

ORIGINAL ARTICLE – PEER REVIEWED

Building capacity towards health leadership in remote Indigenous communities in Cape York

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Abstract

This paper describes an established approach for building capacity used for the first time with Health Action Teams (HATs) in three remote indigenous communities in Cape York. A key purpose was to determine if the approach was an appropriate and practicable 'tool' in an Aboriginal context. This is not a research study but rather the reflections on a project evaluation to collect and interpret information recorded during workshops to build and measure the capacity of the HATs using eight domains. The domains represent those aspects of the process of capacity building that allow the HATs to better organise and mobilize themselves towards gaining greater control. The analysis of each domain included a description and visual representation of capacity. There were similarities in the measurement of capacity between the three HATs in five domains. This was because each HAT was at an early stage of development and generally had a low capacity. Importantly, each HAT was able to develop a realistic strategy with which to move forward to build capacity with clear roles, responsibilities and timeframes. The key to building HAT capacity was the use of strategic planning based on the eight 'domains' and the use of an appropriate means of visual representation. This is discussed in detail in the paper and provides encouragement for an empirical study into the application of capacity building approaches.

Key words: Indigenous; capacity; community; leadership.

Introduction

The importance of Aboriginal community control in service delivery to improve health outcomes has been recognised in both State and Federal Government policy for some time [1, 2]. Underpinning this health reform process is the need to build community capacity for Indigenous people to take control of and be responsible for their own health.

There is a broad body of literature in regard to the definition of community capacity, for example, Labonte and Laverack define capacity building as the 'increase in community groups' abilities to define, assess, analyze and act on health (or any other) concerns of importance to their members' [3]. Community capacity is seen by several authors [4, 5] as a process that increases the assets and attributes that a community is able to draw upon. The capacity of a group is also dependent on the resource opportunities or constraints (social, political and economic) and the conditions in which people live. Community capacity is not, therefore, an inherent property of a particular locality, nor of the individuals or groups within it, but of the interactions between both.

Interest in community capacity building as a strategy for sustainable skills, resources and commitments in various settings has developed because of the requirement to prolong project gains [6]. These qualities exist in relation to specific people and groups, issues and concerns, activities or projects. For an outside service, the task is not to create a new project called 'capacity-building'. Rather, the task is to examine how its practice can support the development of capacity-building [7]. Capacity building becomes the process by which the end result of increasing community control and project sustainability can be achieved through, for example, increasing knowledge and developing skills and competencies.

Whilst there is a substantial body of literature on the definition of community capacity, there is less on the practical application of approaches, particularly in an Indigenous context. Concepts such as capacity building are hard to make operational because of their ambiguity and because as social constructs they are less tangible than commonly measured health indicators. The approach discussed in this paper was used as a tool to build and measure capacity in three recently established Health Action Teams (HATs): Kowanyama; Coen and Lockhart River. HATs are to act as local health advisory groups in remote Aboriginal communities in Cape York, Far North Queensland. It is envisaged that there will be a gradual shift in focus of the HATs, as they build their capacity and confidence, towards more community based action around locally perceived health needs. The HATs aim to have representation that considers the cultural make up of each community and draws from as many families and clan groups as possible. They also strive to involve representation from existing community based organisations including the council, men's and women's groups, justice groups, aged care and homelands. Members must be recognised by the community as local Indigenous people.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health focuses on community control of health services and building communities' capacity to take control of and be responsible for their own health outcomes [2]. Apunipima Cape York Health Council (ACYHC) was identified as the most appropriate community controlled organisation to plan, prioritize and manage primary health care services and resource allocation in Cape York. The ACYHC aims to promote the ability of Cape York communities to expand the range of choices they have available to them to improve their lives and health. It is not about making choices on their behalf, but to give communities more control over the decisions that influence their lives that will contribute towards a broader health reform process for the Cape York region. In particular, ACYHC have been working with communities to develop the capacity of HATs.

Objective

The Royal Flying Doctor Service (RFDS) was contracted by the Australian Department of Health and Ageing to undertake the Cape York Health Leadership project in close collaboration with ACYHC. The purpose of the project was to support the process of health leadership in the transition to community control by providing leadership training to Health Action Teams.

Three objectives were identified within this project:

1. To collaborate with ACYHC to build capacity around health leadership.
2. To support ACYHC in the establishment and sustainability of HATs in targeted communities.
3. To facilitate the provision of leadership training to HATs in the target communities.

