objective 3	To identify a range of management strategies to support and facilitate health promotion in the workforce
Objective 4	To prioritize and select strategies
Objective 5	To pilot and implement appropriate strategies
Objective 6	To monitor and evaluate the effectiveness of the strategies within a framework of organizational change

Table 2: Themes and recommendations for support structures for health promotion in community health, as identified in the CSHPP

Themes	Recommendations
Acknowledgement for health promotion initiatives already happening	• Adoption of WHO definition of health promotion within the community health service • Formal procedures to acknowledge staff who undertake health promotion activities • Members of Core Skills Reference Committee be co-opted to Community Health Review (CHR) working parties and implementation teams as appropriate • Provision of health promotion update seminars and workshops
Statistics and records to reflect health promotion activities	• Recording and reporting system be developed for health promotion activities, for managers to use for planning processes
Ceiling on clinical work	• Desirable, but difficult to achieve
Mentor support for skills development	• Chosen models and/or 'support' strategies be piloted in local areas • Members of Core Skills Reference Committee assist in ongoing consultation with community health staff • Review ways to link health promotion skills development and program delivery models with practice opportunities • Mentor scheme be established
Sharing resources/re-allocation of resources	• Recording and reporting system be developed for health promotion activities, to enable staff to access resources and expertise more easily
Modular health promotion training courses	• Core Skills training program be expanded and developed in modular formats • Provision of health promotion update seminars and workshops
Job descriptions and manager support	• Seminar for managers on skills in managing change in relation to health promotion infrastructure for community health

quality assurance and health promotion (Poole, 1996), and the other developing health promotion policy for a sector within the health services (Health Promotion Working Group, 1997). The recommendations relating to these three projects were brought together by the community health services and used as the basis for a major restructuring of health promotion management and reporting (Community Health Development Project, 1998) (see Figure 1).

METHODS

A long-term follow-up of the CSHPP was conducted in 1999, 4 years after the project was established. This evaluation was undertaken using three methods.

Semi-structured interviews were conducted with senior managers to determine their perspective of the implementation of the CSHPP recommendations and of the contributions it made to the Community Health Review (CHR) process,

its recommendations and their implementation. All senior managers in Community Health were interviewed (April to May 1998, $n = 5$).

A document analysis of written reports from the three health promotion projects was undertaken to identify their different contributions to the outcomes of the CHR process and its recommendations. The detail and outcomes of this analysis are reported elsewhere (Butt, 1999). The recommendations of the reports were compared with the recommendations of the review and the proposed Forum Model for Health Promotion.

Focus groups (April to May 1999, $n = 18$ participants) were undertaken with middle managers and service delivery staff. These groups aimed to determine participants' perceptions of the extent to which the recommendations of the CSHPP had been implemented, and their knowledge of the new structures for health promotion that had been introduced.

