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Manuscript Title

Evaluation of health promotion training for the Western Australian Aboriginal maternal and child health sector

Abridged Title: Evaluation of health promotion training

Abstract

Issue addressed: Evaluation findings of health promotion training for the Western Australian (WA) Aboriginal maternal and child health (MCH) sector are presented.

Methods: Fifty-one MCH professionals from five regions in WA who attended one of three health promotion short courses in 2012-2013 were invited to complete an online survey or a telephone interview, between four to 17 months post-course. Respondents were asked how they had utilised the information and resources from the training and to identify the enabling factors or barriers to integrating health promotion into their work practices subsequently.

Results: Overall response rate was 33% (n=17). 94% of respondents reported they had utilised the information and resources from the course and 76% had undertaken health promotion activities since attending the course. Building contacts with other MCH providers and access to planning tools were identified as valuable components of the course. Barriers to translating knowledge into practice included financial constraints and lack of organisational support for health promotion activity.

Conclusions: Health promotion training provides participants with the skills and confidence to deliver health promotion strategies in their communities. The training presents an opportunity to build health professionals' capacity to address some determinants of poor health outcomes among pregnant Aboriginal women and their babies.

So what? Training would be enhanced if accompanied by ongoing support for participants to integrate health promotion into their work practice, organisational development including health promotion training for senior management, establishing stronger referral pathways among partner organisations to support continuity of care, and embedding training into MCH workforce curricula.

Key words

health promotion, maternity services, midwives, pregnancy, training

Introduction

Aboriginal* pregnant women in Western Australia (WA) experience significantly poorer health outcomes than non-Aboriginal women, particularly in relation to modifiable risk factors such as tobacco smoking, diabetes, hypertension and antenatal care attendance.¹ Frontline maternal and child health (MCH) service providers** are well-positioned to engage with Aboriginal pregnant women, mothers and families to promote healthy behaviours and assist in the creation of supportive environments.^{2, 3} These are two of the multifaceted set of individual and population level strategies that comprise effective health promotion practice and can contribute to efforts to address the multiple, interacting determinants of health.^{3, 4}

However, MCH workers often lack time and confidence to provide preventive health support since health promotion is a small part of, or absent from, their professional training.⁵⁻⁸ Health promotion training has been identified as a critical component of building health promotion capacity⁹⁻¹⁴ and integral to the reorientation of health services towards the principles and practice of health promotion.^{3, 4} The collaborative, participatory features of capacity building echo those valued within Aboriginal communities.^{15, 16} Building health promotion capacity among the MCH workforce therefore offers a culturally secure and sustainable strategy that, when delivered in combination with other initiatives, can contribute to efforts to address some of the health determinants that influence poor health outcomes experienced by pregnant Aboriginal women and their babies.^{1, 16-18}

The Aboriginal Maternity Services Support Unit (AMSSU) as part of the Women and Newborn Health Service in Western Australia is funded under element two of the Council of Australian Governments' (COAG) Indigenous Early Childhood Development National Partnership Agreement.¹⁹ The AMSSU is a support unit that provides evidence-based clinical advice, research, resources, information, linkage, and professional development for Aboriginal MCH services across WA.²⁰ The AMSSU is underpinned by a collaborative relationship with the Aboriginal Health Council of WA with the shared vision of both organisations to improve the health and wellbeing of Aboriginal people.²⁰

In 2012 the AMSSU established a partnership with Curtin University's WA Centre for Health Promotion Research (WACHPR) to develop an action plan to support the WA MCH sector in delivering sustainable health promotion programs.²¹ One component of the plan, based on a key finding from the *Aboriginal Maternal and Child Health Strengths and Needs Analysis*,²² recommended health promotion training for the AMSSU and MCH service providers. A health promotion short course (herein written as Short Course), was tailored for delivery by Curtin University to AMSSU stakeholders to specifically address MCH issues in Aboriginal communities.

The Short Course provides participants with information, skills and tools to plan, implement and evaluate a health promotion program, and an opportunity to work in small groups to develop a plan for

* In Western Australia, the term *Aboriginal* is used in preference to *Aboriginal and Torres Strait Islander*, in recognition that *Aboriginal people* are the original inhabitants of Western Australia. No disrespect is intended to our *Torres Strait Islander colleagues and community*.

