Working invisibly: health workers talk about capacity-building in health promotion

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SUMMARY
A series of six focus groups was held with health promotion workers to explore the meaning and experience of ‘capacity-building’, a term which is used variously in the literature. The research is part of a participatory, practice-based project to develop outcome indicators in capacity-building. Capacity-building was defined as seeking to develop health promotion skills and resources, and also problem-solving capability, at five levels: the individual; within health care teams; within health organisations; across organisations; and within the community. While workers had little difficulty in identifying outcomes of capacity-building, indicators of quality or good process were more difficult to articulate. This was partly because capacity-building was described as an invisible, even secret process. Capacity-building is hidden from funders and administrators because it is not generally regarded as a legitimate project activity; that is, it is not directly linked to risk factor behaviours in priority areas such as cancer, heart disease and injury control. Capacity-building is also hidden from other workers in order to make it more effective. This is particularly the case with health promotion workers working within what they perceive to be hostile climates, such as health care settings experiencing funding cut backs. The invisibility of practitioners’ capacity-building work has implications for quality control, guiding theory, practice ethics, peer support, worker morale and funding mechanisms in health promotion.

Key words: capacity-building; community development; health care settings; health promotion; reorientation

INTRODUCTION
The field of health promotion can be increasingly characterised by its jargon. Further, the quick adoption of a new term may give a semblance of understanding and consensus to a concept which may in fact be vague or complex.

‘Capacity-building’ is a relatively recent term in health promotion. It appears in the newly declared Jakarta statement on health promotion and it is used in various ways in the health promotion or public health literature as summarised in Figure 1 (Hawe et al., 1997). For example, some people use the term capacity-building to refer to the building of infrastructure (staff, skills, resources, structures) across health and other agencies to tackle particular health problems. These authors refer to building capacity for a specific purpose such as cancer control or heart disease prevention. Other authors have used the term to refer to the notion of program sustainability, or the capacity to maintain and continue a particular health promotion effort after it has passed through a
demonstration stage. At a more fundamental level, capacity-building has been used to refer to problem-solving capability among individuals, organisations, neighbourhoods and communities. The last use relates closest to how the term has been used in the organisational development literature (Sashkin and Burke, 1990). It has been argued that this type of capacity-building is superior to efforts directed to promoting program continuation or sustainability alone. This is because there are times when the more appropriate action is for a program to be modified or terminated, allowing the development of alternative strategies to address new problems as they evolve (Green, 1989; Hawe, 1994).

We set out to explore how health promotion workers use the term capacity-building and to gain insights into their experience of this style of work. This is part of a practice-based, participatory research project to design outcome indicators in capacity-building and to identify ways to improve practice in capacity-building. We also set out to identify current dilemmas and issues for health promotion workers in this field.

METHODS

The study was conducted in New South Wales, where health promotion workers are located in area-based community health services and in units attached to hospitals in 13 health regions across the state. In addition to generalist workers, the workforce includes project workers on short-term funding in particular fields such as skin cancer prevention, women’s health and falls prevention.

We employed maximum variation sampling techniques because we were searching for shared patterns and issues across the heterogeneity of practice approaches in area-based health promotion services (Patton, 1990). Six focus groups were conducted, three in rural areas, two in metropolitan Sydney and one on the outskirts of Sydney. The sample encompassed area health units where written health promotion plans and documents revealed a strong adoption of capacity-building terminology, as well as area health units where formal documentation of health promotion work remained centred on more mainstream health status/preventive health behaviour issues. Forty-three people were involved in groups ranging from six to ten people in size. The research was described on a project information brochure as an opportunity to talk about the meaning and experience of capacity-building, as a relatively new term in health promotion. We anticipated that the word alone might not have been sufficiently engaging. So, mindful of not wishing to lead participants’ thoughts, a short paragraph on the brochure added that the purpose of the discussion was to try to help us gain a