It is important to note that this was not a research study but rather the reflections on a project evaluation to build and measure the capacity of the HATs. A key purpose was to determine if the approach was an appropriate and practicable 'tool' in an Aboriginal context.

The first six months of the project involved RFDS staff building relationships with community members, with the HATs and with ACYHC, through regular community meetings in order to develop an understanding of the HAT needs. This resulted in HAT members completing 5 training modules (Governance; Community Development; Advocacy; Effective Communication and Marketing, Promotion and Submission Writing). In addition, HATs came together for three regional workshops to share experiences and consolidate new knowledge and skills.

Method

The process of community capacity is influenced by several characteristics or 'domains' that significantly contribute to its development. In particular, the organisational characteristics that influence community capacity provide a useful means to build and measure this concept. The 'capacity domains' represent those aspects of the process of community capacity that allow individuals and groups to better organise and mobilize themselves towards gaining greater control of their lives. The method used for measuring and building the capacity of each HAT was an established participatory approach [8] employing eight domains. These were originally categorized from a textual analysis of the literature and the validity of this data was cross-checked by other researchers using a confusion matrix [9]. The 'capacity domains' are robust and collectively capture the essential qualities of a capable community and further information on their use and definition is provided elsewhere [10].

A meeting was held with RFDS and ACYHC staff to adapt each domain to the cultural appropriateness of the setting. Each domain was then discussed with each HAT prior to implementation to further adapt their interpretation. A brief description of each domain is provided in Table 1 and the details of the forty statements used to measure each domain in an Aboriginal context are provided elsewhere [11].

The domains serve as a framework for building HAT capacity and the approach was implemented in three remote Indigenous communities: Kowanyama; Coen and; Lockhart River in far north Queensland. All three communities are characterised by remoteness, with access only by flights or long drives, and all experience several months of the year where they are cut off by road due to the wet season. Each community has a primary health care centre managed and funded by Queensland Health. There are also a range of other outreach services including child health, drug and alcohol, community liaison development, health promotion and mental health.

Each HAT was asked if they were interested in utilising this approach and their consent verbally received before they participated in its implementation. The verbal consent of each HAT member was also received after reading this paper prior to submission for publication.

Table 1 Capacity ‘domains’ for Aboriginal communities

Domain	Interpretation
HAT participation	Participation is basic to building capacity. Only by participating can individual members better define, analyse and act on issues of concern to the broader community that they represent.
Local leadership	Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong HAT leadership. Both play an important role in the development of the community.
Problem assessment capacities	Capacity building presumes that the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the HAT. This process assists them to develop a sense of self-determination and the skills necessary for greater community capacity.
Organisational structures	Organisational structures include committees such as the HAT and the Council. These represent the ways in which people come together in order to address their concerns and problems. The existence of and the level at which these function is crucial to building capacity.
Resource generation	The ability of the HAT to generate resources both from within and the ability to negotiate resources from beyond itself is an important factor to achieve successes in its efforts towards capacity building.
Links to others	Links with people and organisations, including partnerships, coalitions and alliances between the HAT and others, can assist the community in more effectively addressing its issues.
Ability to ‘ask why’	The ability of the HAT to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies for capacity and empowerment.
Health Services Management	HAT/ACYHC control should extend to decisions over planning, implementation, evaluation, finances and administration of the health services. The first step is to have clearly defined roles and responsibilities of all the stakeholders with outside services acting to support community capacity.

The implementation of the 'domains' approach

Each workshop was attended by the HAT members and held over a one to two day period in their community. The workshop was facilitated by RFDS and ACYHC project staff. The purpose of the workshop was to firstly measure HAT capacity and then to formulate a strategic plan to address identified weaknesses. To do this, the HAT members were provided with five statements for each capacity domain. Taking one domain at a time each statement had been written on a separate sheet of paper and was read out aloud before being discussed by the HAT. These statements were not numbered to avoid selection bias and represented a scenario of the range between the least to the most capacity building situation. Participants selected one statement that best described the current situation in their HAT. Only the facilitator of the workshop was aware of the rating used for the five statements. This allows each domain to be quantified using a numerical value and visually represented in the spider graph configuration (see figures 1, 2 and 3). The purpose of visual representation is to provide a means by which to share the analysis and interpretation of the evaluation with all the stakeholders. The information may have to be compared over a specific timeframe and between the different components of a project. For this purpose, visual representations that are culturally sensitive and are easy to reproduce are an appropriate way to interpret and share qualitative information. The spider graph is actually created by inserting a chart from any spreadsheet software and choosing from the standard 'Radar' chart type and then following the simple chart wizard steps to set the data range, the chart options and the chart location [12].

