

Integrated health promotion resource kit



Integrated health promotion

A practice guide for service providers



Published by the Primary and Community Health Branch in partnership with the Public Health Branch, Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services, Melbourne, Victoria, June 2003.

For further information contact:

Ms Susan Heward

Primary and Community Health

Rural and Regional Health and Aged Care Services Division

Victorian Government Department of Human Services

Level 11, 555 Collins St. Melbourne 3000

Email: susan.heward@dhs.vic.gov.au

Phone: (03) 9616 8382

Fax: (03) 9616 8277

This publication is also available on the Internet at <http://www.dhs.vic.gov.au/phkb>

This publication is not for commercial use or sale.

© Copyright State Government of Victoria 2003. This publication is copyright.

No part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

ISBN 0 7311 6176 9

Authorised by the State Government of Victoria, 555 Collins Street, Melbourne.

Printed by Gill Miller Press, 34 Stanley Street, Collingwood.

Foreword

I am pleased to present the *Integrated health promotion resource kit*, which includes the *Integrated health promotion: A practice guide for service providers*. There is growing evidence worldwide of the benefits and effectiveness of investing in health promotion programs, through an integrated approach. Integrated health promotion programs deliver benefits for the community through promoting positive wellbeing, strengthening community capacity and minimising the burden of serious diseases, such as diabetes and cardiovascular disease. This guide is a practical resource to support agencies and organisations to plan, deliver and evaluate effective integrated health promotion programs.

An earlier version of this guide was distributed in December 2000 as the *Primary Care Partnerships draft health promotion guidelines*. This practice guide is an evolution of that document, building on the experience of Primary Care Partnership member agencies and the Department of Human Services in using the draft guidelines during the past two and a half years.

I would like to take this opportunity to thank the many individuals, agencies and organisations that contributed their expertise and enthusiasm for quality health promotion practice during the development of this guide. The consultation process to produce this guide included both written feedback from, and dialogue with, the sector and across the department including:

- Primary Care Partnership member agencies
- Consumer and carer organisations
- Peak bodies and statewide health promotion organisations
- Statewide advisory committees
- Academic institutions
- Regional health promotion officers, regional primary health advisors and primary care partnership regional contacts.

This guide will assist practitioners, agencies and organisations to deliver quality integrated health promotion programs and improve the health and wellbeing of communities.

This guide will assist practitioners, agencies and organisations to deliver quality integrated health promotion programs and improve the health and wellbeing of communities.



Tracey Slatter
A/Director, Primary and Community Health
Department of Human Services

Contents

Foreword	i
1. Introduction	1
1.1 Purpose of this guide	1
1.2 Using this guide	1
1.3 Integrated health promotion	3
2. Integrated health promotion in Victoria	9
2.1 Primary health reform	9
2.2 Key stakeholders in the primary health care sector	10
3. Foundations for integrated health promotion	21
3.1 The determinants of health	21
3.2 Social capital and community development	24
3.3 International, Australian and Victorian context	26
4. Integrated health promotion planning and implementation	31
4.1 A common framework	31
4.2 Planning for integrated health promotion	32
4.3 Implementation	41
5. Health promotion interventions and capacity building strategies	43
5.1 Integrated health promotion in action	43
5.2 Health promotion interventions	44
5.3 Capacity building – support and resources	53
6. Evaluation and dissemination	63
6.1 Process evaluation	64
6.2 Impact evaluation	65
6.3 Outcome evaluation	66
6.4 Dissemination	70
7. Useful resources and endnotes	73
Department of Human Services	73
Other resources	73
Endnotes	92
8. Other information	99

Health promotion programs deliver benefits for the community in promoting positive wellbeing, reducing preventable illness and lowering overall health care expenditures.

1. Introduction

1.1 Purpose of this guide

The Victorian public hospital system, like others in Australia and internationally, has been experiencing unprecedented and sustained increases in demand.¹ Increasingly, however, the view taken by the Government in Victoria is that while demand pressures may be most prominent and most urgent in emergency departments and acute settings, the solution requires a system-wide approach. This, in part, involves reorienting policy and service responses to health promotion and disease prevention and management initiatives. The primary health care sector is progressively positioning itself to provide workable solutions to hospital demand, including reorienting the system to become more integrated and population focused.


There is growing evidence worldwide of the benefits and effectiveness of investing in health promotion programs. Health promotion programs deliver benefits for the community in promoting positive wellbeing, reducing preventable illness and lowering overall health care expenditures.^{2,3}


Integrated health promotion: a practice guide for service providers (2003) ('the guide') will assist agencies and organisations to strengthen the development and delivery of quality integrated health promotion programs in Victoria. This strengthened approach will lead to a greater focus on planned and integrated health promotion that will improve the health of local communities and build the evidence base for the effectiveness of integrated health promotion.


1.2 Using this guide

The guide recognises and values the broad range of agencies, organisations and practitioners delivering integrated health promotion programs. It is, therefore, useful for agencies that receive funding from the Primary and Community Health Branch of the Department of Human Services as well as for the broader range of organisations and practitioners involved in planning, implementing and evaluating integrated health promotion programs and activities.

Throughout this guide there are resources to assist agencies, organisations and practitioners to apply the theory of integrated health promotion to practice. The resources include the following:

 **Toolkits:** These provide further information to supplement the main text of the guide. Toolkits often include lists of additional relevant resources such as other documents and web sites.

 **Checklists:** These provide a series of questions to assist in applying a particular section of the guide to practice.

 **Case studies:** These explore a concept in more detail by providing a detailed example.

This edition of the guide features case studies from Primary Care Partnership (PCP) funded health promotion programs.

This guide uses a ring folder format to make it easy to include new and updated resources in the future. More case study examples from agencies and organisations will be developed and disseminated as updates to the guide are made.

The guide should be read and used in conjunction with the following department publications:

- *Primary Care Partnership community health plan implementation agreement* (2003)
- *Community and Women's health program guidelines* (2003)
- *Measuring health promotion impacts: A guide to impact evaluation for health promotion* (March 2003). This is a companion document developed by the department. It has been designed to be included in Section 8 of the resource kit.
- *Environments for Health* (2001)

These publications and other information supporting integrated health promotion can be downloaded from <http://www.dhs.vic.gov.au/phkb> and <http://www.dhs.vic.gov.au/phd/localgov/mphpf/index.htm>

1.3 Integrated health promotion

The Ottawa Charter (1986) defines health promotion as:

...the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.⁴
(For further information about the Ottawa Charter, see Section 3.3)

In Victoria, the term ‘integrated health promotion’ refers to agencies in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues. To achieve effective integrated health promotion program delivery in the current Victorian context, the following points should be considered:

1. The role of partnerships – Integration intensifies from networking through to formalised collaborative partnerships (see Table 1). The aim is to move towards the highest level of integration – **collaboration**. The entry point and progression along this continuum may vary (as demonstrated by the PCPs across Victoria) depending on background, leadership, capacity and prior development of the working relationships leading up to the strategy. The individual role of an agency or organisation may also fall on different parts of this continuum.
2. Quality integrated health promotion practice and delivery should focus on implementing an appropriate mix of health promotion interventions (that encompass a balance of both individual and population-wide health promotion interventions) supported by capacity building strategies to address the priority issues identified.
3. Clear identification of the key stakeholders or partners is required to make a difference to the identified priority issue. Integration across a broad range of sectors, including non-government organisations and community groups, is essential to address the determinants of health. Other organisations outside the ‘traditional’ primary health care sector, such as local government, schools, housing, recreation clubs and commercial businesses, are seen as key partners in the development of the integrated health promotion strategy.



 **Toolkit:** Integration can be presented as a continuum – see Table 1.

Table 1: The continuum of integration⁵

Integration	Process	Purpose
Low  High	Networking	The exchange of information for mutual benefit. This requires little time and trust between partners. Clearinghouse for information.
	Coordination	Exchanging information and altering activities for a common purpose. Match and coordinate needs and activities. Limit duplication of services.
	Cooperation	As above plus sharing resources. It requires a significant amount of time and high level of trust between partners.
	Collaboration	In addition to the other activities described, collaboration includes enhancing the capacity of the other partners for mutual benefit and a common purpose. Building interdependent systems to address issues and opportunities. Sharing resources and making equal commitment.

What are the stages in building collaboration?⁶

Stage one: priority setting and problem definition

- Shared understanding of problems and goals and each partner’s position
- Shared definition of the problem
- Shared commitment to the collaboration
- Identification of resources required to support the collaboration
- Collective identification of key stakeholders and the convenor

Stage two: reaching agreement

- Establish the ground rules
- Jointly agree on an agenda for the collaborative venture
- Reach agreement on how problems will be solved

Stage three: implementation

- Build external support for the solutions agreed
- Institutionalising/implementing agreements reached
- Monitoring the agreement and ensuring compliance

The following are the **State's guiding principles or core values for integrated health promotion**. These are built from the social model of health philosophy, the Ottawa Charter definition of health promotion, and key priorities identified in national health promotion documents. These principles can be used as a guide for planning and delivering effective integrated health promotion programs.

1. **Address the broader determinants of health**, recognising that health is influenced by more than genetics, individual lifestyles and provision of health care, and that political, social, economic and environmental factors are critical.
2. **Base activities on the best available data and evidence**, both with respect to why there is a need for action in a particular area and what is most likely to effect sustainable change.
3. **Act to reduce social inequities and injustice**, helping to ensure every individual, family and community group may benefit from living, learning and working in a health promoting environment.
4. **Emphasise active consumer and community participation** in processes that enable and encourage people to have a say about what influences their health and wellbeing and what would make a difference.
5. **Empower individuals and communities**, through information, skill development, support, advocacy and structural change strategies, to have an understanding of what promotes health, wellbeing and illness and to be able to mobilise resources necessary to take control of their own lives.
6. **Explicitly consider difference in gender and culture**, recognising that gender and culture lie at the heart of the way in which health beliefs and behaviours are developed and transmitted.
7. **Work in collaboration**, understanding that while programs may be initiated by the health sector, partnerships must be actively sought across a broad range of sectors, including those organisations that may not have an explicit health focus. This focus aims to build on the capacity of a wide range of sectors to deliver quality integrated health promotion programs; and to reduce the duplication and fragmentation of health promotion effort.

? Checklist: applying the guiding principles for integrated health promotion

The following is a series of questions to help apply these principles in your work:

- Have you looked beyond the individual and beyond health services to what is happening in the broader community that affects people's health and wellbeing?
- Have community members had the opportunity to participate and have a say about what health issues need to be collectively addressed and how they can make a difference?
- Have you asked why there is a need for action and what actions are most likely to make a lasting difference?
- Have you asked who the key stakeholders are and are you/they working in partnership?
- Have strategies been put in place to make it easy for people and groups from a wide range of backgrounds, gender and situations to participate and benefit, and to provide assistance to do so where necessary or appropriate?
- Have strategies been put in place so that all parts of a program are clearly stated and easily understood, including the objectives of the program and the extent to which participants can influence the outcome?
- Have strategies been put in place to ensure that relevant information is made available and accessible to community members in a timely matter? Information must be presented simply, honestly and with the option for more detailed information also available.
- Have effective communication strategies been initiated that demand honesty, clarity and responsiveness by those coordinating the program?
- Have participants been treated with respect and their views and experiences valued?
- Have evaluation processes been undertaken to reflect on participation and partnership strategies?
- Have you considered the workforce development needs of key participants so they are able to apply a social model of health framework to service planning and provision?⁷

Case study: integration in Upper Hume Primary Care Partnership

What was the issue?

Upper Hume's planning process showed falls among older people to be a major public health problem causing an unnecessary toll on older people's health, vitality and independence. There was a need for strategies to improve health and wellbeing and to reduce demand on hospital services.