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<tr>
<th>1. Health infrastructure or service development</th>
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<tr>
<td>Refers to capacity to deliver particular program responses to particular health problems. Usually refers to the establishment of minimum requirements in structures, organisation, planning and evaluation skills and resources</td>
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<td>For examples, see Roper et al. (1992), Meissner et al. (1992), Schwartz et al. (1993)</td>
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<th>2. Program maintenance and sustainability</th>
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<td>Refers to capacity to continue to deliver a particular program through an organisation or network of organisations, in addition to or instead of, the organisation which initiated the program</td>
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<td>For examples, see Bracht et al. (1994), Rissel et al. (1995)</td>
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<th>3. Problem-solving capability of organisations and communities</th>
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<td>Refers to capacity of a more generic kind to identify issues and develop appropriate mechanisms to address them, either building on the experience of a particular program, or as an activity in its own right</td>
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<td>For examples, see Biegel (1984), Thomas et al. (1984), Clark et al. (1993), Eng and Parker (1994)</td>
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Fig. 1: Three uses of the term ‘capacity-building’ in the health promotion literature (adapted from Hawe et al., 1997).
better understanding of, and ultimately derive indicators about, the indirect work put in by health workers in program development. Groups were recruited and formed with the assistance of a local contact person. No area health unit that was approached refused to participate.

Focus groups were chosen as the interviewing technique for two reasons. Focus group interviews are considered to be superior to one-to-one interviews for researching topics which are not well known or where an individual respondent may feel that they have little to say (Bender and Ewbank, 1994; Kitzinger, 1995). Secondly, a focus group design was more useful as a method of engagement with workers, as the researchers entered the process with the intention of returning to feed back research findings and build and refine the concepts developed as part of an interactive and on-going exchange.

We endeavoured to promote within-group homogeneity and not to mix senior and more junior practitioners in the same group. However, for the most part this was resisted by the participants who felt that holding separate consultations within the same geographic area would undermine local team development ethics and the opportunity the discussions were seen to provide for reflection and learning. While occasionally participants in a focus group were unknown to each other, in most cases participants were known to each other. Kitzinger argues that working with existing groups allows the researcher to observe naturally occurring patterns of interaction and language (Kitzinger, 1994). Further, participants can challenge each other, build on each others’ experiences, and draw out contradictions between what members of the group profess to believe and how they actually behave (Kitzinger, 1994). This seemed particularly important for exploring relatively uncharted territory.

The theme list for the focus group covered the following main issues: the meaning and acceptability of the term capacity-building; the process or steps in capacity-building; outcomes of capacity-building; how to recognise good practice; and dilemmas and issues for workers conducting this style of work. One investigator (PH) led all the group discussions. All group discussions were tape-recorded with the permission of participants. Tapes were transcribed and the transcriptions checked back against the audio tape, revised as necessary and given to participants for comments or corrections.

Work on the analysis and development of the coding categories commenced early, after three transcripts were complete, following the advice of Patton (1990). Three of the investigators read three transcripts and met to compare notes about the principal themes which had emerged by examining recurring regularities in the data as described by Strauss and Corbin (1990). Following this the principal investigator revised the draft codes, testing to see if they could be applied to a further three transcripts. All six transcripts were then sent to a researcher thus far unconnected with the project, a health anthropologist (SG). She was briefed about the purpose of the study and invited to give an independent opinion of the manuscript themes. Her reading of the transcripts confirmed the themes and coding categories developed thus far and identified a further one. This was associated with the discourse or style of language used by workers and the way they described their purpose or mission. The final coding of the transcripts was conducted by the principal investigator and a research assistant, with each transcript being double-check coded by the other. The final sorting and organising of the data was assisted by the use of the computer package Ethnograph. Methods for developing summary tables from the data followed the recommendations of Miles and Huberman (1984). The numbers following each quotation refer to the manuscript number and line of transcript.