The participants were also asked to record the reasons for selecting the statement. This overcomes one of the weaknesses in the use of qualitative statements, that of reliability over time or across different participants making the assessment [13]. The justification includes verifiable examples of the actual experiences of the participants taken from their community to illustrate in more detail the reasoning behind the selection of the statement.

The measurement is in itself insufficient to build the capacity of the HAT who must also have the ability to transform this information into action. This is achieved through strategic planning using three simple steps: a discussion on how to improve the present situation; the development of a strategy to improve upon the present situation; and the identification of any necessary resources. This simple and systematic approach is based on the well established logical framework system to set clear objectives, identify in advance indicators of progress and prior assessment of risks. Although a westernised model its adaptation has been successfully used in different cultural contexts, preceded by adequate field-testing [14].

The purpose of strategic planning is to bring about positive actions in each of the domains where a need for improvement has been identified by the HATs. Each domain was discussed and a broad approach to improve the present situation was firstly identified so as to lead into a more detailed strategic plan. If the participants decide that the present situation does not require any improvement, no strategy will be developed for that particular domain. A more detailed strategy to build capacity is then developed based on the guiding themes of: the specific activities; sequencing activities into the correct order to make an improvement; setting a realistic time frame including any significant benchmarks or targets; and assigning roles/responsibilities to complete each activity. The HAT participants also assess the resources that are necessary to improve the present situation, for example, technical assistance, equipment, land, finance and training. This includes a review of locally available resources and resources provided by outside services.

The measurement and strategic plan for each domain were summarized in a table, called the matrix, which formed the basis for further discussions, planning, and action. Down the left-hand side column are listed the 'Domains'. The next two columns refer to the measurement and the reasons why the statement was selected. The matrix can include the rating given to each measurement so that this can also be discussed. The next two columns of the framework refer to the development of a strategic plan for community empowerment: how to improve the

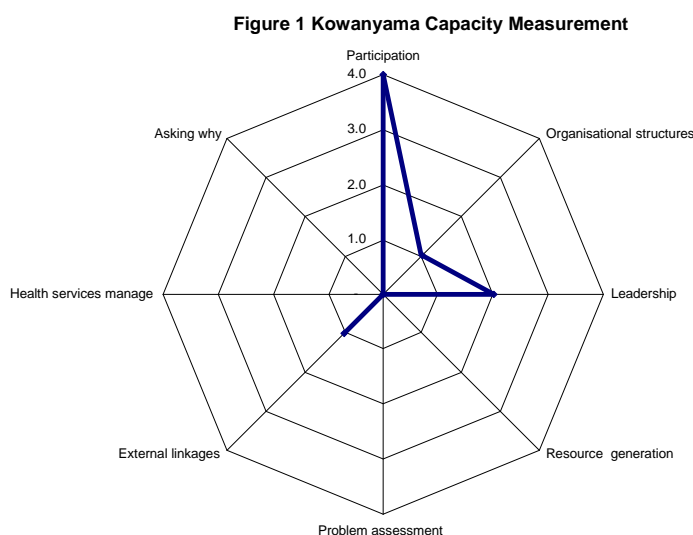
present assessment; and a strategy for implementation to improve the assessment (where this is necessary). The final column outlines the resources necessary to implement the strategy.

The matrix and spider graph were both given to all HAT members for future follow-up in collaboration with the ACYHC, RFDS and other outside services. As a group, the HAT members were asked at the end of the workshop which parts they had found to be useful and which parts they felt needed to be improved upon when used again in an Aboriginal context. Some of these responses are provided later in this paper.

Results

The Kowanyama Health Action Team

Kowanyama has a population of approximately 1110 people of which 85% are Indigenous and is located 740km or approximately 9 hours drive from the regional centre of Cairns. The Kowanyama HAT is comprised of 10 members, 4 males and 6 females. Feedback from the HAT indicated that they found this a useful tool to determine their strengths and weaknesses and were able to develop a realistic plan for improving their capacity. In particular, HAT members reported finding the visual representation of the measurement (figure 1) a useful way of sharing ideas and planning for future activities.