What has been the integrated health promotion response?

Member agencies of the PCP developed an integrated health promotion strategy to address this issue. The goal of the program is to reduce the number of injuries caused by falls. The target population groups are older people over 65 years old and Koori people over 40 years old.

The program incorporates a mix of interventions and capacity building strategies as described below (also see Section 5 for more information about intervention types). The program involves a range of organisations, each with the role of leading particular interventions.

The integrated approach means that agencies and local government areas (LGAs) are coordinating their health promotion efforts and are more effective at addressing falls prevention in a systematic way. There are clear benefits for consumers, including improved access to physical activity, better information about health, better access to services through improved referrals, reduced isolation and overall improved wellbeing.⁸

1. Screening, individual risk factor assessment and immunisation

General practitioners (GPs): Assess and refer patients to specific physical activity programs.

Acute: Assess and refer cardiac rehabilitation and diabetes patients to physical activity. Fund a physical activity aid worker at Beechworth.

Local government: All LGAs and/or local health services provide home safety assessments for people aged 65+ (where requested) to increase knowledge of falls risks and general home safety. This is overseen by one peak safety committee (covering the three shires), which includes the Police, Country Fire Authority, Department of Veterans Affairs and Neighbourhood Watch.

2. Health education and skill development

Community health: Agency staff and trained community members deliver tai chi, strength training and a range of other physical activity classes in all seven major towns, as well as many small communities.

Allied health: Allied health professionals provide health information and supervision to volunteers leading or participating in physical activities.

3. Social marketing and health information

PCP as a whole: Develop local press releases and media opportunities to highlight benefits of physical activity on reducing falls (coordinated through PCP).

4. Community action (for social and environmental change)

Community members: Involved in planning and implementing program activities (for example, determining the location and timing for tai chi and considering the physical and safety needs of participants). Community members also take an ongoing leadership role in delivering physical activity as trained volunteer leaders.

5. Settings and supportive environments

Community managed transport: Provide transport for isolated residents to access physical activity.

Planned activity groups (Home and Community Care - HACC): Work with local sporting facilities to reorientate services to suit older people.

Local government: Negotiate for cheaper access to gymnasiums for organised physical activity sessions (council owned and private gymnasiums).

6. Organisational development

PCP as a whole: Joint planning through health promotion working group across the whole range of health issues, including physical activity, diabetes, vision and cardiac health.

7. Workforce development

Statewide organisations and allied health: Train agency staff and community members to run physical activity classes, and provide expertise in design of classes. Statewide organisations involved include Arthritis Victoria, Diabetes Australia-Victoria, the Council on the Ageing (strength training) and Monashlink ('Powerpal' training).

Optometrists Association, Vision Australia and Royal Victorian Institute for the Blind: Provide workforce development on the link between falls prevention and early detection of vision loss.

Women's health: Train health promotion work group on planning and evaluating falls prevention activities using a gendered approach.

PCP as a whole: Train health promotion providers in documenting progress and impact as a result of physical activity. All PCP members audited for their health promotion capacity and targeted for health promotion training.

8. Resources

PCP as a whole: Project worker supports program development and leadership within the PCP.

Peaks/statewide organisations: Provide expert advice and support to program.

2. Integrated health promotion in Victoria

2.1 Primary health reform

Improving and strengthening the primary health care sector is a priority of the Victorian Government. It is also a process that many other jurisdictions in Australia and overseas are undertaking. Stronger primary health services are necessary to respond to:

- escalating demand
- consumer preferences to receive services in the community
- the need to support the ageing population
- the incidence of preventable disease that leads to poor health outcomes and the requirement for more acute and specialist care.

2.1.1 Primary Care Partnerships


In April 2000, following consultation with the sector, the Government launched the PCP strategy⁹ to achieve reform of primary health and to address the perceived fragmentation in the primary health care system.

Based on voluntary alliances between more than 800 service providers in 32 catchments across Victoria, the strategy is achieving improved health and wellbeing outcomes by supporting a functionally integrated service system.

Based on voluntary alliances between more than 800 service providers in 32 catchments across Victoria, the strategy is achieving improved health and wellbeing outcomes by supporting a functionally integrated service system. This is based on the development of partnerships between service providers, government and communities to improve service coordination and the delivery of integrated health promotion programs. The strength of the reform lies in the partnerships that have developed.

One of the two key deliverables¹⁰ of the PCP strategy is strengthening the existing capacity of the service system to plan, deliver and evaluate effective, integrated health promotion programs. Individual department program policy (particularly in community and women's health programs) is critical in supporting the agency and organisational cultural changes necessary to adequately recognise integrated health promotion as part of their core business, not just as optional project work.

Each PCP alliance has been funded specifically to develop an integrated health promotion strategy as part of their Community Health Plan (CHP). This strategy focuses on implementing a mix of health promotion interventions (encompassing a **balance** of individual and population-wide health promotion interventions) supported by identified capacity building strategies, to address the priorities identified in the CHP.

 **Toolkit:** The reporting requirements for all PCP funded integrated health promotion activity (including rural health promotion funds) have been developed to reflect the quality planning, implementation and evaluation practices explained in this guide. For further details related to the funding and reporting requirements for the PCP strategy, refer to the Community Health Plan Implementation Agreement (CHPIA) at <http://www.dhs.vic.gov.au/phkb>.


The expected outcome of this strengthened approach is a greater focus on planned and integrated health promotion that will improve the health of local communities, in particular for those groups with the most disadvantage and poorest health status.

2.1.2 Primary health funding approach

An extensive research and consultation process was conducted to develop a new divisional approach to the funding of community and women's health services. Through an incremental implementation process the new approach will distribute agency funds across the following three components:

- services to individuals
- health promotion programs
- development and resourcing.

Strengthening integrated health promotion planning and reporting in community and women's health services builds on the policy framework introduced through the PCP strategy.¹¹ The expected outcome of this strengthened approach is a greater focus on planned and integrated health promotion that will improve the health of local communities, in particular for those groups with the most disadvantage and poorest health status.

 **Toolkit:** For details specific to the funding and reporting of this activity, refer to the *Community and women's health program guidelines* at <http://www.dhs.vic.gov.au/phkb>

2.2 Key stakeholders in the primary health care sector

2.2.1 Department of Human Services

In supporting integrated health promotion programs, the Department of Human Services aims to:

1. Enable communities and individuals to increase control over and improve their health.
2. Support the reorientation of the primary care system to a population focus underpinned by the social model of health.
3. Consolidate and enhance the integrated health promotion infrastructure and resources.
4. Reduce duplication and fragmentation of integrated health promotion effort.
5. Contribute to the evidence base for integrated health promotion around specific issues and population groups.
6. Increase the potential to involve sectors other than health in quality integrated health promotion service delivery.
7. Build on the capacity of the service system to plan and deliver effective quality integrated health promotion programs.
8. Contribute to a reduction of preventable hospital admissions.

To achieve these aims, at a **central office** level, the department:

- develops a strategic policy framework to support the delivery of quality integrated health promotion programs, in conjunction with regional offices
- provides guidance on priorities and disseminates good practice examples to ensure systematic demonstration of the effectiveness of integrated health promotion strategies
- supports local and regional planning for integrated health promotion by providing data and analysis and coordinating a consistent statewide planning and funding framework
- establishes workforce development opportunities, such as training and information sharing programs
- monitors service quality and effectiveness, in conjunction with regional offices, to ensure the effective use of integrated health promotion resources
- explores opportunities across the department, whole-of government and with the Commonwealth to ensure a systematic approach to integrated health promotion.

At a **regional office** level, the department:


- advises regional key stakeholders on regional health promotion priorities, provides relevant planning information and links to broader policy objectives including neighbourhood renewal and sustainable communities
- monitors integrated health promotion plans (at the partnership and agency level) and provides advice on program quality, effectiveness and accountability in conjunction with central office
- ensures that special needs groups are targeted, such as socially and economically disadvantaged populations, and that programs are tailored to the needs of linguistically and culturally diverse groups, where appropriate
- coordinates and supports skills development, training and information sharing programs
- facilitates and supports collaboration across the region among key stakeholders and links with other sources of technical support.

2.2.2 Community and Women's health services

Community and Women's health services play a leadership role in the PCP strategy and, in particular, in integrated health promotion.

Community and Women's health services play a leadership role in the PCP strategy and, in particular, in integrated health promotion. The PCP structure provides an integral link between community and women's health and other agencies within a given catchment area in the planning, implementation and evaluation of integrated health promotion programs. This focus on integration supports key stakeholders to have greater capacity to address key health and wellbeing issues effectively, and to minimise duplicated, fragmented effort. Working with existing networks within a catchment population has been essential to build on the current knowledge and expertise.

Across Victoria, community and women's health services are individually funded for one or a mix of the following services: community health, women's health, innovative health services for homeless youth (IHSHY), suicide prevention, family and reproductive rights education (FARREP) and family planning services. Through these programs, integrated health promotion is funded as a single activity – health promotion. This also applies to statewide agencies, namely the Victorian Foundation for Survivors for Torture Inc., International Diabetes Institute, Centre for Adolescent Health, Centre for Culture, Ethnicity and Health and Statewide Women's Health Services.

 **Toolkit:** For further details specific to the funding and reporting of this activity, refer to the *Community and Women's health program guidelines* at <http://www.dhs.vic.gov.au/phkb> under Community Health.

2.2.3 Local government

Local governments are also leading members of all PCPs. They provide and fund a range of primary health care services and have an important role in local area public health planning, advocacy, community action and delivery.

Strengthening the capacity of local government to promote health and wellbeing is a priority of the Victorian Government.¹²

Local governments:

- **Are a distinct level of government** with a governance role that includes strategic planning, advocacy, coordination and facilitation of democratic community participation.
- **Have a close relationship with their local constituencies** and are well placed to consult with and respond to local and diverse community needs. Fundamental in developing these responses is the active participation of local communities.
- **Have the authority and responsibility for public health leadership**, including creating a vision and goals, promoting partnerships and integrated planning, supporting active community participation and community development principles, advocating for local needs, establishing structures for corporate cooperation and facilitating change.
- **Have an identified population and geographical basis.** This enables a coherent approach to strengthening the public health infrastructure and to the delivery of a wide range of public health programs.

Strengthening the capacity of local government to promote health and wellbeing is a priority of the Victorian Government.

The tenets of the Ottawa Charter for Health Promotion have underpinned local government approaches to dealing with preventable conditions, injury and more traditional public health issues, such as infectious disease control, sanitation and food safety.


Under the *Health Act 1958*, all local government authorities are required to prepare municipal public health plans (MPHPs) every three years, with an annual review. This planning cycle enables councils to document their public health activity and set local priorities through a defined approach. The planning process includes needs assessment and community consultation, and promotes place-based planning for a defined geographical area and identified population.

MPHPs outline public health strategies aimed at supporting and enhancing municipal functions and initiatives that address issues related to the health and wellbeing of the people of the municipality. The tenets of the Ottawa Charter for Health Promotion¹³ have underpinned local government approaches to dealing with preventable conditions, injury and more traditional public health issues, such as infectious disease control, sanitation and food safety.

These plans are an important instrument in engaging community groups and individuals and supporting integrated approaches to health and wellbeing issues. Local governments work cooperatively with their local communities, service providers, other levels of government and statewide organisations to develop and implement their plans. The MPHP can be an integrating mechanism for many municipal planning requirements that have health impacts, such as urban planning. There are also opportunities for neighbouring councils to prepare joint MPHPs. In rural regions with smaller populations and fewer resources, a cooperative approach can be an effective way of addressing the wide range of public health issues that are shared across sub-regions.

*Environments for Health*¹⁴ is the department's policy framework for municipal public health planning. Released in 2001, the framework offers local governments an opportunity to involve all sectors of the community in a collaborative process to strengthen community capacity, health and wellbeing.