RESULTS
Capacity-building, its meaning and strategies
Participants identified five levels or aspects to capacity-building in health promotion. These were individual-level, within health care teams, within health organisations, across organisations and within the community. Thus,

when I talk about capacity-building I guess its about the ability of teams and individuals to do health promotion. (2:179–182)

for me in my work its about increasing the organisation’s capacity to promote health. (2:17–19)

Workers with a more community orientation explained:

I guess for me its more like a community development term in that sense where its enabling people to do what they want by starting at where they are at. (4:365–371)
There was general consensus about the need to confront the term ‘capacity-building’ and make sense of meanings attached to it. No one was able to think of an acceptable substitute term or phrase, the principal concept being best reflected by the following:

I think of it as potential, like capacity to me means that there’s potential for something to develop, whether that’s about individuals or organisations. It could be about health or it could be just doing their job better. (6:67–71)

Of particular interest was the way workers reported that they had to alter their language when working with different groups. This was particularly important for intersectoral work and work at different levels of the health system:

we take up opportunities with them to talk their language and they start to share our language and that in a way broadens out the way they view us. (5:295–298)

Workers complained that it was difficult to describe to other people what they actually do in health promotion. This affects personal credibility and created a need to adopt different languages for different occasions:

I actually have almost two or three different types of languages that I think you use when you are dealing with different people. (6:304–308)

However, the tactic does not always work. There is also frustration with not being able to explain what capacity-building in health promotion is really about:

it is so hard to say what you do in health promotion. (5:490–492)

It appears that being forced to use different language when working with others, and accepting that one’s own work is not well understood, has contributed to a culture of invisibility in health promotion in general, and in capacity-building in particular:

the program might be heart health or whatever, but your hidden agenda is for empowerment. (5:1262–1264)

[the program] almost buys time, and allows you to do the invisible things. (4:551–552)

Invisibility was needed for two reasons. Firstly so that others would gain the credit for project success, and thus projects would be more likely to be sustained by these other parties. Secondly, in relation to work with sectors outside of health, one needs to work invisibly because confronting another person or organisation with an agenda about health promotion in the first instance is unlikely to set the right conditions for collaboration:

health is not necessarily on everyone’s agenda the way it might be on ours . . . we’re continually wanting to be on their agenda in such a way as they see us as being useful for their purposes as well. (6:513–523)

Table 1 reflects the range and some of the sequence of strategies used for structuring a reorientation or awakening among colleagues.

**Outcomes of capacity-building**

Workers found it relatively easy to nominate what the outcomes of capacity-building might be and how one would recognise success in capacity-building. There was a broad spectrum of responses. Workers whose main work was in health care teams or with health care organisations suggested the following: a more favourable attitude towards health promotion; skill acquisition in health promotion; confidence and knowledge building in health promotion; when parties start to initiate health promotion activities independently; more organisational effort and focus on health promotion; and when health promotion appears in the organisational mission, policy documents, the duty statements, performance agreements, and routine activity of a broad range of workers. Plus something more:

you want people to value health promotion workers, value the essential results of health promotion work, and from my point of view, the evidence that they value it is that they devote resources to it. (1:264–270)

Health promotion workers referring to capacity-building at the community level suggested that outcomes would include an increase in the size and density of organisational networks in the community; when non-health-sector organisations devoted resources and energies to health matters and became initiators and leaders in community level activity and when the community itself starts to work together to tackle local issues:

it’s an empowered community, that has the ability or the potential to take action. (5:1239–1241)

**Indicators of good quality in capacity-building**

However, when the conversation switched from outcome to process, workers found it much
harder to articulate what good quality practice in capacity-building would look like, seemingly because it had not been discussed or thought about previously. To gain a perspective on the question being asked, in most cases groups had to return first to a more general discussion about how they generally would recognise quality in health promotion, such as indicators of quality in patient education programs or health counseling. Even then, groups could not identify principles or markers of good quality, instead preferring to rely on: (1) intuition; (2) feedback, such as favourable responses from participants/‘recipients’ of capacity-building; and (3) the degree to which the capacity-building activities are open to scrutiny by peers.