The interviews and focus groups were all undertaken by the first author and were audiotaped and transcribed. The transcripts were
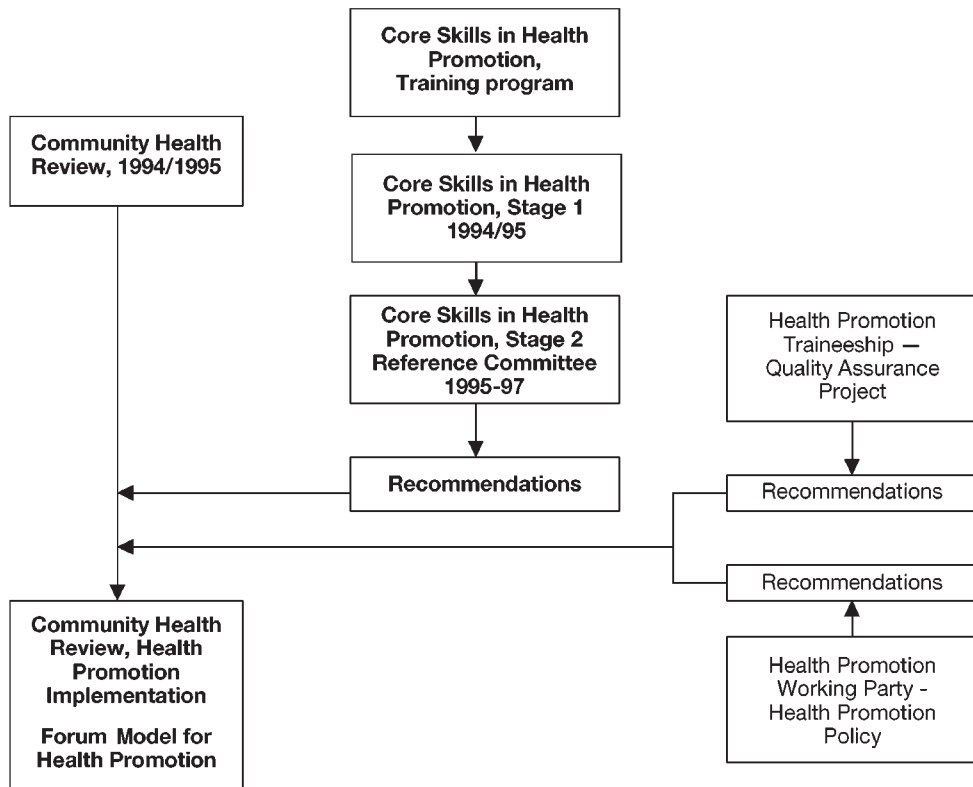
Fig. 1: Relationship between Health Promotion Projects and the CHR.

analysed for recurring themes and issues. The documents were analysed for possible linkage between the frameworks and recommendations of the health promotion projects, and the process and outcomes of the Community Health Review of health promotion. Consistencies between the different reports were noted, together with unique contributions made by the reports to the final outcomes.

Examination of links between the reorientation of health services and actual changes in health outcomes of programs delivered by those services was not undertaken, as the reorientation of the services had commenced but was not fully implemented at the time of this study.

RESULTS

Manager interviews

The interviews with senior managers were undertaken 15 months after the recommendations of the CSHPP had been handed over to the CHR team. During this period of time the CHR had developed new structures to support health promotion initiatives within the community health services. Overall, there was general agreement amongst senior managers that the CSHPP had made a valuable contribution in shaping the new structures. However, direct attribution by the CSHPP to the outcomes of the CHR was not possible. This was also the finding of the documentary review of the various project reports (Butt, 1999).

Several of the senior managers made specific reference to contributions of the CSHPP. Some thought that the commitment and enthusiasm shown by the Reference Committee members had influenced the CHR to raise the priority of health promotion issues in their deliberations. Senior managers also cited specific recommendations arising from the CSHPP that were taken into account in the CHR, including the role of mentoring, the need for monthly statistics to reflect health promotion activities more accurately, the need to develop partnerships to further health promotion initiatives and the need for more training in health promotion. The recommendations of the CSHPP to promote good communication within and between organizational levels were considered by the managers to have been acknowledged by the CHR through the proposal to establish three levels of health

promotion forums across the community health services.

Focus groups

The focus groups with staff were conducted more than 2 years after the recommendations of the CSHPP had been handed on to the CHR team. Participants in the focus groups had variable knowledge of the previous health promotion evaluation projects, including the CSHPP and of the proposed Forum Model for Health Promotion that had arisen from these previous projects. Middle managers who had been involved in the Reference Committee of the CSHPP were most informed. Other managers and service delivery staff generally had poor knowledge of health promotion initiatives.

Lack of knowledge of the health promotion initiatives could be attributed to several things. The time delay between undertaking the review of health promotion and disseminating the recommendations was important. Little communication with community health unit staff about the activities of the CHR team had occurred during this period. When communication about the new health promotion model did finally occur, the context of the need to restructure health promotion planning and support had been lost. The time delays also meant that a significant number of staff had changed positions or had left during that period. Despite the poor communication of information, participants were keen and interested to know that the health services did have a planned structure for health promotion and had commenced its implementation.