**For example, roles such as midwives, nurses and *Aboriginal Health Workers*

a health promotion program of their choice (see Table 1).²³ The Short Course is endorsed by the Australian College of Midwives, and participants can apply for Credit for Recognised Learning for elective units in tertiary health promotion courses following completion of an additional assessment.²³

Table 1 here

In 2013 WACHPR and the AMSSU undertook an evaluation of three such Short Courses delivered to service providers in the Aboriginal MCH sector in WA between 2012 and 2013. The evaluation aimed to investigate the impact of the Short Course, including how participants had subsequently utilised the information and resources from the training and the enabling factors or barriers to integrating health promotion into their work practices. This paper presents the results from the evaluation and presents health promotion training as one strategy to build health professionals' capacity to address some of the determinants of poor health outcomes experienced by pregnant Aboriginal women and their babies.

Methods

Respondents were purposively sampled from the 51 health professionals who completed one of three Short Courses delivered by Curtin University through the AMSSU between May 2012 and June 2013. High staff turnover reduced the number of contactable course participants. Of the 41 attendees who were contactable, 14 were invited to participate in a telephone interview and 27 were invited to participate in an online survey. Those invited to undertake a telephone interview were selected from the Short Course registration database in order to capture a cross-section of job roles and WA regions. 78% of those invited for telephone interviews and 22% invited for online surveys completed the evaluation. Qualitative data were analysed using a general inductive approach, guided by the evaluation objectives but not based on predetermined expectations of findings.²⁴ This involved interpreting the raw data to derive frequent, dominant themes, and developing a framework to categorise key experiences, comments and suggestions. The study received ethics approval from the Human Research Ethics Committee at Curtin University.

Results

Course respondent demographics

A total of 17 health professionals (response rate 33%) provided data on their experience of attending the Short Course. The regional representation of respondents (Figure 1) reflected the WA regional distribution of all participants at the three Short Courses.

Figure 1 here

Respondents to the telephone interviews and online surveys had a diversity of job roles (Table 2). These roles highlight the variety of professionals working in the Aboriginal MCH sector as well as the diversity of staff seeking training in health promotion. Although three participants' job titles included 'health promotion', this did not necessarily reflect that they had qualifications nor extensive experience in health promotion; this is not surprising given the deregulated nature of the current Australian health promotion workforce.²⁵ Data from pre-course evaluation indicated that participants typically had no formal training in health promotion and had roles in clinical and social support settings in which health promotion was not a current expectation in their work, or health education roles where health promotion was relevant and/or required.

Table 2 here

Use of information and resources from the Short Course

Sixteen respondents (94%) reported they had used the information and resources from the Short Course. Respondents most commonly identified the practical tools and information, relating to project planning and management, as the most useful resources: *"The planning tools have been most useful; we've used it to review our existing program and reflect on how we can do things better and whether we're being consistent"* (R2).

Learning about evaluation was reported as particularly valuable by 24% of respondents: *"[It] highlighted the importance of evaluation ... in order to improve programs"* (R14).

"I particularly enjoyed the creative ideas/tools for evaluation, engaging and energising groups - I have taken these back to my workplace" (R11).

Perceived benefits of the Short Course

Respondents described what they thought had been the main benefits to their work since attending the Short Course. The most frequent response related to the opportunity to network; 53% commented on the benefits of making new contacts at the course and expanding their awareness of other programs and services. In particular, comments demonstrated that the interactive nature of the course, including working in groups to design a project plan, enabled the development of strong connections where respondents had, or intended to, make contact with these new networks.

"I met the Women's Health Nurse from another service at the course and this has been a great connection because she works directly with the young women in the clinics ... I have invited her onto the Maternity Group Practice committee ... her input is really valuable" (R17).

"The networking at the course was really important – I have the list of names of participants ... and intend to contact them when I need to collaborate with people from other regions" (R16).

Six respondents (35%) noted the main benefit of the course was deepening their knowledge and understanding of health promotion, and in some cases strengthening their interest in it: *“I went into the course ambivalent about health promotion and came out feeling enthusiastic about health promotion.”* (R9).

“It strengthened my passion for health promotion as opposed to treating sickness/problems” (R7).

Four respondents (24%) described learning about evaluation as one of the most valuable outcomes: *“The big plus was evaluation ... I realised the depth and detail you need to include in evaluation. I realised we need to do a lot more evaluation.”* (R3).

“The content on evaluation has made me put more emphasis on evaluating the education sessions I deliver ... now I make sure the pre and post evaluation forms are handed out and completed” (R14).