CHPs and MPHPs are complementary.¹⁵ The two processes share a common aim to focus planning on local areas and empower local communities to work together on key health and wellbeing issues. The underlying basis for both plans is common; the areas where they differ are about focus, breadth and specificity. While this means one plan can inform or be part of the other, the MPHP is recognised as being an important building block to informing the development of the CHP.

 **Toolkit:** See the websites below for further information in relation to Local Government and municipal public health planning.

Environments for Health (2001)

<http://www.dhs.vic.gov.au/phd/localgov/mphpf/index.htm>

Community health plans and municipal public health plans information resource (2003) downloadable from: <http://www.dhs.vic.gov.au/phkb>

VicHealth Letter: Planning for Health (2003)

<http://www.vichealth.vic.gov.au/default.asp?artid=522&tmid=37&level=1>

Also on the VicHealth site is information on the social determinants of health and the role of local government, including the resource *Leading the way: councils creating healthier communities*. To access this resource you can contact VicHealth on (03) 9667 1333 or email kjolly@vichealth.vic.gov.au

The central aim of the Divisions of General Practice program is to improve health outcomes for the community by encouraging GPs to link with each other and with other health professionals to upgrade the quality and comprehensiveness of health service delivery at the local level.

2.2.4 Divisions of general practice/general practitioners

The central aim of the Divisions of General Practice program is to improve health outcomes for the community by encouraging GPs to link with each other and with other health professionals to upgrade the quality and comprehensiveness of health service delivery at the local level.

Divisions take a population health perspective in determining their activity and support general practice (GPs, practice nurses, practice managers) to adopt a similar view. Their strategic plans and business plans focus on national goals and target areas, such as cardiovascular disease and mental health, as well as local health needs.


Increasingly, GPs are being asked to consider their 'practice population', that is, to understand more about the health status of all those who attend their practice. Divisions play a critical role in ensuring that general practice is able to undertake the system development tasks involved in this new approach. They do this through activities including skills training and education, practice demonstration and problem solving, dissemination of information and provision of networking opportunities between practices. Additionally, Divisions play a crucial role in developing linkages with other health organisations to strengthen the working relationships between general practice and other providers.

GPs in Victoria currently undertake more than 25 million consultations with patients annually. As well as managing the presenting problem, the GP encounters considerable opportunities during these consultations to offer a range of health promotion interventions. Attention to risk factors and adherence to recommended screening and immunisation protocols for various risk groups is a major contribution that can be made in the general practice setting. GPs understand that screening, risk factor assessment, health education and understanding of whole patient care form part of every clinical consultation. Divisions focus their efforts on involving all

The general practice contribution to integrated health promotion in PCP catchments is supported by systematic approaches to individual care, broader population-wide interventions and strong working relationships between general practice and other service providers.

general practices in initiatives that aim to increase the quality of existing general practice services across the board.

The general practice contribution to integrated health promotion in PCP catchments is supported by systematic approaches to individual care, broader population-wide interventions and strong working relationships between general practice and other service providers. For example, this includes general practice and other service providers establishing processes for GPs to refer patients into integrated health promotion programs where appropriate. (See the case study below for an example of this approach.)

 **Toolkit:** For more information about implementing prevention activities into general practice, refer to the websites below.

Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting (1998) from
<http://www.racgp.org.au/folder.asp?id=301>

Guidelines for preventive activities in general practice (2002) from
<http://www.racgp.org.au/folder.asp?id=605>

Evaluation of the General Practice Immunisation Incentive (GPII) Scheme from
<http://www.health.gov.au/haf/docs/vol1part1.pdf>

The SNAP framework for general practice, prepared by the Joint Advisory Group on general practice and population health:
<http://www.health.gov.au/pubhlth/about/gp/snap.pdf>

Case study: Wimmera PCP, Grampians Pyrenees PCP, and the West Vic Division of General Practice

What was the issue?

Research conducted by both PCP member agencies and the Division of General Practice showed that one of the leading risk factors contributing to the region's high incidence of cardiovascular disease and diabetes was high levels of physical inactivity.

What has been the integrated health promotion response?

The West Vic Division is a member of both PCPs and is leading the Active Script service. The Division and a local GP designed this service based on the statewide Active Script program and the New Zealand Green Prescription program. Through this service, GPs **prescribe** physical activity to patients who would like to become more physically active.

The Division and other member agencies of the PCPs wanted to link Active Script to physical activity programs run by agencies and other organisations in the area. To achieve this aim, Wimmera and Grampians Pyrenees PCPs are jointly

funding a worker, called a physical activity enabler, who is located at the Division of General Practice.

GPs refer patients who would like to become more physically active to the enabler who phones the patient to discuss options for physical activity, refers them to local activities where appropriate, and follows up at three-monthly intervals to sustain motivation.

The role of the service directory

Both PCPs have mapped the physical activity options available in their communities to assist GPs, the enabler and other organisations to make appropriate referrals. In time, this will be attached to the electronic service directory.

What helps to make the program work for GPs?

The Division promotes the use of Active Script by GPs through continuing professional development (CPD), visits to GPs and distribution of an Active Script kit.

The creation of an enabler position makes it easier for GPs to promote physical activity as part of their everyday practice. They know they can refer their patients to someone who can discuss physical activity options thoroughly. They also know that the enabler will assist their patient within 10 working days and will provide email or written feedback to the GP on the outcomes of the patient consultation.

Link to broader physical activity programs

Both PCPs have other elements (following good practice principles of implementing a mix of individual and population-wide health promotion interventions) to their broader physical activity program and the enabler can link patients to these activities where appropriate. For example, the enabler can refer people to one of the 11 agencies leading the Walking Wimmera program or to the Grampians Pyrenees Lift for Life mobile strength training program.

2.2.5 Consumers, Carers and the wider community

There is growing recognition that consumers have enormous potential to influence their own health outcomes if they are actively involved in decision-making and provided with quality information and appropriate self-management skills.¹⁶

Active consumer, carer and community participation has been associated with increased ability and capacity at a personal level and, at a community level, with the strengthening of communities, social connectedness and trust and increased competence to solve health problems. Specifically, integrated health promotion programs are more likely to be sustained if consumers, carers and community members are actively involved in identifying needs, planning, implementing and evaluating activities.

Specifically, integrated health promotion programs are more likely to be sustained if consumers, carers and community members are actively involved in identifying needs, planning, implementing and evaluating activities.

Consumers, carers and community members can be consulted and involved in many ways, including individually, in groups or as members of committees.

§ Toolkit: Consumers, carers and community members can be consulted and involved in many ways, including individually, in groups or as members of committees. There are numerous resources available to support consumer participation. Specific to the PCP strategy, see the information resource and newsletter:

A supplementary report on primary care partnerships consumer, carer and community participation (2002).

Newsletter: PCP Consumer and Carer Advisory Group, second edition (2002)

Building community partnerships: consumer, carer and community participation in Primary Care Partnerships (2003)

These can be downloaded from <http://www.dhs.vic.gov.au/phkb> under PCP Strategy Publications. See Section 7 for more resources in relation to consumer, carer and community participation.

2.2.6 Other key stakeholders


Other key stakeholders – such as secondary school nurses, psychiatric disability support services, drug and alcohol services, disability services, visiting nursing services, hospitals and acute services, Aboriginal and Torres Strait Islander health services and culturally specific health agencies, schools, sporting clubs and police – can also have a significant role in planning and implementing integrated health promotion programs. The role definition of these key stakeholders depends on the priority issues and population groups identified through the community health planning processes for each individual PCP catchment.

2.2.7 Victorian Health Promotion Foundation

The Victorian Health Promotion Foundation (VicHealth) is a statutory body established under the *Tobacco Act 1987*. The Foundation receives funding via an annual parliamentary allocation administered on behalf of the Minister of Health by the Department of Human Services. The legislation provides for VicHealth to fund activity related to the promotion of good health, safety and the prevention of disease. VicHealth is accountable through a board of governance appointed by the Minister for Health.

*VicHealth strategic directions for 1999–2002*¹⁷ seeks to advance VicHealth's role as a driver for innovation and development, working across sectors with emphasis on research and capacity building to change community cultures and behaviours and to develop supportive environments for good health.

VicHealth is committed to enhancing the integrated health promotion role at both the partnership and agency level by funding innovative health promotion initiatives and supporting capacity building activities. VicHealth continues to liaise closely with the Department of Human Services, at central and regional levels, to plan funding investments that are consistent, complementary and responsive to identified priorities.

 **Toolkit:** See VicHealth's website at <http://www.vichealth.vic.gov.au>
This website has an enormous range of information and resources for practitioners in relation to quality integrated health promotion practice.

Victoria has a well-established group of non-government (charitable or not-for-profit) organisations operating on a statewide basis, with a strong health promotion focus.

2.2.8 Other statewide health promotion

Victoria has a well-established group of non-government (charitable or not-for-profit) organisations operating on a statewide basis, with a strong health promotion focus. These organisations define their business variously in terms of specific health conditions, risk factors or population groups. They also provide significant skills and capacities in relation to health promotion research, program development and service delivery.

Effective working relationships between the PCP member agencies and statewide health promotion organisations are crucial to effective, quality integrated health promotion delivery. Operationally, these links will vary depending on the identified priorities at the PCP catchment and action at the agency level. These organisations have various roles and responsibilities, such as providing resources and advising on programs in areas such as education and training, information, research and development, telephone counselling, social marketing and advocacy.¹⁸

Case study: The Heart Foundation working with Campaspe PCP member agencies

What was the issue?

The Victorian Burden of Disease Study 2001 revealed cardiovascular disease to be the major debilitating disease in the Campaspe area.

What has been the integrated health promotion response?

Agencies, local government and consumers within Campaspe PCP designed an integrated health promotion program to reduce the risk factors for cardiovascular disease in the workplace. The program focuses on male employees within two workplace settings (a milk processing factory and a rice mill).

The achievements of the project to date include an increase in employees' knowledge of risk factors for cardiovascular disease, workplaces taking increased responsibility for the health and wellbeing of employees, and the creation of a local awards scheme for 'health promoting work'.

How do the Partnership member agencies and the Heart Foundation work together?


Campaspe PCP has worked with the Heart Foundation from the beginning of the program to draw on the knowledge and expertise of the statewide organisation. The Heart Foundation has had a role in:

- providing input into the draft of the integrated health promotion strategy for the Campaspe PCP catchment
- providing information about best practice in heart health and discussing potential strategies
- directing PCP member agencies to other organisations that have done similar activities, to learn about what did and did not work for others
- conducting a workshop with the PCP member agencies to plan the second stage of the program.

In Campaspe, the PCP member agencies plan to work with the Heart Foundation again in the evaluation of the heart health program.

What are the benefits of working with a statewide organisation?

The Heart Foundation's involvement has helped develop PCP heart health strategies in Campaspe that have a strong evidence base. Working with the statewide organisation has also made it easier to engage other agencies and workplaces in the project, because the Heart Foundation's involvement has added validity and credibility to the program.

 **Toolkit:** See the *Statewide health promotion organisations: a partnership resource for local agencies (2002)* at

<http://www.dhs.vic.gov.au/phd/statehealthpromo/index.htm>

This directory provides a map of statewide health promotion organisations in Victoria, defines the activities of each organisation and provides a point of contact for further information.

3. Foundations for integrated health promotion

This section outlines the foundations of, and gives a historical background to, integrated health promotion practice and principles. It provides an overview of the broader determinants of health that reflect a social model of health (fundamental to integrated health promotion practice), the link to social capital and community development and the policy context for integrated health promotion.

3.1 The determinants of health

The primary health care sector aims to achieve positive outcomes for consumers by working with the community to improve health and wellbeing.