The types of health promotion issues and concerns expressed by community health staff in the focus groups were the same as those reported at the outset of the CSHPP. Concern was expressed about lack of recognition for health promotion activities within community health services, lack of management support, lack of resources, difficulties in getting health promotion initiatives to be considered priorities, variable quality of health promotion work, the need to develop partnerships to undertake health promotion, and lack of higher level skills training in health promotion. Clearly the delays in acting on the recommendations of various health promotion reviews had resulted in little change for the community health staff.

It was considered by participants that some of the issues would not be resolved by the proposed

new structure for health promotion, in particular the issue of gaining health service acknowledgement through routine record keeping (monthly statistics) of staff involvement in health promotion. This issue had been taken up by the state health services, but the anticipated progress on developing meaningful methods of recording health promotion involvement of staff had not occurred. This lack of acknowledgement of the health promotion initiatives of the community health staff by 'the system' appeared to remain a sensitive issue with the staff.

Key roles of the Reference Committee

Focus group participants who had been members of the Reference Committee of the CSHPP identified several factors that they considered had contributed to the effectiveness of the project. The dissemination to staff of the findings of the first stage of the project (Tunny, 1996) by the Reference Committee members raised broad awareness of the need for support for health promotion activities within the health services. The active participation of the Reference Committee members was thought to have encouraged ownership and promoted communication between community health staff, managers and the project. The importance of this communication role had been reinforced during the project through staff praise for how well information was communicated.

The structure of the Reference Committee was thought by the staff to be important. It was considered to be inclusive of all community health units and of different levels of responsibility. Wide representation on the committee was considered to have ensured that the CSHPP took account of the different organizational cultures and needs of each community health unit. Also it was thought that involvement of managers on the Reference Committee demonstrated their support to subordinate staff and provided opportunities for cross-fertilization of ideas, as managers represented the project in other forums.

The Reference Committee was outside the line management structure of the community health services. It continued to be active despite significant organizational changes in the community health services during the course of the CSHPP. Past members of the Reference Committee had reflected on these organizational changes and had used them to investigate and clarify health promotion policies and communication structures within community health. Reference Committee members in the focus groups also reported that they learnt a lot through involvement in the Committee, as it provided an environment in which to explore health promotion issues with other staff and to develop support strategies for health promotion in the workplace.

The existence of the Reference Committee was considered by focus group participants to be symbolic. The Reference Committee was viewed as a voice supporting health promotion for all of the community health services, not just a single region or the designated health promotion unit that had been the foci of other projects underway at the same time. The Reference Committee (and the project) was thus considered to have provided important leadership for health promotion within the community health services.

DISCUSSION

Long-term evaluations of health promotion initiatives are uncommon. This study has provided useful insights into a range of factors that influenced the capacity of community health services to be more involved with health promotion initiatives.

The CSHPP was considered to have acted as a stimulus for the organization to consider health promotion issues as a priority, resulting in a new structure for health promotion. The CHR established three tiers of forums through which health promotion service agreements were negotiated and funding committed. Local health priorities were to be considered alongside state-wide priority areas.

Linking consideration of local and state priorities within the one organizational process can be considered important for two reasons. First, as identified by Vinzant and Crothers, an organization must maintain its relevance within its local environment (Vinzant and Crothers, 1996). They identify that local-level professionals have an important role in linking the organization's goals to those of the local community. In this case local community health staff were advocates for local health promotion priorities, which were given legitimacy by the organization through joint consideration in the new structure for health promotion priority setting and budget allocation. Secondly, the new structure represents a key institutional response to the issue of health promotion within the health services

(Schlager, 1995). It was designed to ensure organizational communication channels for health promotion initiatives and also acted to embed health promotion programs within the health services. The effect of this would be to increase the capacity of the health services at the program level to undertake health promotion.