Health promotion activities after the Short Course

The majority of respondents (76%) reported they had initiated health promotion projects or activities since attending the Short Course and explained how the course had contributed to this work:

“I’ve planned and delivered an [alcohol education] project ... and the information and skills from the course encouraged and supported me to implement it. I’ve used some of the ideas and strategies that other participants discussed at the course too” (R13).

“The course has provided me with information and guides to remind me how to set out projects ... and to seek approval and collaboration between units within the hospital” (R8).

“[I] continued delivering the mums and bubs sessions but with a greater emphasis on evaluating the sessions” (R14).

Enablers for implementation of Short Course content

Fourteen respondents (82%) commented on the support, structures or processes in their workplace that had enabled them to implement what they learned during the Short Course. Respondents who had dedicated health promotion staff in their workplaces emphasised that this provided the motivation and support they needed to undertake health promotion work.

“I work within a health promotion team and the other staff have trained in health promotion so now I feel more in sync with these colleagues ... it makes our team more unified” (R3).

“We have a dedicated health promotion team within our Public Health Unit and they support us with their expertise if we have ideas for health promotion activities. We have a good relationship with the health promotion team and collaborate well with them” (R17).

Four respondents (24%) commented that flexibility in their workplace enabled them to incorporate health promotion concepts or practice into their work:

“There are no formal structures but the organisation was very flexible in allowing me to work on projects as I needed to and were very supportive of the need to focus on prevention and the non-clinical factors to improve maternal and child health” (R14).

In each of the Short Courses to date there have been at least two attendees from the same organisation. Informal feedback following the courses indicated that attending the course with a colleague was an enabling factor for having the capacity and confidence to integrate health promotion into their work practice.

Barriers to implementing health promotion concepts and strategies

Seven respondents (41%) reported experiencing barriers to implementing health promotion concepts or strategies they learned at the Short Course in their work practice. The most frequently mentioned barrier was limited funding to develop new health promotion projects, incorporate health promotion into their current practice, or travel to other regions to collaborate on projects. Financial barriers were most commonly cited by respondents in rural or remote regions: *“Limited funding reduces opportunities for initiatives to be rolled out and limits travel outside the region, so it is more difficult to undertake projects with other regions” (R16).*

Three respondents commented on difficulties in implementing health promotion activities because it was beyond the recognised scope of their role, it was not their area of expertise or because there was no formal support for health promotion in their organisation.

“I am not able to implement all of what I learned as I am not in a health promotion role. Nonetheless, health promotion concepts are very relevant to my work as a project officer” (R11).

“There are no specific health promotion teams / staff members in the organisation so there is no formal support for health promotion” (R9).

Likelihood of recommending the Short Course

All respondents (100%) stated they would recommend the Short Course to others. They provided a range of comments highlighting the usefulness and relevance of the course for people working in Aboriginal health: *“For anybody working in Aboriginal health and community health the Short Course is really relevant because it focuses on preventative health strategies which are so important” (R14).*

Six respondents (35%) remarked that the Short Course provided a good insight into, and challenged common perceptions of, health promotion.

“It is particularly useful for workers with a nursing background, to increase their understanding of health promotion and to realise it is more than education (resources/brochures) and includes other things like policy” (R13).

“If you will be delivering health promotion in your role it is a useful course ... gives you the basic principles” (R1).

Cultural security of the Short Course

All but one of the respondents (94%) reported the Short Course was culturally secure. Respondents mentioned the mix of people, the relevance of the course to Aboriginal health, and the course environment that encouraged participation, as contributing to cultural security. *“I felt like the women who were at the course liked it because it focused on programs and health issues ... in their communities” (R6).*

“All Aboriginal attendees were listened to, had a voice and participated as equal to other non-Aboriginal attendees” (R12).

Two respondents also provided suggestions on improving the cultural security of the Short Course:

“It would be better if there were Aboriginal people delivering the course. I’ve been to a course before where an Aboriginal person sat in on the course for the entire week as a cultural broker and this worked very well” (R2).

“There should have been more focus on the importance of speaking to the community to identify what the issues are ... Greater emphasis on community consultation needed” (R10).