The primary health care sector aims to achieve positive outcomes for consumers by working with the community to improve health and wellbeing. To achieve these outcomes, practitioners need to understand the broad determinants of health and wellbeing¹⁹ and apply a **social model of health** to service planning and provision.

A social model of health is a framework for thinking about health. Within this framework, improvements in health and wellbeing are achieved by addressing the social and environmental determinants of health, in tandem with biological and medical factors.²⁰ Underpinning and supporting this conceptual framework is the Alma Ata declaration and the World Health Organisation definition of health:

Health is a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity.²¹

Planners of services that aim to improve health and wellbeing and reduce the burden of preventable disease, need to be concerned not only with the individual context or factors, but also with the context of broad public policies and environmental influences, group and family influences and the community context.²² It is not possible to decide how best to support the improvement of health without understanding this context as illustrated in Figure 1.²³

Figure 1: The context of health

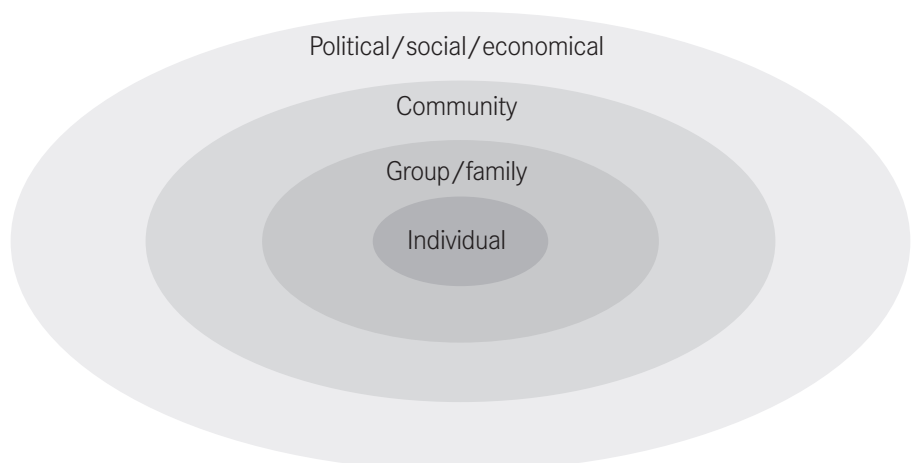
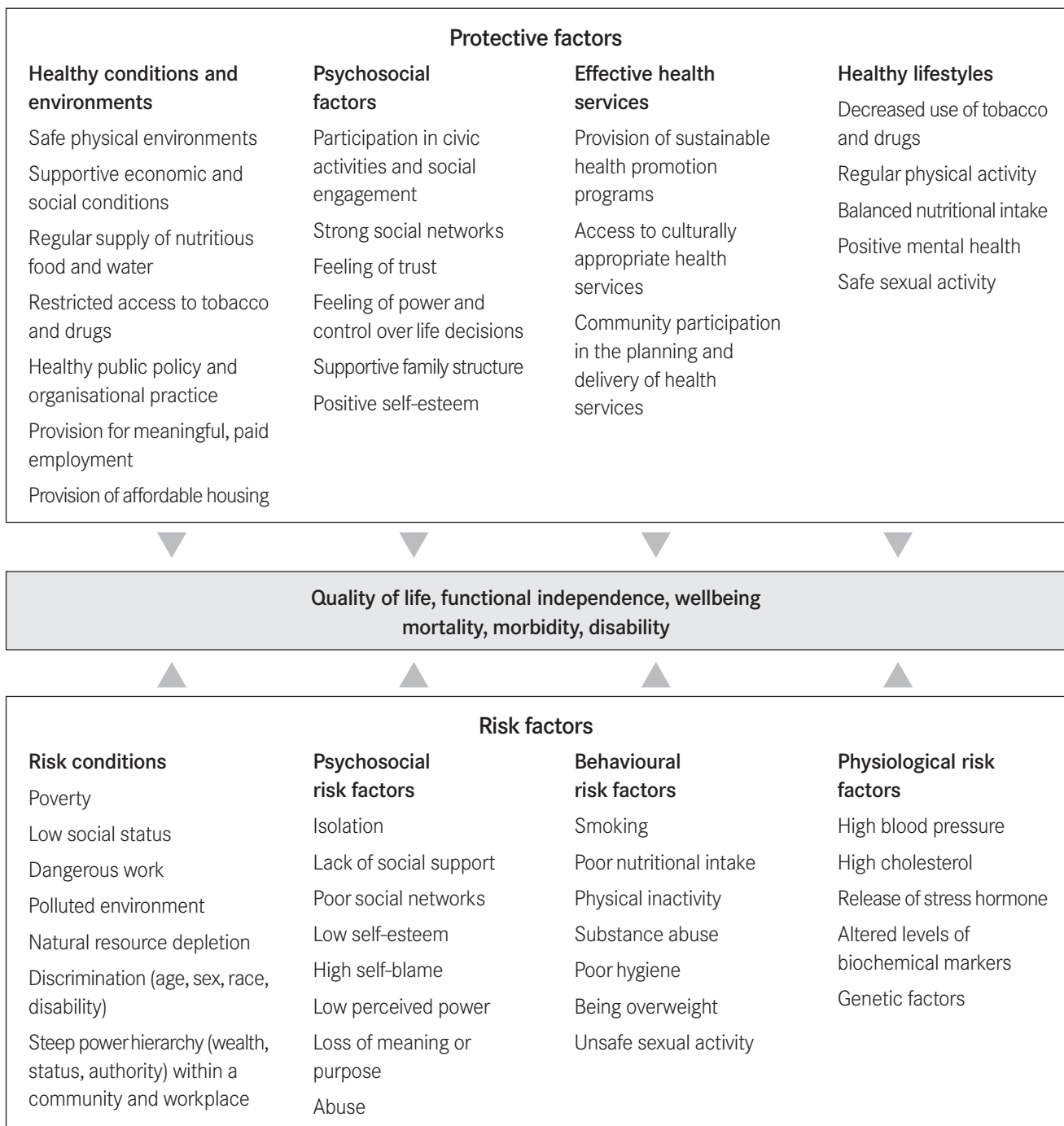


Figure 2 lists examples of the relationship between the determinants of health (grouped as protective and risk factors) and health and social outcomes, further illustrating the importance of applying the social model of health to service delivery.²⁴

Figure 2: The factors affecting health and wellbeing²⁵



There is a growing consensus on the importance of systematic differences in exposure to health hazards and risk conditions in the population.

There is a growing consensus on the importance of systematic differences in exposure to health hazards and risk conditions in the population. This means some groups in society have a much poorer chance of achieving their full health potential as a result of their life circumstances – including political, social, economic and environmental conditions as illustrated in Figure 2.

Differences are observed in the health status of groups according to a range of socioeconomic indicators. The most disadvantaged groups have the poorest health and the highest exposure to health-damaging risk factors.²⁶

There is evidence that poorer socioeconomic groups tend to have poorer nutrition, less physical activity in leisure time, greater prevalence of smoking and more damaging patterns of alcohol use. However, each factor should not be considered separately. The life circumstances or determinants of health (including people's social and economic circumstances, indigenous status and ethnicity, stress, gender, early life development and experiences, social exclusion, work and unemployment, and social supports)^{27,28} of people experiencing disadvantage highlight the greater restrictions on 'making healthy choices the easy choices'.²⁹ Further, cultural diversity and the failure of the system to address issues of access to appropriate services and programs for diverse groups can create inequalities in health status. Integrated health promotion attempts to close the equity gaps by supporting social networks; developing and advocating healthy public policies; and strengthening community capacity.³⁰

Inequity and inequality are often used interchangeably, but have very different meanings. If one person lives longer or suffers less sickness and disability than another, then inequalities in health status exist—but not necessarily as a result of inequity. These differences may not have arisen from living conditions, but from genetics, personal lifestyle choices or particular accidents. However, if differences in health status result from different living conditions (such as reduced access to nutritious foods, inadequate housing, lack of access to appropriate health care, lower income levels, stressful work conditions and frequent periods of prolonged unemployment), then inequalities in health status are the result of social inequities.³¹

Toolkit: the determinants of health³²

In practice, working within a social model of health means investigating what determines health and wellbeing or the determinants of health, including:

The social gradient: People's social and economic circumstances affect health throughout life. A continuum exists from the disadvantaged to well off rather than a binary effect at the extremes.

Stress: The individual response to stress can cause physiological changes, which affect health. It is recognised that people's social and psychological circumstances can affect health through stress.

Early life: The effects of early physiological and psychological development, both negative and positive, last a lifetime. The infant is dependent on their circumstances and significant others for both physical and emotional experiences.

Social exclusion: This may be imposed by law, result from economic circumstances or from failure to supply social goods or services. Groups that are socially excluded include the unemployed, ethnic minorities, homeless, pensioners or people with disabilities. These groups experience worse health outcomes than the general population.

Work: Stress in the workplace increases the risk of disease. An imbalance in two aspects of workflow control when work demands are high and an imbalance in effort in relation to reward (income, self esteem or status) – have been identified with negative health consequences.

Unemployment: Unemployment and job insecurity have a negative effect on health. Psychological and social resources are likely to increase in employment and decline in unemployment.

Social supports: Friendships, good social support at home, at work and in the community improve both physical and mental health.

Addiction: While individuals use alcohol, drugs and tobacco, their use is influenced by a wider social setting. Addictive behaviours are generally detrimental to health.

Food: Strong links have been established between nutrition (both under and over nutrition) and a range of diseases.

Transport: Healthy transport means reducing driving and encouraging more cycling and walking, backed up by better public transport.

In all of the checklists, key questions have been included to prompt practitioners to continually consider their role in affecting these determinants.

Participating in social and civic activities, such as community group meetings, child care arrangements with neighbours, neighbourhood watch schemes and voting, all work to produce a resource called social capital.

3.2 Social capital and community development

Participating in social and civic activities, such as community group meetings, child care arrangements with neighbours, neighbourhood watch schemes and voting, all work to produce a resource called social capital. Social capital is critical to the health, wealth and wellbeing of populations.³³ It is a key indicator of the building of healthy communities through collective and mutually beneficial interaction and accomplishments.³⁴ Recent research has linked these types of activities to improved health outcomes.^{35, 36, 37, 38}

A focus on social capital supports a balance of strategies that address behaviour and those that focus on the settings in which people live, work and play.

The notion of social capital represents a way of thinking about the broader determinants of health and about how to influence them through community-based approaches to reduce inequalities in health and wellbeing.³⁹ A focus on social capital supports a balance of strategies that address behaviour and those that focus on the settings in which people live, work and play. The implication for integrated health promotion is that more emphasis is needed on efforts to strengthen the mechanisms by which people come together, interact and, in some cases, take action to promote health. Simple measures, such as providing space for people to meet, may be as health promoting as providing health information in an effort to change behaviour.

Service providers can also enhance the social capital within a community by supporting community projects that bring neighbours together to achieve a mutually beneficial goal, such as beautifying the environment of a public housing estate, establishing a community fruit and vegetable garden or working with the local sporting club to encourage all parts of the community to participate in sporting activities.

It is important to note that the literature on social capital can present a romantic view of community and assumes that close-knit communities are necessarily healthy. It is, however, possible that a community can be socially cohesive but also exclusionary and distrustful of outsiders, and may in fact be unhealthy for those who are not a part of it or those within who disagree with the majority. Baum presents a range of factors that distinguish 'unhealthy and healthy' forms of social capital (see Table 2).⁴⁰

Table 2: Healthy and unhealthy forms of social capital⁴¹

Healthy social capital	Unhealthy social capital
Trust	Distrust of strangers/difference
Cooperation	'Them' and 'us'
Understanding	Tight knit but excluding
Empathy	Fear of the unknown
Alliance across difference	Dislike change and new ideas
Questioning and open to new ideas	Racism

Community development, in very simple terms, is the process of developing social capital.⁴² It is a process that emphasises the importance of working with people as they define their own goals, mobilise resources, and develop action plans for addressing problems they have collectively identified.⁴³

§ Toolkit: Service providers are in a unique position to employ community development concepts when delivering integrated health promotion programs by understanding their role as a:

Catalyst: Stimulating other people to take action by assisting in the problem definition of shared concerns and helping to bring individuals together who may not normally meet, but share common issues.