An organization needs to build the capacity to maintain a change once that change has been decided. This is needed at the individual, program and organizational levels. The Reference Committee of the CSHPP was identified as acting as a support to individuals through direct involvement in the project and via linkage back to the community health units. Through their joint representation on the committee, links between local community health services and the health promotion services unit within the health services were achieved. Staff also considered that the community health workforce's health promotion capacity was improved through involvement in the Reference Committee and through specific staff training initiatives developed in response to the early actions of the CSHPP.

The development of organizational capacity for health promotion by the CSHPP was reflected in the integration of changes into the policies and procedures of the organization after the initial intervention was withdrawn (Hawe *et al.*, 1997). The CSHPP aimed to achieve change at the individual and program level, and to set up a collaborative problem-solving framework within which to work. These same aims were subsequently incorporated within the CHR process. Senior managers of health promotion and community health were, for the first time, working together to determine an 'integrated', 'coordinated', and 'quality' model of health promotion (Community Health Development Project, 1998). The implementation of new health promotion policies, indicated by the establishment of the Forum Model for Health Promotion, was a clear reflection of the organization's increased health promotion capacity, persisting after the completion of the CSHPP.

A key structural factor contributing to the effectiveness of the CSHPP was the Reference Committee. The Reference Committee had a pivotal role within the action research approach of the CSHPP. It had very important roles in communicating early project outcomes, in overcoming resistance associated with organizational change and in providing an environment for collaborative problem-solving. The Reference Committee could be considered to have developed into what Sabatier refers to as a policy community or advocacy coalition, supporting the development of agreed health promotion support structures with the health services (Sabatier, 1993).

The roles of the Reference Committee are worthy of in-depth consideration. In addition to the roles just described, it contributed three key elements to the effectiveness of the project. Specific contributions directly made by, and also facilitated by, the Reference Committee were leadership, partnership and commitment.

Leadership

Leadership was essential to the effectiveness of the CSHPP. The Reference Committee and the project's manager both acted to maintain the core focus of the project within the very complex organizational arrangements of the community health services and over a significant period of time. Due to its broad representation, the Reference Committee was an alternate organizational structure that cut across line management structures. It provided both legitimacy (due to its composition) and ensured professional interests were considered (Laffin, 1986). The middle managers on the Reference Committee provided leadership within the community health services. They acted to motivate and support staff, and they implemented small activities to support health promotion within service units. The project's manager did not work within the community health services but worked with them in a staff development capacity. She was able to identify with their needs, while maintaining some objectivity due to her organizational distance. She was also able to communicate with a broad range of staff, including key managers, as she did not have a line management position. In this professional position and with actions taken on behalf of the Reference Committee, she demonstrated clear leadership for the CSHPP.

Partnership

The important element of partnership was closely linked to leadership. As already mentioned, the Reference Committee comprised staff from all levels of the community health services, together with health promotion staff, a representative of the funding agency and an academic. The Reference Committee members were very active in

ensuring that they were truly representing their health units. This effectively formed a partnership between all of the health units represented on the committee.

The presence of the funding agency's representative and the external academic on the Reference Committee reinforced the importance of the partnership with the funding agency. Front-line health staff are not often in the situation of working alongside representatives of federal health agencies and academics. These representatives clearly denoted the external credibility and accountability of the project's work, and the importance that the federal agency and the academic community placed on the partnership

Commitment

The third element was commitment, specifically building commitment, demonstrating commitment, maintaining commitment over the time of the project and ensuring ongoing commitment through the development of new organizational structures. Building and demonstrating commitment were the main roles of the Reference Committee, through the process of its work. Publicly it represented a clear resource commitment of the project. It supported the project officers who worked on the CSHPP and required a significant commitment of staff time to the outcomes of the project.