However, the degree to which good practice should be reflected in favourable feedback was also disputed, with some group participants arguing that making other people uncomfortable, at least initially, may be part of capacity-building. Some people argued that taking all opportunities to undertake capacity-building would be a sign of good quality, while others suggested that in fact being strategic, and knowing whom to focus on and whom to ignore, was a better sign of quality. There was a general agreement that simply making capacity-building more visible might be a sign of good quality:

Table 1: Strategies workers identified as part of capacity-building with illustrative quotes

<table>
<thead>
<tr>
<th>Engaging people</th>
<th>‘we want to establish a relationship so that we can take it to the next step’ (1:2024–2027)</th>
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<td>Challenging the way people act or think</td>
<td>‘looking really at the positive aspects that they’ve done and then begin gently to get them to question other ways that they might go around doing it’ (3:552–556)</td>
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<td>Responding to their needs/issues first</td>
<td>‘it’s a foot in, it creates interest, awareness at some sort of level and then you can move on from that’ (5:556–559)</td>
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<td>Using the right language</td>
<td>‘critically analysing and restating things for others in their own language’ (2:1345–1348)</td>
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<td>Building personal credibility</td>
<td>‘let them see that we are worth something’ (4:1062–1064)</td>
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<td>Building local skills</td>
<td>‘the classic role of a community development worker . . . the enabler, the facilitator’ (5:754–757)</td>
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<td>Building new networks</td>
<td>‘providing opportunities for potential partners to mix’ (3: 683–685)</td>
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<td>Structuring rewards and incentives for others to do promotion, such as seeding grants</td>
<td>‘we have in built structures to look at how health promotion activities gain you some sort of health kudos in the organisation (3: 833–837)</td>
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<td>Ensuring other people get credit and recognition for actions taken</td>
<td>‘when they do start to run with it they need some acknowledgement and recognition for that’ (4:2330–2333)</td>
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<td>Working invisibly</td>
<td>‘if you’re the silent mover you can be more successful long term’ (5:641–643)</td>
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Dilemmas and issues in capacity-building

Going unrecognised

As the conversation of groups turned to the dilemmas, frustrations and issues that capacity-building raised for workers, some ironies in this field became clear. For example, participants explained that working invisibly or behind the scenes means that another person(s) or organisation gets the credit for one’s own endeavours. It follows that one’s own organisation may not value a worker who engages in capacity-building. It is hard for us to claim credit for any effort we put into doing that when you’ve got to finally acknowledge all of their hard work, and take a background stand, its always a dilemma. (3:1486–1492)

if you’re struggling within your own health service for acknowledgment of these things, it matters a lot. (1:710–714)

our operational plans have increasingly taken into account staff development, administration, resource management . . . health literacy . . . we have tried to identify some of that invisible work and make it visible and count it in what we do. I don’t know that its gone the full distance. (4:1463–1479)
This is aggravated by the fact that capacity-building takes a lot of time.

**Frustration and not knowing when to stop**

Capacity-building may lead to very little. It was also not clear when to give up, as the developmental approach gives the feeling that a breakthrough can be just around the corner. This is hampered by the uncertainty of the process itself, that is, what is really going on:

you make an assumption that you know a process is going to occur, to get that outcome . . . when in fact you don’t know the process, and you can’t afford to say: we’ll stop now. (6:1475–1482)

**Risk taking and project failure**

Unlike when they are engaged in direct program development, when workers are engaged in capacity-building they do not have control over program processes and outcomes. This is because responsibility is shared. Even though project failure can still be used as a learning experience, the risks involved with failure can be great:

risk taking is something that I’m very aware of and maybe because of being in a smaller community, my exposure is greater, and that, really and truly, can destroy everything you’ve done very easily. (5:1467–1477)

Workers described the ways they dealt with groups which were ‘running off the rails’, reflective strategies which encouraged people to examine why they were doing particular things, assumptions made, alternatives generated and so on. However, an unresolved debate was the degree to which achieving project goals was balanced against the need to allow groups to develop experience.

**Capacity-building has to be disguised in program budgets**

Workers feel that they cannot formally articulate the effort they are putting into capacity-building with colleagues and other organisations because, increasingly, health promotion activities have to be packaged into national priority areas (for example, cancer, heart disease, injury). This leads to subterfuge. To be explicit about capacity-building was seen to be hijacking the purpose of the project:

I think you know subconsciously what you want to do, but I don’t write it down. No. No. [interjection: ‘Too risky.’] I get caught up with the fact that you have to fit this national goals and targets and that’s where my boundaries are . . . we’ll play by the rules and get the money, but . . . we have two layers . . . the one to get the bucks, and the other that says: but this is really what I’m at. (5:2152–2169)