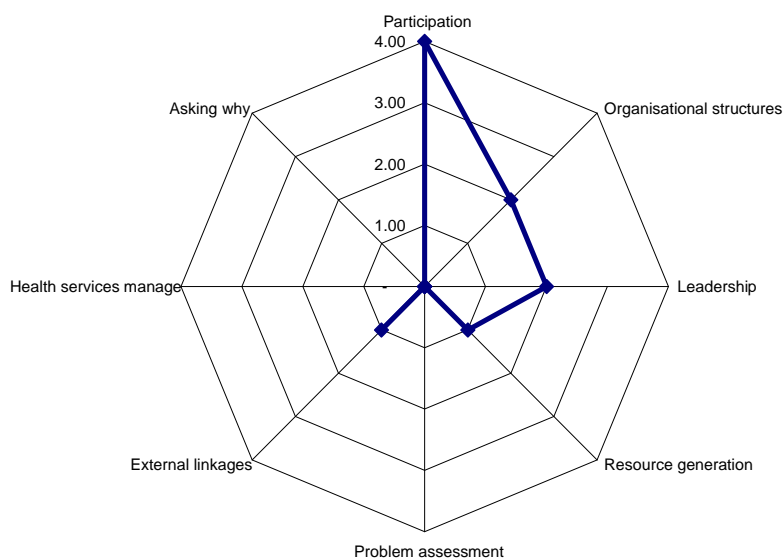
The spider graph in Figure 1 shows a distribution of high and low ratings of the eight domains, indicating a range of strengths and weaknesses in capacity. In general, capacity was quite low as the HAT was in the early stages of establishment. Participation was ranked the highest as the members reported active involvement in monthly meetings. The need to obtain support from leaders outside the HAT and being recognised by the wider community as the peak local health advisory group was identified as a key strategy to build capacity. The strategy developed included a range of marketing and promotional activities and the development of a Memorandum of Understanding between the HAT, ACYHC and the Kowanyama Shire Council. Training was another strategy identified by the HAT to develop skills in specific areas including resource generation and (local) health problem assessment.

The Coen Health Action Team

Coen is located 8 hours drive from the regional centre of Cairns. The community has a population of approximately 300 people in the dry season which increases as people come in

from Outstations or Homelands during the wet season. Indigenous people make up over 80% of the local population composed of members of several language groups from the surrounding region. The Coen HAT is a voluntary membership and comprised of 6 members, 5 women and 1 man.

Figure 2. Coen Capacity Measurement



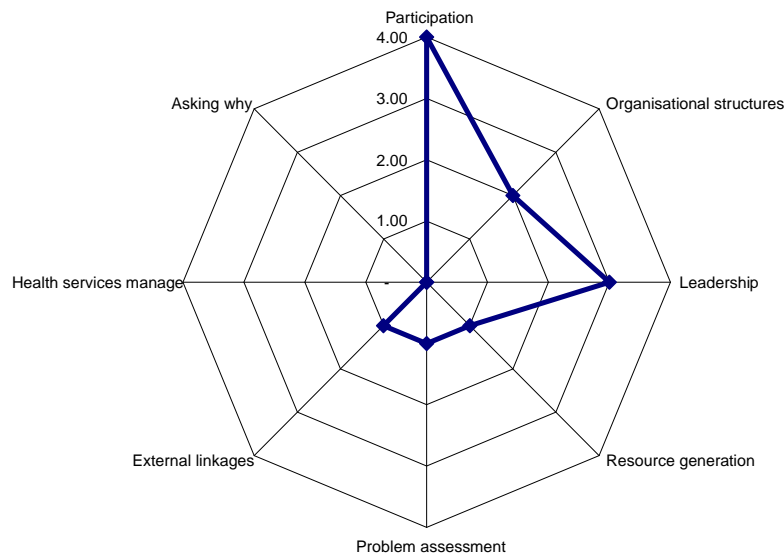
The measurement of capacity by the HAT team (Figure 2) shows that there were existing strengths in participation, organisational structures and leadership. The HAT felt that participation in decision making by its members had been maintained, that this was promoted by the organisational structure of the group and that they had established mechanisms to share information. The HAT leadership was functioning well internally but did not have established links with other community leaders. In general, capacity was quite low, the HAT was in the early stages of development and had not established itself as a key community-based organisation. This latter issue was identified by the HAT as an important next step to build its capacity. The HAT, ACYHC and the Coen Regional Aboriginal Corporation (CRAC) were to agree upon a formal Memorandum of Understanding in regard to the roles and responsibilities of the HAT. This was to be supported by each member taking the responsibility to visit an area of the community to inform householders about their role. The HAT was to also write a letter of introduction requesting a meeting with the CRAC, Chamber of Commerce, Justice Group and other key organisations in the community.