Organizational change takes time. Staff turnover reduces knowledge of and commitment to the project, and external factors can intervene. It was critical to foster manager support during the project, to keep staff informed and to respond to their needs for changes in timeframes to complement other health service initiatives. Commitment to the project's objectives was reinforced when recommendations from the Reference Committee were incorporated into new management structures for health promotion within the health services. These new management structures had budgets and responsibilities linked to them, demonstrating that the organization had taken on a commitment to maintain the changes.

CONCLUSION

Evaluation of an initiative that aimed to provide organizational support for health promotion action within a health service has provided some important insights into the usefulness of the capacity building framework (Hawe *et al.*, 1997), literature on elements of organizational change, and strategic roles that can be undertaken by alternative organizational structures.

First, partnership and leadership elements are important in the implementation of the three main strategies/action areas of the capacity building framework: workforce development, organizational structures and resource allocation. Action was effective at the levels of individuals, programs and organization, all considered to be important to capacity building (Hawe *et al.*, 2000).

Secondly, key components of organizational change frameworks are important, such as involving staff at all levels in the change process to help overcome resistance, promoting effective communication and obtaining commitment for change. Also important is the involvement of both senior and middle managers as key catalysts for the change, as well as them acting as role models for staff. Hence, theoretical models from other fields, such as management, can be usefully applied within projects that aim to reorient health services. Health promotion staff should look more broadly than behaviour change frameworks if they are to achieve reorientation of health services, a key strategy for achieving health promotion outcomes (Lopez-Acuna *et al.*, 2000).

Thirdly, organizational structures as well as individuals are essential to achieving the reorientation of health services. In this project an alternate organizational structure, the Reference Committee, played key roles of partnership and leadership within the project. It developed leaders for the project by providing members with the necessary information to assume a key role in their own units. Indirectly it provided managers, already in leadership positions, with insight into the project, which was shared and developed further in other forums. The Project Manager also undertook a strong leadership role. She was a strong advocate of the project and understood the need to ensure the long-term success of the project.

Finally, commitment is important to the achievement of organizational change and increased capacity for health promotion. By highlighting commitment as a separate element, it may provide insight into why other elements such as policy development or new organizational structures may be effective in some circumstances but

not others. The element of commitment may be especially important in sustaining such change projects over the many years that are required to produce the desired outcomes. Commitment is clearly linked to partnership and leadership. All three elements work together to develop, enhance or support workforce development, resource allocation and organizational structures. The role of commitment within organizational change and capacity building frameworks warrants further investigation.

In conclusion, this 4-year evaluation of a health promotion initiative identified the importance of the organizational environment to the achievement of outcomes. Partnership, leadership and commitment were found to be key elements in achieving the organizational change necessary to support health promotion. These elements were the result of a combination of individual, structural and management contributions. They acted together to achieve improved capacity for health promotion through workforce development, resource allocation and structural change. Practitioners need to be cognizant of the importance of such elements in their health promotion initiatives and must strive to achieve an effective combination of such organizational factors when implementing health promotion initiatives.

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REFERENCES

Australian Centre for Health Promotion (2002) *Final Report. Strengthening Health Promotion in New South Wales: a Map of the Work and Implication for Workforce Planning and Development*. Australian Centre for Health Promotion, Sydney University, Australia. Unpublished.

Bohr, M. and Nove, T. (1997) *Core Skills in Health Promotion Outcome Evaluation Study. Stage 2. Interim Report*. Western Sydney Area Health Service, Health Promotion Professional Services Unit, North Parramatta, NSW, Australia.

Butt, J. (1999) Evaluating organisational change strategies: health promotion, Western Sydney. Master of Science (Nutrition and Dietetics) thesis, University of Wollongong, unpublished.

Community Health Development Project (1998) *The Health Promotion Forum Model—a Planning, Coordination and Communication Framework for Health Promotion in Community Health*. Western Sydney Area Health Service, Australia.