**Discomfort with capacity-building**

Although working invisibly was seen as having its advantages, it was an uncomfortable admission for a few workers, particularly when working with organisations from sectors outside health:

I think capacity is a negotiated thing and I feel almost uncomfortable with this discussion in some way because I try not to be the expert . . . they’re building our capacity as well. (1:349–392)

Yet other workers pointed out that even before the parties reach negotiation, some invisible work has gone on simply for the health promotion worker to be seen as credible and worth talking with, especially when referring to capacity-building within the health system. As such, time spent in establishing relationships and building credibility was accepted as more of a soft marketing. (5:963)

One worker suggested that the paternalism, or the ‘doing to’ rather than the ‘doing with’ was evident with the use of such words as ‘targeting’, as in targeting communities for capacity-building:

there isn’t that sense of engaging in it together, so I think the language is extraordinarily important. (2:1127–1130)

I don’t work in a context where I would ‘target’ anybody for anything . . . I think to me it jars and maybe it is that word, it is the power implication about it that jars for me. (2:1036–1041, 1072–1076)

**Missionary zeal**

The final issue was partly articulated by the workers themselves and also evidenced through the researchers’ examination of the words and phrases that group participants used to describe their work. It was the notion of zeal. Workers told stories of how others see them as fanatics and ideologues. For example, one group told the story of a nutrition project where,

we were accused of being avenging angels from the health department . . . we were excited and gung ho and we were intending to engage the school canteens in a partnership arrangement . . . but fundamentally I don’t think they were really interested. (4:1544–1571)
Others concurred with that view, confirming that:

the moral police is how some other people see us. (3:2711–2712)

you know, [with your own colleagues] you’re buddies in a hostile environment. (1:1336–1338)

Workers develop strategies to deal with hostility and suspicion among other health workers. Adopting techniques from capacity-building (as per Table 1) appears to help:

I think in the first workshop they were really frightened of what I might be going to ask them. . . . ‘We did not ask for this. Who is she?’ You know. By the time I got to the first planning morning I thought, bugger the project, I have to survive here and get them to stay with me otherwise I have lost it, so I rephrased it. . . . I talked about being there to support them with developing the quality of the health promotion that they’re already doing. (2:2557–2598)

The extent of the perceived hostility towards health promotion in a climate of reduced funds for health care services was strong:

that’s why you do end up taking the approach, when there’s so much hate, and it is only by role modelling and all of the other things that we’ve talked about that people start seeing you as a human being. (3:1936–1944)

‘The approach’ referred to in the above quotation is organisational development within a health care service to make the entire organisation responsible for health promotion. Part of ‘the approach’ is about

biding time. Some of it is about coming back and having another go. Its almost like Chinese water torture, is this, you know, another drip, another chip away, you know walk away, another chip, and then get people interested. (3:493–499)

It is in this quotation and others that workers’ own language and phraseology reveals the strength of intensity of purpose—a mission. It involves persistence and suggestion, almost like indoctrination. Workers recognise that at some point the person they are working with is fragile, there’s a fragility there. It can go either way. (6:741–743)

Biding time and being flexible has its pay offs because

when people want you, they want you and if you give them that, if you do readjust your schedule, whatever it takes to give them what they want, they’re appreciative, and they will then, as you say, spread that further. (4:1072–1080)

The work involves ‘vision’, ‘selling’ and double messages:

its also the way you market something, its the way that we’ve got to sell a concept. (5:419–423)

vision, having a vision I think . . . the place where I had a vision which came true was this heart health project. (6:1555–1564)

we will provide you with resources which will assist you and, in brackets, do things the way we think that they should be done. (2:446–451)

Indeed, capacity-building among some groups is like a philosophy and among people who subscribe to the philosophy there is a ‘party line’. A new worker who had joined a health promotion team with a strong commitment to capacity-building used the expression:

if I understand the philosophy correctly. (3:267–269)

She told a story about being corrected by others from the focus group in a meeting earlier in the day:

suddenly your colleagues kick you under the table and say ‘That’s not the line.’ (3:2378–2380)

Telling this story about learning the party line in the focus group led to much nodding and laughter.