Discussion

The results from this evaluation highlighted the value of the Short Course to support respondents to incorporate health promotion into their work practice. Respondents’ feedback demonstrated a demand for tools and skills to plan, implement and evaluate health promotion programs. The need to increase knowledge and understanding of health promotion and prevention theory and practice among the health workforce, to contribute to the ultimate goal of improved health outcomes, has been well articulated.^{3, 4, 9-14, 26} Given the need for tangible improvements in health outcomes for Aboriginal mothers and babies,²² building the capacity of service providers to develop well-designed, sustainable health promotion programs that have the potential to effect real change is an important element to achieving these improvements.^{27, 28}

A supportive, flexible workplace and the existence of dedicated health promotion staff in an organisation were strongly identified by participants as key enabling factors to the integration of health

promotion into work practices. It appeared to be important that more than one person within an organisation or region was skilled in health promotion to mobilise activities. Given many respondents did not work in such an environment, increasing organisational health promotion capacity through training at all staff levels, including management, could better support Short Course participants to implement health promotion practice.^{9, 13} This would also encourage organisations to prioritise and embed health promotion practice within their core business.¹⁰ Introducing a target-setting activity for participants around their intention to use the course content may improve the integration of health promotion into work practice.

The value of networking was also emphasised by respondents; this highlighted a need for increased opportunities for MCH service providers, especially those in rural and remote areas, to regularly meet and share information to ensure health promotion projects are collaborative and strengthened through inter-regional support. However respondents from all regions, but particularly those in rural or remote regions, identified financial constraints as a barrier to implementing collaborative health promotion strategies. This poses a challenge to the development of partnerships and the delivery of collaborative, evidence-based activities in areas of identified need in Aboriginal MCH services. Strengthening shared responsibility for preventive health through health promotion capacity building may be one strategy to address this challenge.^{11-13,17}

It is important to have realistic expectations of the improved health outcomes frontline staff can achieve for Aboriginal mothers and babies. Partnerships and recognition of shared responsibility are critical in this area. Frontline MCH staff understand the needs of, and have direct access to women but due to time, role and expertise constraints, may need to refer women to specialists, preventive health workers or non-health services that address the social determinants of health, for the most effective support². Thus, establishing strong partnerships with other agencies to enable appropriate referral pathways and build supportive environments is critical to ensure pregnant women receive the support they need, to have a healthy pregnancy.

What is achievable by frontline staff is also constrained by current investment in health promotion in Australia. The short-term nature of health promotion funding cycles poses a significant barrier to implementing comprehensive, well-evaluated programs that can lead to sustainable improvements in health outcomes,^{27, 28, 29} and can generate distrust among communities of such programs.³⁰ Sustainable funding models that allocate resources effectively and efficiently are required to support integrated approaches to health promotion that ensure long-term viability of programs and health outcomes.^{28, 31}

Our findings are similar to those from an evaluation of a five-day health promotion short course in Queensland, which identified that the majority of respondents had subsequently incorporated health promotion into their work despite the fact that there was a perceived limited understanding of, and commitment to, health promotion within the respondents' organisations.³²

Since 2012, six Short Courses have been delivered and training completed by 100 participants. This represents a significant investment by the AMSSU to upskill MCH service providers in WA and also reflects a substantial demand for health promotion training. Based on respondents' recommendations on the need for a 'cultural broker', the delivery of subsequent courses has included an Aboriginal Health Promotion Officer in attendance to offer support and assistance to participants as required, and guest presentations from Aboriginal health staff.

Limitations

The low overall response rate highlights the need for approaches that successfully engage course participants in follow-up evaluation. The response rate of those invited for telephone interviews was much higher than that for online surveys; this suggests telephone and in-person communication methods may be more effective in engaging with MCH service providers and should be utilised in future evaluation studies.

Respondents may have been those more likely to have integrated health promotion into their work practice and thus self-selected into the study. For some respondents, the evaluation was conducted up to 17 months after their attendance at the course. Given the strongest response rate was from participants from the more recent courses, a four-month follow up with participants is recommended to maximise response rate and recall accuracy.

The evaluation results capture a snapshot of the impact of the Short Course on participants' health promotion practice. However, it would be beneficial to capture the outcomes of the projects and activities subsequently implemented by participants to identify changes in health outcomes among Aboriginal women and families.

Conclusion

The Short Course provides an example of culturally secure training that offers participants the opportunity to develop their skills and confidence to deliver health promotion strategies in their communities. These strategies, delivered in conjunction with other initiatives, can contribute to the ultimate goal of achieving healthy outcomes for Aboriginal mothers and babies.