Goldstein, J. (1988) A far-from-equilibrium systems approach to resistance to change. *Organizational Dynamics*, **17**, 16–26.

Hawe, P., Noort, M., King, L. and Jordens, C. (1997) Multiplying health gains: the critical role of capacity-building within health promotion programs. *Health Policy*, **39**, 29–42.

Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B. (2000) *Indicators to Help with Capacity Building in Health Promotion*. NSW Health, Sydney, Australia.

Health Promotion Working Group (1997) *Health Promotion Policy. Division of Community and Allied Health*. Western Sydney Area Health Service, Division of Community and Allied Health, Blacktown/Mt Druitt, NSW, Australia.

Laffin, M. (1986) *Professionalism and Policy: the Role of the Professions in the Central-Local Government Relationship*. Gower Publishing Company, Aldershop.

Lopez-Acuna, D., Pittman, P., Gomez, P., Machado de Souza, H. and Fernandez, L. (2000) *Reorienting Health Systems and Services with Health Promotion Criteria*. Technical paper prepared for the Fifth International Conference on Health Promotion, 5–7 June 2000, Mexico City. WHO, Geneva. Available online at http://www.who.int/hpr/conference/products/techreports/indextechreports.html (accessed 13 August 2002).

More, E. (1991) Communication and organisational change: is that all there is? *Australian Journal of Communication*, **18**, 1–13.

Nirenberg, J. (1991) Managing change as if people mattered. *Bond Management Review*, **2**, 11–18.

Nove, T. (1994) *Report on Health Promotion Professional Services Unit 1994*. Western Sydney Area Health Service, Health Promotion Professional Services Unit, North Parramatta, NSW, Australia.

Nove, T. and Hesle, J. (1994) *Health Promotion Core Skills program*. Western Sydney Area Health Service, Health Promotion Professional Services Unit, North Parramatta, NSW, Australia.

Nove, T. and Yeatman, H. (1998) *Building Capacity for Health Promotion*. XVI World Conference on Health Promotion and Health Education, 21–26 June 1998, San Juan, Puerto Rico.

NSW Health (2001a) Health Promotion. Available online at http://www.health.nsw.gov.au/public-health/health-promotion/. Updated 28 August 2001 (accessed 28 October 2001).

NSW Health (2001b) A Framework for Building Capacity to Improve Health. Available online at http://www.health.

nsw.gov.au/public-health/health-promotion/pdf/framework/ Capacitybuilding.pdf. Updated 25 October 2001 (accessed 21 February 2002).

Pettigrew, A., McKee, L. and Ferlie, E. (1988) Understanding change in the NHS. *Public Administration*, **66**, 297–317.

Poole, H. (1996) *Quality Assurance for Health Promotion in Community Health*. Discussion Paper. A Health Promotion Traineeship Project. Western Sydney Area Health Service, Western Sydney Area Health Promotion, North Parramatta, NSW, Australia.

Sabatier, P. (1993) Policy change over a decade or more. In Sabatier, P. and Jenkins-Smith, H. (eds) *Policy Change and Learning: an Advocacy Coalition Approach*. Westview Press, Boulder, CO, pp. 13–41.

Schlager, E. (1995) Policy making and collective action: defining coalitions with the advocacy coalition framework. *Policy Sciences*, **28**, 243–270.

Tunny, N. (1996) *What Support Factors are Needed by Non-designated Health Workers to enable their Involvement in Health Promotion? An Investigation of Manager and Worker Perceptions*. Masters of Public Health thesis, Department of Public Health and Nutrition, University of Wollongong, unpublished.

Vinzant, J. and Crothers, L. (1996) Street-level leadership: rethinking the role of public servants in contemporary governance. *American Review of Public Administration*, **26**, 457–475.

WHO and Canadian Public Health Association (1986) *The Ottawa Charter for Health Promotion. First International Conference on Health Promotion: The Move Towards a New Public Health*. November 1986. WHO and Canadian Public Health Association, Ottawa, Canada.