Another key strategy towards building HAT capacity was identified as the need for specific skills training on marketing and submission writing. The training would be organised by an outside service provider, the RFDS, and delivered as a workshop in the community.

The Lockhart River Health Action Team

Lockhart River is a remote Aboriginal Community on the east coast of Cape York and is about 850 km north of Cairns by road. During the wet season, creeks and rivers flood and close the road into town. Sea and air are the only access at this time which can extend from December until June. The community has a population of approximately 650 people of which 61% are Indigenous. The HAT is comprised of ten people, 3 male and 7 female.

Figure 3 Lockhart River Capacity Measurement



The measurement of capacity by the HAT team (Figure 3) showed a similar pattern of capacity as demonstrated in Coen and Kowanyama communities. The Lockhart River HAT had strengths in participation, organisational structures and leadership but did not have a developed capacity in 'asking why', external linkages, health services management, resource generation and problem assessment. This pattern of high and low capacity rating is typical in newly formed community-based organisations and the next step was to prepare a strategy to address a few of the weaker domains within a feasible timeframe.

The Lockhart River HAT strategy included the following activities to build their capacity:

- Problem assessment, resource generation and local leadership: Undergo specific training in participatory health needs assessment skills, submission writing and marketing and leadership skills to be organised by an outside service provider within 3 months;
- Organisational structures: Organise a community BBQ to raise awareness of the role and responsibility of the HAT. Raise funds by submitting a proposal to an appropriate funder within 3 months;
- Links to others: Prepare a letter to be sent to the Council to request a meeting to clarify the roles and responsibilities of the HAT.

Conclusions

There were a number of similarities in the measurement of capacity between the three HATs. Firstly, each HAT identified strengths in participation and leadership and a need to improve external linkages, resource generation and health problem assessment capacities. Each community rated their capacity for health service management and the ability to 'ask why' as very low. The overall capacity in each HAT was measured to be at about the same level and had been established for about the same length of time. Building capacity is a process that strengthens participation, organisational structures and local leadership so that it is meaningful to carry out a problem assessment, to mobilise resources and to establish external linkages. At a later stage their capacity will have developed to further enable the leadership, through the HAT membership, to engage with health services management and to take community based action on the underlying causes of their powerlessness.

Each HAT agreed that it recognised the importance for strategic planning in this process and that it offered them with the means to link the measurement of capacity to tangible actions through their participation and planning. It was the intention of the project that each plan was to be followed by the HAT, supported by ACYHC and the RFDS. Each HAT also reported that the 'spider graph' was an appropriate means of visual representation in an Aboriginal context to show the strengths and weaknesses in capacity. They felt that it helped to promote the free flow of information and allowed both HAT members and outside services to visualise, better articulate and to share their ideas on the building of capacity.

Implications

As the only local group on health in these Aboriginal communities there is an enormous amount of interest in the Health Action Team from both within the community and from visiting services. But the need for communities and supporting organisations to have realistic expectations of these newly formed groups is paramount. The HAT members are currently in voluntary positions and these people have to balance this responsibility with other work and family responsibilities. It is important that the HAT sets boundaries based on their measured capacity and scope of practice otherwise they run the real risk of failing in their attempts in advice and action towards health reform. HAT members are often faced with a range of competing priorities and are already balancing responsibilities including working full time and holding other key positions within the community. It is therefore important to have a clear plan for capacity building towards which each HAT member can commit themselves to make it work.

An important implication is how assistance is provided by the outside services to facilitate the transformation of information gained from the measurement, by the HAT, into action. The documented strategic plan and the visual representation for capacity provided the focus around which the community and the outside services could begin to develop a 'partnership for cooperation'. This was defined by the level of support requested by the HAT to implement activities, based on the strategy it had developed, to directly strengthen its own capacity.

In addition to the points of caution raised above, it is necessary to appreciate that this approach is based on westernised models and although its adaptation has been successfully used in other cultural contexts, thorough field-testing is essential. This paper provides evidence that such an approach to measure and build capacity is appropriate in remote Indigenous settings. The authors intend to publish a subsequent paper documenting the results of using the approach over a longer period of time including an interpretation of the reasons for the growth and/or reduction in capacity for each HAT. The authors feel that this type of an approach is worthwhile pursuing because it facilitates Indigenous people having a more active role in the planning towards health reforms.

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