Our evaluation suggests that such training would benefit from the provision of ongoing support for course participants to integrate health promotion into their work practice, such as providing refresher training, following-up participants earlier to offer assistance, and enhancing organisational health promotion capacity by offering training to staff at all levels of an organisation. Longer-term aims to promote sustainability of health promotion skills among the MCH workforce include embedding training into MCH workforce curricula, and funding for networking and mentoring opportunities to

facilitate greater collaboration among MCH service providers. However, training is only one component of capacity building and needs to be part of a comprehensive workforce development plan to build health promotion skills⁹. Other components include integration of health promotion into existing organisational structures; fostering partnerships and collaboration; establishing stronger referral pathways among partner organisations to support continuity of care and consistent preventive health messages; and opportunities for ongoing skills building and skills exchange, such as placements for health promotion officers to work within Aboriginal MCH services.

This study highlights current challenges and gaps in the integration of health promotion practice within the roles of staff working in Aboriginal MCH services. It points to a high demand for health promotion knowledge and skills among this workforce and an opportunity to improve health outcomes for pregnant Aboriginal women and their babies.

Table 1. Outline of Curtin University's *Planning, Implementing and Evaluating Health Promotion Interventions* four-day short course

Day	Learning Outcomes	Teaching method / assessment
1	<ul style="list-style-type: none"> • Introduction to health promotion • Social determinants of health • Health promotion planning cycle • Planning and evaluation frameworks and models • Needs assessment and setting program goals 	<p>The Short Courses are designed to accommodate different levels of health promotion knowledge and experience. Teaching methods include interactive content delivery, group discussions and activities, brainstorming and worksheets to facilitate active learning. There are no tests to assess skills; instead the course uses an applied approach and participants work in groups to develop project plans for a health promotion program, which they present to the class on the final day. Process evaluation is conducted throughout the course including end-of-day evaluation surveys, quizzes to recap and assess knowledge and understanding, and informal verbal consultation to determine participants' engagement and understanding. These evaluation activities ensure each course is responsive to the specific needs of the participants and that participants are achieving their expected knowledge and skills gains from the course.</p>
2	<ul style="list-style-type: none"> • Understanding health and behaviour • Theories for health promotion • Writing program objectives • Selecting health promotion strategies 	
3	<ul style="list-style-type: none"> • Evaluating health promotion interventions • Defining program effectiveness • Evaluation approaches 	
4	<ul style="list-style-type: none"> • Effective partnerships • Program sustainability and capacity building • Influencing policy • Presentation of project plans and discussion 	

Figure 1: Regional distribution of Health Promotion Short Course survey respondents (n=17)

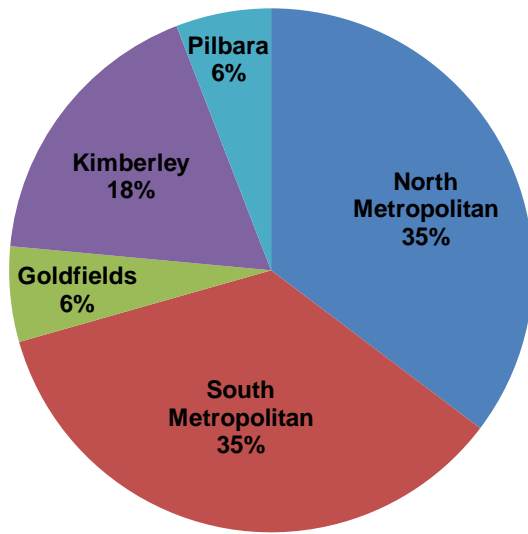


Table 2. Job titles of Health Promotion Short Course survey respondents

Reference Number⁺	Professional Title
R1	Aboriginal Health Officer
R2	Aboriginal Health Promotion Officer
R3	Aboriginal Health Promotion Officer
R4	Aboriginal Health Worker Maternal Services
R5	Aboriginal Maternal Support Worker
R6	Aboriginal Maternity Group Health Worker
R7	Aboriginal Maternity Group Practice Program Clinical Midwife
R8	Aboriginal Senior Health Promotion Officer
R9	Clinical Midwife
R10	Clinical Trainer
R11	Early Years Project Officer
R12	Educator/Midwife
R13	FASD Prevention Program Coordinator
R14	Health Education Officer
R15	Health Project Officer
R16	Public Health Nurse/Midwife
R17	Service Development Coordinator

⁺ *Comments from respondents will be shown in italics and these reference numbers will be used e.g. (R1)*

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