Teacher: Increasing the capacity, knowledge and skills of people and organisations to deal with their own challenges and priority issues. There is an approach to teaching based on principles of adult education where teachers and students are partners who move between teaching and learning roles.

Facilitator: Supporting community organisations in decision making and implementing actions. This includes undertaking organisational tasks and contributing technical skills to planning, implementing and evaluating. In this process, the service provider is not the manager but has a role in facilitation with the community committee or project advisory group and the policy makers.

Linking person: The service provider is in a unique position to build good relationships between the key stakeholders involved in the program for example, community organisations, funding agencies and the local media.⁴⁴

3.3 International, Australian and Victorian context

This section gives a brief overview of the key policy directions and activities for integrated health promotion in international, Australian and Victorian contexts.

3.3.1 International

The Declaration of Alma-Ata (1978)⁴⁵

The Declaration of Alma-Ata is regarded as an important milestone in the promotion of world health. The principles documented in the declaration are the blueprint for primary health care and later became known as 'Health for All by the year 2000'. The key to understanding primary health care is to realise that it is a philosophy of practice rather than just a particular type or level of health service. Several concepts stand out in the Declaration of Alma Ata:

1. Social justice.
2. Equity.
3. Community participation and maximum community self-reliance.
4. Use of socially acceptable and affordable technology.
5. Health promotion and disease prevention.
6. Involvement of government departments other than health.
7. Political action.

The principles documented in the declaration are the blueprint for primary health care and later became known as 'Health for All by the year 2000':

8. Cooperation between countries.
9. Reduction of money spent on armaments in order to increase funds for primary health care.
10. World peace.⁴⁶

This declaration is reiterated in the *Health for All in the 21st Century* (1998) global health policy framework. See <http://www.who.int/archives/hfa/index.html> for further information about the process and the contents of this policy.

Ottawa Charter for Health Promotion (1986)⁴⁷

The first World Health Organisation (WHO) International Conference on Health Promotion was held in Ottawa, Canada, in 1986. The Ottawa Charter for Health Promotion was developed as a clear statement of action for health promotion, aiming to increase the relevance of the primary health care philosophy for industrialised countries. Building on the Declaration of Alma-Ata, the Ottawa Charter defines health promotion as:

Health is, therefore, seen as a resource for everyday life, not the objective of living.

The process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.⁴⁸

The Ottawa Charter directs strategic health promotion thinking and planning to five action areas:

1. Building healthy public policy.
2. Creating supportive environments for health.
3. Strengthening community action.
4. Developing personal skills.
5. Reorienting health services.

Jakarta Declaration on Leading Health Promotion into the Twenty-First Century (1997)⁴⁹

This declaration identifies the importance of health promotion as an investment and reiterates the need to address the significant social determinants of health. While emphasising the five action areas listed in the Ottawa Charter, the declaration goes further to set five priorities for health promotion in the twenty-first century:

1. Promote social responsibility for health.
2. Increase investments for health development.
3. Consolidate and expand partnerships for health.
4. Increase community capacity and empower the individual.
5. Secure an infrastructure for health promotion.

In July 2002, Australian health ministers announced arthritis and musculoskeletal disorders as a new national health priority area in recognition of the major health and economic burden these diseases place on the community.



Toolkit: The WHO Department of Non Communicative Diseases (NCD), Prevention and Health Promotion, works to reduce the incidence of NCD and promote positive health and wellbeing, with a focus on developing countries. Their website gives full details of these initiatives.

Go to <http://www.who.int/hpr/support.material.shtml>

The Ottawa Charter can be downloaded from:

<http://www.who.int/hpr/NPH/docs/OttawaCharterforHealthPromotion.pdf>

3.3.2 Australia

As a signatory to the Declaration of Alma-Ata, Australia formally committed in 1981 to achieve the 'Health for All' goals by 2000.⁵⁰ Significant policy directions have followed, including the *Goals and Targets for Australia's Health in the Year 2000 and Beyond*⁵¹, the *Better Health Outcomes for Australians*⁵² and the *National Health Priority Areas*.⁵³ These policies have highlighted the need for a consolidated approach to meet goals in the prevention of cancer, cardiovascular disease, injury, mental health, diabetes and asthma. In July 2002, Australian health ministers announced arthritis and musculoskeletal disorders as a new national health priority area in recognition of the major health and economic burden these diseases place on the community.

In 1995 the Commonwealth Government commissioned the Health Advancement Standing Committee of the National Health and Medical Research Council to conduct a review of health promotion activity and infrastructure needed to support health promotion in Australia. The review⁵⁴ recommended improvements to a range of areas, including improvements in health promotion capacity and in funding, implementing and evaluating health promotion programs. Subsequent national and State health promotion work has reflected these recommendations.

The National Public Health Partnership established in 1996 recognises the need for a more systematic national approach for health promotion to respond to the above recommendations. This partnership is establishing core competencies for the workforce; strategy coordination; accreditation standards for education and training in health promotion; and national data sets (such as indicators and intermediate review outcomes).⁵⁵ The partnership has emphasised the importance of integrated public health practice and key factors required to support integration. Its National Strategies Coordination Working Group is developing strategies and tools to support and facilitate integrated local public health practice.⁵⁶

The Department of Human Services has a leadership role for integrated health promotion, disease management and injury prevention strategies.

3.3.3 Victoria

Integrated health promotion (including early intervention and prevention) were clearly identified in the 2002 Victorian Government's election policy – namely, *Healthy Communities: Labor's plan for seniors and community health*⁵⁷ and the Government's signpost document *Growing Victoria Together* – as an important component of the human services sector.⁵⁸ The policy adopts a social model of health to guide work in the human services sector, clearly recognising the effect of broader social determinants of health on the wellbeing of the Victorian population.

The Department of Human Services has a leadership role for integrated health promotion, disease management and injury prevention strategies. The international and Australian policy contexts discussed above are strengthened by Victorian policy initiatives such as the PCP strategy, municipal public health planning (as discussed in Section 2) and neighbourhood renewal. They reflect an emphasis on people, community-centred participation and service delivery.

Case study: Neighbourhood renewal is a new approach that offers a better deal for disadvantaged communities in Victoria. The strategy is an initiative of the Department of Human Services as part of the State Government's *Growing Victoria Together* agenda to build more cohesive communities and reduce inequalities.

Neighbourhood renewal is tackling health inequalities by narrowing the gap between the most disadvantaged neighbourhoods in Victoria and the rest of the State. Projects targeted to areas with high concentrations of public housing are promoting health and wellbeing by improving access to health services and programs and by tackling the key social determinants of health such as housing, employment, education, crime, transport and social inclusion.

Communities are being revitalised by tackling the multiple and interconnected causes of disadvantage. Local people are being empowered to shape their own futures by connecting to key decision makers across whole-of-government, businesses and service providers. An emphasis on 'neighbourhood' is refocusing government programs on local issues identified by communities in the places they live, work and play.

In a short period of time, houses have been upgraded, local environments improved, jobs have been created, educational opportunities improved, streets are becoming safer and residents are getting better access to key health and community services.

Neighbourhood renewal provides a unique opportunity for health service providers and integrated health promotion initiatives to join with other programs and agencies that are influencing the structural drivers of health inequality in Victoria.

For further information see www.neighbourhoodrenewal.vic.gov.au

4. Integrated health promotion planning and implementation

4.1 A common framework

This section provides a common planning framework for integrated health promotion, both at the partnership and individual agency level.

When planning, implementing and evaluating integrated health promotion programs, there are key steps to ensuring quality practice.

When planning, implementing and evaluating integrated health promotion programs, there are key steps to ensuring quality practice. These steps are collectively known as program management.

The key features of program management are:

- A constantly evolving and interrelated set of actions, including planning, implementing, evaluating and ensuring the quality and effectiveness of practice. This is reflected in Figure 3.
- The collection of data, or evidence, at each stage of the cycle of planning, implementation and evaluation.⁵⁹

Figure 3 The cyclic nature of program management for integrated health promotion

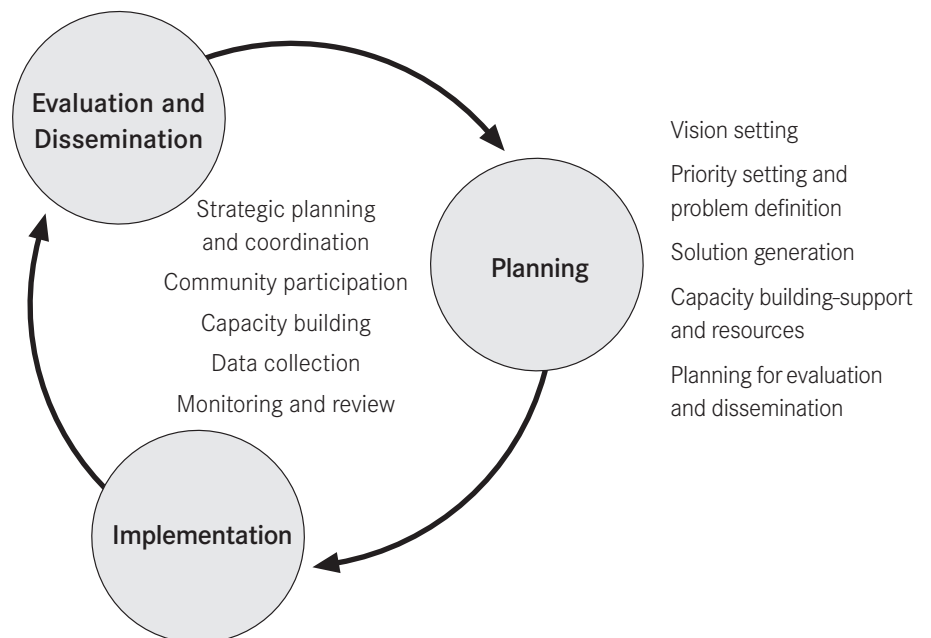
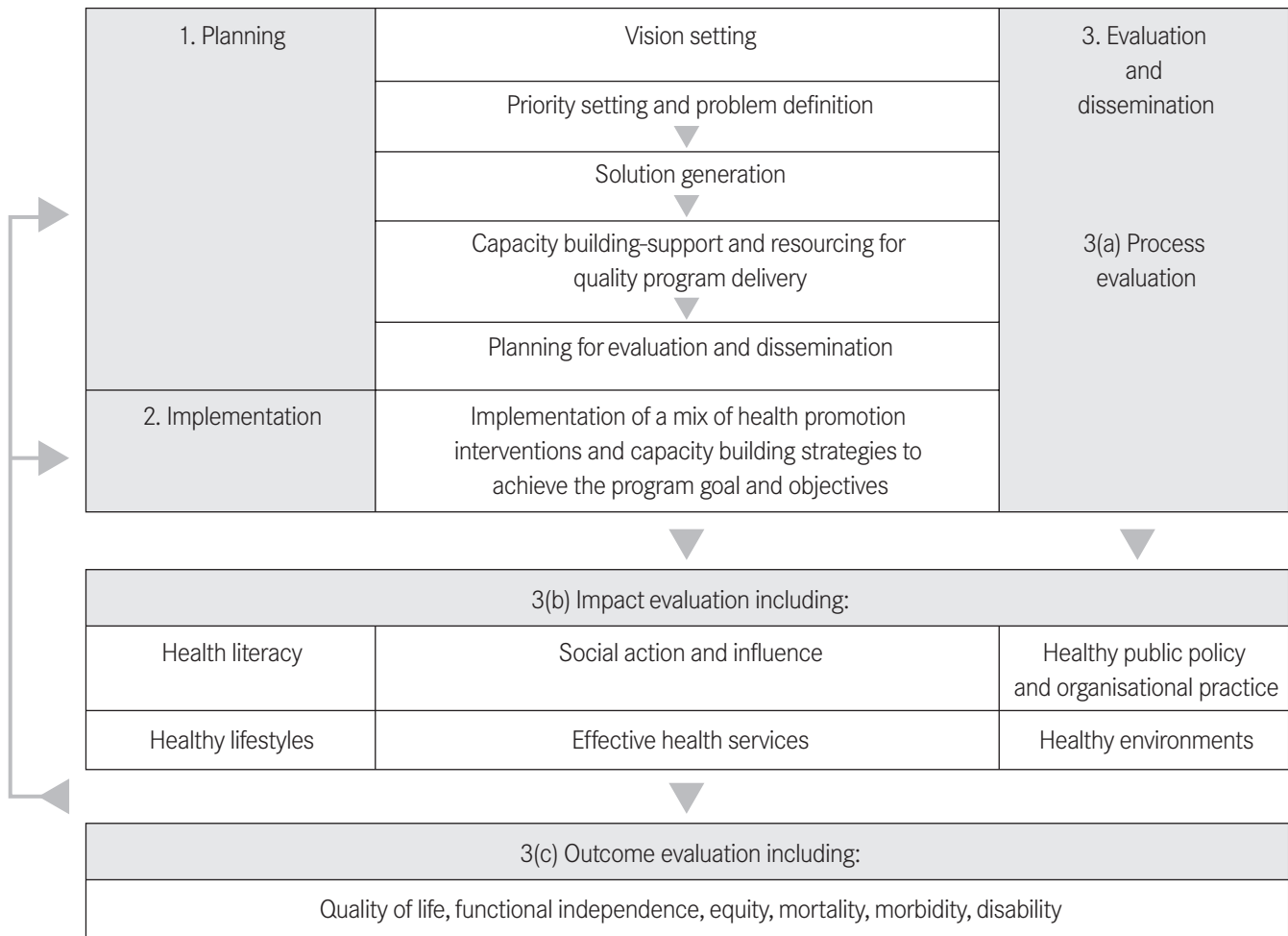