**DISCUSSION**

In the debriefing session following each of the groups all participants said that they found the discussion interesting and useful. Most groups commented that this was something they had never discussed before, so the process was really one of discovery on the part of researchers and participants. One worker expressed the view that towards the end of the group discussion, when discussing dilemmas and contradictions in capacity-building she had felt slightly constrained about expressing her doubts because she was among colleagues who were ‘believers’. We were aware of this; an unavoidable trade-off in a research design which pays respect to the way in which participants wish to take part. We were satisfied at the conclusion of the six groups that we had reached saturation on the major domains of interest and that further work on specific capacity-building situations would require
different methods. In our case the appropriate next steps were not seen to be further ‘pure’ research, but as outlined later, discussion and development work with health workers reflecting the participatory style of the project.

When judged in terms of the knowledge about capacity-building levels, processes, outcomes and the more common dilemmas yielded by the groups, a proportion of what was said is not different from what one would gain from a literature review in capacity-building, coalition building (Butterfoss et al., 1993) or community development (Dixon, 1989). For example, the need to work over long time frames and the dilemma associated with giving away recognition for project success have been well discussed among community development workers in various disciplines. However, the purpose of the research aspect of the project was not to test what workers know, but to understand more about the experience with capacity-building and to uncover unknown domains of interest. One of the most striking and significant issues in this regard was the extent to which capacity-building was hidden.

Capacity-building was hidden in two ways. Firstly, it was hidden from funders and administrators because the official purposes of most programs are national health priority areas and the only legitimate activities were seen to be those directed specifically to risk factor change among population groups. The irony of this deception is that capacity-building by health promotion workers may in fact be a highly cost efficient and value-added dimension to health promotion because, in theory, more parts of the system are made more health-promoting (Shiell and Hawe, 1996; Hawe et al., 1997).

The second way in which capacity-building was hidden was the way it was disguised from the ‘receivers’/partners of capacity-building in order to make it more effective. Words and phrases such as ‘invisible’, ‘secretive fashion’ and ‘real agenda’ were common. Some people described this as a necessary way of working in an environment where one’s intended goals (for example, persuading clinical colleagues to undertake health promotion rather than whatever they normally do) may not be initially welcome. It is therefore part of a ‘softening up’ process. It was also seen to be part of an empowerment strategy, where, at least in the first instance, clinical colleagues are not aware of the way in which a health promotion worker is encouraging them to view issues differently and their own capabilities more positively.

However, in commenting on the discourse themselves, a few workers said that the implied paternalism and ‘egocentricism’ of health promotion working in this way made them feel uncomfortable (for example, the view that ‘I am going to develop you’). Interestingly, the workers who expressed these views the most ardently dealt with the issue in their own work in different ways. One worker went on to explain that her work was mostly with decision-makers in other sectors. There she felt able to make her own agendas clear and talked about capacity-building as a ‘two-way street’, a process of negotiation between equal parties. The second worker was a more grass-roots style community worker who emphasised that she enters the community arena believing that communities already have ‘capacity’ (a view that is widely accepted, see Rappaport et al., 1975; Israel, 1985; Hawe, 1994). She dealt with her discomfort about capacity-building by attacking the terminology, by further insisting that she does not ‘target’ anyone, that she ‘works with’ people. The alternative language she offered was to ‘to focus on’ something/somebody and ‘shift the focus off’ something/somebody. However, the extent to which the alteration to language disguises, rather than removes, the workers’ purposes and power could still be disputed.

The most subtle or hidden style of capacity-building appeared to be the type conducted in health settings, with other workers, as part of the commitment to reorient health services, as per the Ottawa Charter for Health Promotion. Here the time-honoured tactic in community development of ‘starting where the people are at’ was being conducted. Health promotion workers reported that they had abandoned attempts to get other workers to engage in program activity around priority health issues such as smoking or nutrition, and instead had opted to help community health teams with anything they needed, such as developing more efficient case-management systems. This built trust and relationships. They hoped that this would develop over a few years into working partnerships for health promotion, program development between health promotion workers and community health teams.