Figure 4 shows this common framework linked with a hierarchy of different impacts and outcomes (see Section 6).

Figure 4: Program management for integrated health promotion program – linking to impacts and outcomes⁶⁰

Program management for integrated health promotion involves managing the total set of actions, including:



4.2 Planning for integrated health promotion

Planning for integrated health promotion involves:

- vision setting (section 4.2.1)
- priority setting and problem definition (section 4.2.2)
- solution generation (section 4.2.3)
- capacity building – support and resourcing for quality integrated health promotion • action (section 4.2.4)
- planning for evaluation and dissemination (section 4.2.5)⁶¹

These steps are interrelated due to the cyclic nature of program management. Therefore, each step may need to be revisited several times and the program goals and objectives may also need to be revised.

4.2.1 Vision setting

The vision statement should articulate where the partnership or agency wants to be in respect to their health promotion response within a defined period of time.

The setting of the vision is an essential part of the strategic planning process both at the partnership and individual agency level. The guiding principles for integrated health promotion, as described in Section 1, guide the elements that may form part of the vision statements. However, there is also ample scope for incorporating local perspectives and priorities. The vision statement should articulate where the partnership or agency wants to be in respect to their health promotion response within a defined period of time.

To achieve the integrated health promotion vision, processes need to be established so that:

- all key stakeholders are involved in developing this vision
- all key stakeholders have access to this information and are involved in the implementation process
- there is a link to the broader corporate and strategic planning processes.

? Checklist: vision setting⁶²

- What are the partnership's and individual agency's overall beliefs in relation to integrated health promotion?
- Have you shown a clear link between the vision for integrated health promotion and the overall organisational/strategic/corporate plan?
- Does the vision reflect the guiding principles for integrated health promotion?
- What are the governance/management arrangements and organisational structure supporting, driving and resourcing the achievement of the vision? This also links with capacity building discussed in sections 4.2.4 and 6.3.

4.2.2 Priority setting and problem definition

From the outset, it is essential to identify the priority issues related to a defined population group. Through the community health planning process, priority issues, such as mental health or diabetes, and population groups are identified for each of the 32 catchment areas. As part of the CHP, the integrated health promotion strategy for the PCP catchment is articulated. Community and Women's health services, as member agencies within each PCP, develop organisational health promotion plans. These organisational plans should obviously reflect and link with those priority issues and population groups identified in the PCP integrated health promotion strategy.

Sources of data that inform this process include information from ongoing demographic, health surveillance and service data collections; behavioural and social research on the determinants of health; community consultation processes; and information collated in regional health promotion plans, municipal public health plans, Divisions of General Practice plans and statewide and national health priority areas.

Planning for integrated health promotion action must begin with being clear about broad priorities and using these to develop program goals and objectives.

Planning for integrated health promotion action must begin with being clear about broad priorities and using these to develop program goals and objectives.

? Checklist: priority setting⁶³

- What are your population health data sources? For example, PCP community health plan, MPHP and national health priority areas, Victorian Burden of Disease data, Community Health Info@mart planning data, Australian Bureau of Statistics population statistics, Jesuit Social Services report: *Unequal for Life*, your organisation's strategic plan, previous community needs assessment reports.
- What issues are important in your community? How do you know these are important?
- Are there additional emerging health and disease issues arising from other types of need identification?

In relation to these emerging issues:

- Who in your community does this most affect? Are there groups within the community whose needs have not been considered (for example, homeless people, young people, people with low English fluency)? How are their needs going to be addressed?
- What can your agency influence and with whom do you need to work? What publicity and resourcing is required to engage community members and other key players in working together?
- Do you have the resources (human, financial, information, technology) or can you get them to do something about any of these issues?

- Who else is doing something about these issues? Is there a gap you can fill, or how could a combined effort enhance the program?
- Would you have to drop something in order to work on this area, or is it something you already had a focus on before? If so, what would you no longer be doing and how will you make a change?
- Based on these, have you now decided which health issues and population groups are your priority? How is this priority setting process being documented? Can the priority setting be justified to community and other stakeholders?

Given the huge number of competing health, wellbeing and disease issues, the priority setting process can be very difficult. It requires a structured process and very good communication with community groups and other key stakeholders, such as boards of management. The document *Deciding and specifying an intervention portfolio*, produced by the National Public Health Partnership, gives a detailed process and a section of frequently asked questions. It also includes other references to assist agencies and organisations in their priority setting process.⁶⁴

Through the priority setting and problem definition process, a series of program goals and corresponding objectives should be developed.

Through the priority setting and problem definition process, a series of program goals and corresponding objectives should be developed. Collectively, the priority setting and problem definition processes are also known as **needs assessment**.

Program goal

The program goal is a statement about long-term outcomes. These are broad statements that relate to improving health and wellbeing status, through changes in mortality and morbidity, disability, quality of life and equity. The program goal is evaluated in outcome evaluation.

Program objectives

Program objectives elaborate on and restate the goals in operational terms. They state what must occur for the goal to be achieved and what the program is meant to achieve immediately after its completion. The objectives address the factors that cause or contribute to the priority health issue that is covered in the goal. A careful analysis of the determinants of the priority health issue is the starting point for developing objectives.^{65,66} Program objectives are evaluated by impact evaluation.

Specific information relevant to planning an integrated health promotion program needs to be collected to define the issue more clearly, focusing on factors such as the exact priority population group, the causal factors involved, the community settings concerned and the aspects of the problem amenable to effective action.

? Checklist: problem definition – focusing on each of the priority issues:⁶⁷

- What do you know about this issue? Who is affected?
- How do you know this? What have you observed/been told/read about? What are you doing and what changes have you seen?
- What are the broader determinants of health that contribute to this issue? (See Section 3.1)
- What consultation has there been with stakeholders? How are they involved in the planning? Have previous consultations been representative of all target groups and been conducted in, for example, culturally appropriate and gender sensitive ways (for example, were interpreters provided or were gender separate consultations undertaken where appropriate)?
- What might be able to be changed?
- What does the published evidence tell you? How does this apply across different population groups, for example culturally and linguistically diverse groups, Koori populations, women, older persons, people with disabilities, refugees and asylum seekers?
- What would you like to change in relation to this issue – broadly, in terms of a **goal** and more specifically, through a set **of objectives**? How is this problem definition process being documented?
- How will you tell if you've made a difference – what will this change look like? How will you observe and describe this change? What are your evaluation outcome and impact measures?
- How will you get the message out about what works and what doesn't? Who will 'talk up' the project, advocate and lobby?
- How will the impact and outcomes be communicated to target communities and other stakeholders? Have the communication needs of the targeted communities been considered, for example clients or communities with low English fluency?


4.2.3 Solution generation

The next stage in program planning requires analysis of the collected community data, published information, evidence-based research, relevant theory and intervention models and evidence from past programs. The context of your program delivery also needs to be considered to develop a range of health promotion interventions to achieve the objectives.

Health promotion interventions

Health promotion interventions are actions taken to achieve the program objectives. Effective approaches involve a mix of interventions at multiple levels (from the individual through to populations).^{68,69}

Section 5 describes in detail the broad range of health promotion interventions, as a guide for service providers. Further reference to evidence-based health promotion, effectiveness and commonly used models in health promotion practice are in Section 7.

 **Toolkit:** A key requirement of quality integrated health promotion program delivery is the implementation of a **mix** of health promotion interventions (encompassing a balance of individual and population-wide interventions) that contribute to achieving the goals and objectives stated for that priority issue. These interventions need to be supported by evidence-based capacity building strategies.

? Checklist: devising the interventions⁷⁰

- What interventions could be taken to address the specific priority issues and changes defined through the program goal and objectives?
- Which mix of interventions (individual balanced with population interventions) has proved to be effective in achieving desired outcomes and shown potential to produce the largest health gains in terms of the identified goals and objectives?
- Which strategies does the relevant community think would be best? How will you involve community members, in a representative manner, in deciding what to implement? What factors help or hinder people becoming involved in action (for example, timing, physical access, English fluency, information formats, family and work commitments, level of experience in community participation)? How are you addressing these?
- Which mix of interventions address the broad determinants of the issue? Are certain priority population groups (such as children, mothers, culturally and linguistically diverse communities, people with low English fluency, recently arrived communities, older persons or Koori groups) at special risk? Is a need being neglected? How will you involve these particular population groups in the development of the program?
- Where investments are already being made by other agencies, are there benefits in working cooperatively to build on these investments? How will you involve other key agencies in the process?

- ☑ How will you know you have successfully implemented the health promotion interventions and are working towards meeting the program goals and objectives?
- ☑ How will you tell if you've made a difference? What will this change look like and how will you observe and describe it? What are your evaluation measures?
- ☑ How will you get the message out about what works and what doesn't? Who will 'talk up' the program, advocate and lobby?

4.2.4 Capacity building – support and resources

This stage is concerned with obtaining the resources (such as funds and materials) required to implement a program and with building capacity in an organisation or across the PCP catchment to implement and sustain the program. Sustainability, like evaluation, must be planned for in these early stages of program design. This stage is concerned with creating the optimal conditions for a successful program, and includes:

- assessing financial needs
- determining the availability of human resources, skills and knowledge
- analysing how to generate such resources
- building organisational structures, systems and policies necessary to undertake quality integrated health promotion program delivery.⁷¹

Where there are limited resources or limited community and political support, it will be necessary to change the program objectives to better fit the available resources and clarify the types of action that may be required to secure greater community and political support (so as to then build on the resources and opportunities needed).


Failure to give sufficient time and attention to this capacity building phase is the most frequent reason for the failure to achieve or maintain health and wellbeing improvements. This is especially important when working with other sectors, such as schools, workplaces and different agencies of government. Further explanation of the types of capacity building strategies is covered in Section 5.3.

Failure to give sufficient time and attention to this capacity building phase is the most frequent reason for the failure to achieve or maintain health and wellbeing improvements.

? Checklist: capacity building

Answering these questions will help plan your capacity building strategies but may also require you to revisit your initial program goal, objectives and health promotion interventions.⁷²

- What are the individual and collective skills and knowledge of the key partners in the program? Do staff need further skill development in quality health promotion practice and other topics, such as cross cultural communication training?
- Do you have other resources, including time, infrastructure, personnel and community participation, to implement the integrated health promotion program? If not, do these need to be created or should different interventions, objectives and even program goals be planned for? How have you documented these resources and timelines?
- Specifically related to the budget, has there been an open and transparent process in allocating financial resources to the program?
- Has there been clear definition of roles and responsibilities for integrated health promotion service delivery across the PCP's member agencies and within individual organisations?
- Have all key partners agreed and signed off on the integrated health promotion strategy or organisational plan?
- How are your senior managers, boards and governance committees involved, leading and advocating for the delivery of quality integrated health promotion services?

 **Toolkit:** The Quality Improvement Program Planning System (QIPPS) is a software tool designed by and for community health services to facilitate a more rigorous approach to planning, evaluating and documenting health promotion. Further information about QIPPS can be found at the Victorian Community Health Association (VCHA) website at <http://vcha.org.au> or by emailing qippsinfo@vcha.org.au

4.2.5 Planning for evaluation and dissemination

While Section 6 is dedicated to the different levels of evaluation, it is important to begin planning the evaluation, dissemination and sustainability strategies early in the program management cycle and not at the end of implementation. All the checklists for the planning steps include prompts related to evaluation and dissemination.

? Checklist: questions to ask when planning your evaluation strategies:⁷³

- What is the purpose of your evaluation?
- Who is the evaluation for? What information do they want?
- How will you evaluate? How will the evaluation be coordinated? How will the data be analysed and interpreted?
- How will data be collected?
- What is the format and detail of the evaluation report?
- Is there agreement among the key partners concerning these issues?
- What resources will be allocated to conduct the evaluation? For example, have interpreter costs been considered?
- How will community representation and participation be structured into the evaluation?
- What are the perceived limitations of the evaluation and how can these be overcome?
- How will the results of the evaluation be communicated to key stakeholders, funders and community groups?
- How will the findings be integrated back into the planning for sustainability?

🔧 Toolkit: what to measure?⁷⁴

Health indicators: Characteristics of an individual, population or an environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

Knowledge: Gather data using surveys, focus groups.

Attitudes: Gather data using attitude scales, surveys, interviews.

Behaviour: Gather data using self-report questionnaire, use of diary, observation.

Health status: Depends on definition and aspect of health; gather data using questionnaire tools that have been developed, such as routinely collected data (for example, cancer rates).

Social support: A myriad of tools and scales have been developed, also possible to use qualitative methods, for example, interviews, focus groups.

Quality of life: Established quality of life scales have been developed.

Costs: Outcomes achieved, with reference to cost.

Effectiveness: Outcomes achieved, without reference to cost.

Community strength, competence or participation: Observation of community structures and networks, interviews of key community representatives.

Moving from planning to implementing integrated health promotion programs requires skills to implement the interventions and to manage the actual program.

4.3 Implementation

Moving from planning to implementing integrated health promotion programs requires skills to implement the interventions and to manage the actual program. Section 5 describes in more detail the different types of health promotion interventions and capacity building strategies. There are, however, key steps to ensure quality implementation.

? Checklist for quality implementation⁷⁵

- Are you monitoring, collecting and recording quality information about what is happening in the program? How is this information being analysed?
- How are you communicating internally among staff, key partners and across member agencies? How are you communicating externally with broader stakeholders?
- How are program materials being developed and pre-tested? For example, are focus groups being used to test material translations?
- Are decision-making structures clear and functioning? Are you providing enough appropriate and shared leadership?
- Are you addressing and solving emerging problems? Are you making similar decisions over and over again?
- Are you monitoring resources regularly?
- Who is being informed of the implementation and how is this being disseminated to stakeholders? Does this include a range of accessible formats (translations, large print, electronic formats)?
- Have you got your political antennae working? Are you looking for new opportunities and taking them?
- Are you recognising and celebrating progress along the way?

5. Health promotion interventions and capacity building strategies

5.1 Integrated health promotion in action

The Ottawa Charter, described in Section 3.3.1, provides the broad action areas for health promotion. Section 4 provides a common planning framework for integrated health promotion program management. This section considers in greater depth aspects of solution generation and capacity building.

Integrated health promotion service delivery can be organised from one or more different angles, depending on the key priorities identified and the problem definition, including:

- health or disease priorities, for example, mental health, heart disease, diabetes, oral health
- lifestyle factors, such as physical activity and nutrition, tobacco use, safe sex
- population groups, for example, culturally and linguistically diverse groups, same-sex attracted youth, adolescents, older people living alone
- settings, for example, health promoting schools, health promoting workplaces, health promoting hospitals.

The key requirement for quality practice is how programs are planned, delivered and evaluated.

The key requirement for quality practice is **how** programs are planned, delivered and evaluated. By definition, quality practice is:

- enabling it is done by, with and for people, not on them; it encourages participation
- involves the population in the context of their everyday lives, rather than focusing just on the obvious lifestyle risk factors of specific diseases
- directed to improving people's control over the determinants of their health
- a process it leads to something, it is a means to an end.

Toolkit: enable, advocate, motivate

These three words describe the role of practitioners involved in integrated health promotion programs:⁷⁶

- **Enable:** Integrated health promotion focuses on achieving equity in health. A major aspect of the work of integrated health promotion is to provide the opportunities and resources that enable people to increase control over and improve their health. This includes developing appropriate health resources in the community and helping people to increase their health knowledge and skills, to identify the determinants of their own health, to identify actions by themselves and others, including those in power, that could increase health, and to demand and use health resources in the community.
- **Advocate:** Action for health often requires health workers to speak out publicly or write on behalf of others, calling for changes in resources, policies and procedures. The Cancer Council lobbying for a ban on smoking in all enclosed spaces is an example, as is a local community health worker writing

Each category of health promotion intervention is described in sections 5.2.1 to 5.2.5. Examples, opportunities and generic process indicators are also provided for each intervention. This list of suggested evaluation indicators is not exhaustive. Please refer to *Measuring health promotion impacts: A guide to impact evaluation for health promotion* (March 2003) for further discussion of impact indicators.

5.2.1 Screening, individual risk factor assessment and immunisation

Definition

- Screening involves the systematic use of a test or investigatory tool to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment. It is a population-based strategy to identify specific conditions in targeted groups before any symptoms appear.
- Individual risk factor assessment involves a process of detecting the overall risk of a single disease or multiple diseases. These can include biological, psychological and behavioural risks.
- Immunisation aims to reduce the spread of vaccine-preventable diseases across targeted population groups.

Examples

- Common medical screening procedures include pap smears and blood pressure testing.
- Disease risk assessments include the identification of a range of factors (depending on the specific purpose of the assessment) such as body weight, diet, family history, activity levels, life circumstances and tobacco intake.
- Risk assessment tools can also be used to assess susceptibility to risk conditions – for example, working with older community members to assess their physical environment for the risk of falls. Individuals may self-administer some tools, but for tools requiring diagnostic interpretation, individuals should be referred to qualified professional staff.
- Common immunisations include those for tetanus, measles, polio and influenza.

Further considerations

- Community and workplace based risk factor assessments are most effective as an engagement strategy. For example, the screening or risk factor assessment within an integrated health promotion program may be an **initial contact** point to the broader health and community service system, providing health and/or health service information and may lead to appropriate needs identification, assessment and service provision (see case study below).
- Screening and risk factor assessment may also occur as part of a service provider's **initial needs identification**, which may indicate the need for referral for further assessment, service provision or specific health promotion intervention.

Community and workplace based risk factor assessments are most effective as an engagement strategy.


For this intervention to be effective in its impact on health outcomes, it is important that a complementary range of supporting interventions is also implemented.


For this intervention to be effective in its impact on health outcomes, it is important that a complementary range of supporting interventions is also implemented. These interventions need to consider the underlying determinants of the health issue identified. This intervention must be tailored in its delivery to reach particular high-risk population groups in the community.

Examples of process indicators

Reach: Proportion of target group or number of people participating in screening, individual risk assessment and immunisation activities (counted only once per activity). Information collected through systematic staff estimates and participation records.

Participant satisfaction: Target population reporting the location/timing for the screening, individual risk assessment and immunisation activities were appropriate.

 **Toolkit:** Screening for Type 2 diabetes in asymptomatic individuals has been under consideration for many years. For further information in relation to case detection for Type 2 Diabetes, refer to *National evidence based guidelines for the management of type 2 diabetes mellitus: primary prevention, case detection and diagnosis* (2001) downloadable from <http://www.health.gov.au/nhmrc/publications/pdf/cp86.pdf>
Further resources in relation to diabetes and cardiovascular disease are included in Section 7.

 **Case study:** To explain how integrated health promotion links to service coordination initiatives, this case study is derived from examples across the state.

A PCP integrated health promotion strategy identifies men's health, particularly men's mental health, as a priority issue. A Men's Shed is set up at the local football clubrooms and activities and information sessions are organised on a monthly basis. The community health nurse from the local community health service attends one of these sessions to provide a general risk factor assessment service to look for potential risks for common health conditions such as depression, cardiovascular disease and type II diabetes.

Information is collected using the relevant service coordination tool templates.⁷⁷ The relevant risk factor information is described on the health conditions profile, psychosocial and health behaviours profiles. Where risk is indicated, the community health nurse offers to refer the man to the appropriate service provider (such as counsellor, dietician or GP). Using the PCP referral protocol, a referral is made and the relevant information, with the man's consent, is sent. The service provider then builds on the information collected to identify any further needs, completes an assessment and provides the appropriate service.

Social marketing involves programs designed to advocate for change and influence the voluntary behaviour of target audiences, which benefits this audience and society as a whole.

5.2.2 Social marketing and Health information

Description

- Social marketing involves programs designed to advocate for change and influence the voluntary behaviour of target audiences, which benefits this audience and society as a whole. It aims to shift attitudes, change people's view of themselves and their relationships with others, change lifelong habits, values or behaviours. It typically uses persuasive (not just information) and cultural change processes. It can involve raising public awareness about a health issue through use of mass media, for example advertising in newspapers, magazines, pamphlets and fliers or on radio and television at local, state and national levels. It may also involve a mix of promotional strategies including public relations and face-to-face communications.
- Health information aims to improve people's understanding about the causes of health and illness, the services and support available to help maintain or improve health, and encourage personal responsibility for actions affecting their health.