As well as being subtle or hidden to the ‘receivers’/partners to capacity-building and
funding authorities, we found that for the most part capacity-building also remains undiscussed or even undisclosed among the workers themselves. This was most evident in one group where a worker told the story of a cardiovascular disease prevention project actually being a ‘front’ to do some more grass-roots style organising in an isolated rural community. Her story clearly surprised her colleagues who stated that they were now pleased to reform their view of her project (and her). This was clearly an example of where project funding rules force workers to disguise the real intent of projects so effectively that it has consequences for peer approval, worker isolation and morale.

A consequence of working invisibly is that work is not subject to quality control. Workers in community development have encouraged reflective learning and story telling as a way of elucidating lessons from practice (Butler and Cass, 1993). However, while workers in our project agreed that increasing peer scrutiny and visibility would assist with quality control, there was no real agreement about what one would look for, i.e. acceptable standards or performance criteria beyond ‘gut reaction’ or partner enthusiasm. In the field of patient education, markers of program quality are evidence-based, or based on a meta-analysis of program outcomes (Mullen et al., 1985). However, capacity-building is relatively new and highly diverse. It could be argued that at present we have insufficient information on which to build evidence-based guidelines and, hence, will need to rely for some time yet on theory and/or consensus informed guidelines. The first hurdle to overcome in this direction will be the fact that workers may be unpractised in even talking about what they do in capacity-building, let alone subjecting it to critical analysis. This may be less so for workers in the community development tradition (where, for example, there are specialist professional journals), but it seems particularly the case for health promotion workers engaged in reorienting health settings in relative isolation.

Of further concern is the possibility that articulation of practice may carry some dangers. While conducting the project we became very aware that capacity-building may have strength because it is hidden. What we are calling ‘capacity-building’ in some cases appears to be part of a tradition of practice which has survived generations of workers and also dominant antithetical approaches in health promotion, such as lifestyle modification campaigns. We recognise that a clumsy attempt to capture the process in a set of indicators may do a disservice to the field, by fixing or regularising it. We are also aware that in some cases workers may be using the same capacity-building tools for ultimately different purposes; for example, creating empowered communities versus building a specific capacity to tackle heart health. This has implications for what is envisaged as program success (Hawe, 1994).

In group debriefing procedures, we tested our assumption that working to make capacity-building more visible was a useful purpose for our project. Feedback from group participants was in accord with this view. Workers welcomed the idea that, in future, program plans in health promotion could include goals, objectives and indicators about capacity-building as well as the usual goals and objectives about population health, risk factors or risk conditions. Some research participants had already adopted this practice. Further, our observations about worker zeal and tactics reinforced the belief that capacity-building should be open to scrutiny, lest it evolve into a powerful form of organisational and community control or manipulation. Indeed, we were made aware particularly through the discourse analysis that the strategies of reorienting health services appear much like the tactics of subversion (Stevens, 1976).

As the second step of the project, the results of the focus groups have been fed back to workers, along with information from a literature review on capacity-building (Hawe et al., 1997). Some groups have asked for more opportunity to discuss and reconcile points raised by the research which challenge the ethics and values of health promotion practice; i.e. the extent to which health promoters are not just the ‘moral police’, but also the ‘secret police’. Further insights about capacity-building at the different levels identified and for different capacity-building situations (for example, within health care teams, with coalitions) are being gained from work with individual project groups participating in the development and trial of indicators for these different types of capacity-building situations. This work is informed by theories and models from the literature in organisational development, learning organisations and interorganisational collaboration (Gray, 1985; Field and Ford, 1995; Simnett, 1995) and is the subject of separate publications.

In addition, our views and actions have been
influenced by consultations held with area coordinators of health promotion across the state, and area-based evaluation and research directors in health promotion. The project has also held workshops about the importance of capacity-building with high-level state and federal public health policy-makers, doing ourselves what workers in our groups called ‘soft marketing’. We have been heartened by one senior manager in the health service who supports the notion of capacity-building by his workers stating that as a manager.

One of the things I firmly believe in, I’ve mentioned many times over, is changing the wording of the Ottawa Charter from ‘creating supportive environments’ to ‘supporting creative environments’.

Helping workers to explore and articulate creative practice is a step in that direction.

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