Examples

- Social marketing is often interpreted as the use of mass media. However, it may involve a wide range of media, from radio and television to highly targeted messages delivered through low technology media.
- Developing relationships with local media contacts is not only vital to increase the chance of media coverage, but also enables providers to draw on the expertise from the media field. Establishing an ongoing relationship in this way would be beneficial for partnerships, individual agencies and media contacts, and also would allow the development of new directions for social advocacy, using newer, more interactive technologies (for example, the Internet).
- There is growing interest in the use of social marketing, not only as an influence on individual behaviour change but also as an advocacy tool for broader social and environmental change agendas.
- Health information is provided in a range of formats. Written materials in the form of service directories, brochures, newsletters and magazines are common. Telephone information services, 'infotainment/edutainment' video options, the Internet and other computer programs are increasingly providing health information.
- The Better Health Channel, managed by the Department of Human Services, is an excellent and expanding consumer and staff resource. The Better Health Channel is located online at <http://www.betterhealth.vic.gov.au>. Appendix 2 lists guidelines for the development of health information.

Further considerations

The PCP strategy should continue to create an environment that allows opportunities to:

- Develop and/or disseminate consistent and streamlined health information resources for individual practitioners and the general community.
- Link with statewide health promotion agencies in ensuring that agencies have access to high quality, accurate and up-to-date health information for their communities, and that there is no unnecessary duplication of information products and services.
- Expand on the types of settings for both active and passive dissemination of health information, including local government advisory services, schools and workplace settings.
- Better target information development and dissemination for different socio-cultural groups, and increase the focus on health and wellbeing.
- Expand the types of media used to produce health information, including the use of interactive technologies via the Internet.

Examples of process indicators

Reach: Proportion of target group or number of people (counted as contacts) accessing or aware of funded social marketing/health information activities and resources; OR number of articles published and the population reach of the newspaper or newsletter; OR number of agencies participating in the development and dissemination of consistent information resources (from printed material to interactive technology).

Readability: Target population reporting the health information was easy to read and assisting them in understanding the priority issue.

? Checklist: key questions to consider when reviewing health information resources⁷⁸


- What health issue is addressed in this material?
- What is the main message of the material?
- Who is the intended audience? How do you know?
- Are people likely to notice this material if it were in a waiting area at your organisation? If so, are they likely to pick it up and read it? Think about the language, design and graphics.
- How well does the material get over its main message to the intended audience?
- Is the material likely to bring about change? If so, what?
- What else would people need in order to be able to undertake change?

Toolkit: Health Translations Online Directory

The directory is an initiative of the Victorian Office of Multicultural Affairs. It aims to:

- Improve access to health information for people who speak languages other than English.
- Reduce duplication of translated information. Agencies are encouraged to register their translated health information on the directory.
- Enhance the sharing of translated health information. The directory is a web portal providing direct links to translated health resources.

For more information and to register go to
<http://www.healthtranslations.vic.gov.au>

 **Toolkit:** There are some key criticisms of social marketing as an intervention. Despite these shortcomings, there are clear benefits to using a social marketing intervention in some circumstances. What needs to be recognised is that a mix of health promotion interventions, with community participation, have the greatest possibility for success.⁷⁹ Common criticisms to be aware of include:

- Knowledge alone does not lead to behaviour change.
- Social marketing is often directed at a ‘typical’ person. For example, are all 16 year-old females really so alike?
- The intervention alone ignores the social, economic and environmental determinants of health. Solutions suggested often reinforce the disadvantage of marginalised or poorer groups.
- Single-issue focus can discourage more holistic approaches to health and quality integrated health promotion practice.
- Some social marketing campaigns can lead to victim blaming (for example, anti-gay men sentiments were heightened as a result of the Grim Reaper campaign. See http://www.thebody.com/cdc/news_updates_archive/oct3_02/aids_campaign.html).
- The interventions often encourage a focus entirely on individual choice rather than on a balance of this with structural conditions.

5.2.3 Health education and Skill development

Description

Health education and skill development include the provision of education to individuals (through discrete planned sessions) or groups, with the aim of improving knowledge, attitudes, self-efficacy and individual capacity to change.

Examples

- Education may be offered proactively as part of the planned integrated health promotion program. Health education can also be offered as part of best practice direct care services.
 - These activities may take the form of individual or group sessions, such as healthy cooking classes, motivational counselling for physical activity and personal financial budgeting skills. Health education and skills development can also be a core component of secondary prevention programs, such as cardiac rehabilitation and support programs.
-

Opportunities for development

- As part of an integrated program, a range of service providers such as local GPs, physiotherapists and dietitians could deliver coordinated programs within settings such as workplaces or schools (for example, drug and alcohol programs, adolescent health programs and mental health initiatives).
 - Integrated approaches and bringing together a range of expertise will also support innovation in the delivery of education. This may include the use of seminars, peer group discussions, focus groups and role plays.
 - There are opportunities to enhance and, where appropriate, combine elements of health promotion sessions for people with different chronic conditions.
 - Whatever the form of these activities, health education and skills development must be delivered as part of a mix of interventions that are balanced between individual, group and population approaches that consider the broader determinants of health.
-

Examples of process indicators

Reach: Proportion of target group or number of people participating in funded health education and skill development (counted only once per activity, such as a quit smoking course). Information based on actual participation records.

Participant satisfaction: Target population reporting content of the health education and skill development activities are relevant, interesting and easy to understand.

Whatever the form of these activities, health education and skills development must be delivered as part of a mix of interventions that are balanced between individual, group and population approaches that consider the broader determinants of health.

Toolkit: what does the evidence tell us about educational approaches?

People learn best when:⁸⁰

- The learning relates to a problem they are experiencing or a goal they wish to achieve.
- They see the relevance and value of what they are learning.
- They have some control over how the learning will take place.
- They are involved voluntarily.
- They and their experience are valued.
- They can express themselves without fear of censure.
- They are actively involved with others in the learning process.
- They can make mistakes and use trial and error without fear of censure.
- The learning objectives are clearly understood and broken down into achievable steps.
- A variety of learning methods and activities is experienced, appropriate to the learners and the topic.
- They are asked to apply their knowledge and skills in familiar and new contexts.
- They have the opportunity to ask questions, seek clarification, and have their views listened to.

Community action aims to encourage and empower communities (both geographic areas and communities of interest) to build their capacity to develop and sustain improvements in their social and physical environments.

5.2.4 Community action (for social and environmental change)

Description

Community action aims to encourage and empower communities (both geographic areas and communities of interest) to build their capacity to develop and sustain improvements in their social and physical environments.

Examples

- Community members involved in decision-making committees is an example of community action for environmental health protection, as is a community-led advocacy group for the retention of open space.
- Self-help and support groups for young mothers and people with chronic illness are other examples of community action that can foster social capital and enhance the wellbeing of communities.
- Settings can be wide ranging, depending on the issue. For example, they may include workplaces, sport/recreation/hospitality venues, community service groups (taking action towards healthy practices and environments) and local government areas.

Opportunities for development

- Some agencies within PCPs have a tradition of employing community action strategies. This general participation and action may occur through efforts to strengthen social networks, support community groups and establish mechanisms for ongoing consumer participation within program planning and management.
- They could also play an important advocacy and support role for local community organisations such as neighbourhood houses. This role may involve assisting programs run through these organisations. This advocacy and support role could further assist specific population groups (such as young people in the local community) to establish structures (for example, a youth council) that serve to raise issues in broader catchment area planning processes.
- The integrated platform, provided by the PCP strategy, could also allow the joint coordination of volunteer programs and training opportunities for volunteer staff to enable ongoing sustainable action in implementing health promotion programs (where this has been identified as the best approach). The community health planning process may assist community action interventions by ensuring valid consultative processes.

Examples of process indicators

Reach: Proportion of target group or number of people participating in funded community action activities. Information collected through systematic staff estimates.

5.2.5 Settings and supportive environments

Description

It includes:

- Organisational development: this aims to create a supportive environment for integrated health promotion activities within organisations, such as schools, local businesses and sporting clubs. It involves ensuring that policies, service directions, priorities and practices integrate health promotion principles.
- Economic and regulatory activities: this involves the application of financial and legislative incentives or disincentives to support healthy choices. These approaches typically focus on pricing, availability, restrictions and enforcement.
- Advocacy: this involves a combination of individual, peer and social actions designed to gain political commitment, policy support, structural change, social acceptance and systems support for a particular goal. It includes direct political lobbying.

Examples

- Regulation and incentives have been used to increase immunisation coverage, with school entry certificates and child care payments linked to timely administration of childhood immunisation.

Advocacy involves a combination of individual, peer and social actions designed to gain political commitment, policy support, structural change, social acceptance and systems support for a particular goal.

- An example of economic and regulatory activities at the local level is stricter enforcement of regulations relating to the sale of cigarettes to minors, and advertising and competitions encouraging the sale of tobacco products.

Opportunities for development

- Partnerships and individual agencies are well placed to play a strong local advocacy role in activities that support adherence to and enforcement of regulations and laws; or improve health and social conditions for particular groups (for example, women's health or refugee advocacy). Settings include local governments, hospitals, schools, workplaces, community bodies and local businesses.
- Within the PCP catchment area, member agencies could develop an award scheme to recognise local businesses that are healthy employers, that implement responsible alcohol service practices or that promote and support healthy eating purchases. Such an initiative should link with organisational development interventions that assist local businesses to make such a change in their business.

Examples of process indicators

Reach including the number of:

- Settings (such as schools, local businesses and sporting clubs) involved in creating a supportive health promoting environment through policies, service directions, priorities and practices (each setting counted only once per annum per health priority).
- Stakeholders involved in economic and regulatory activities (each stakeholder counted only once per annum per health priority). Information gathered through staff estimates.
- Settings/stakeholders involved in advocacy activities designed to gain commitment, policy support, social acceptance and systems support for a particular goal (each stakeholder/setting counted only once per annum per health priority).

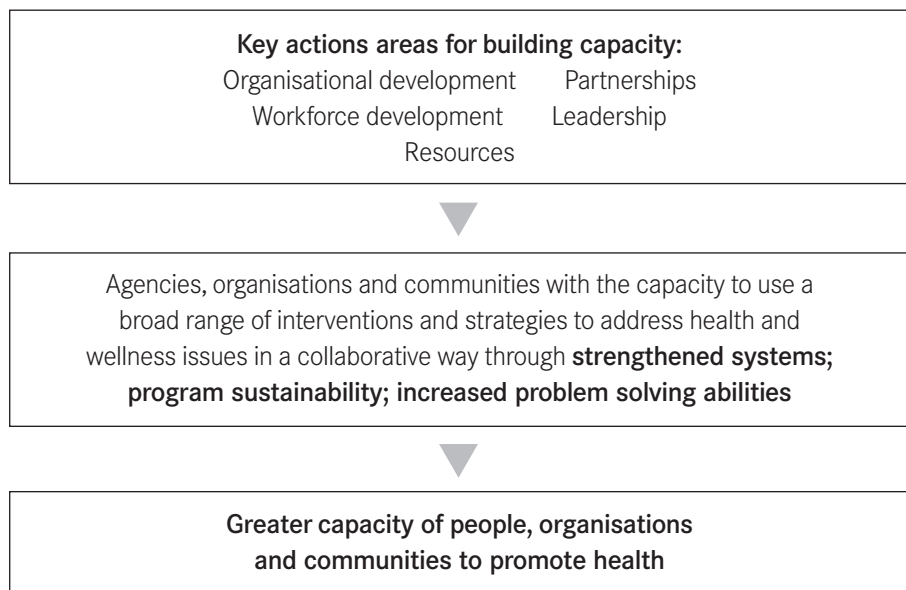
5.3 Capacity building – support and resources

When integrating health promotion principles and processes in an organisation, or when implementing a specific program, it is important to create optimal conditions for success. Capacity building for integrated health promotion enhances the potential of the system to prolong and multiply health effects and to address the underlying determinants of health (see Section 3).⁸¹

Capacity building involves the development of sustainable skills, organisational structures, resources and commitment to health improvement to prolong and multiply health gains many times over.⁸² It can occur within a specific program and as part of broad agency and system development. Figure 6⁸³ highlights the pathways and the key action areas to build capacity to promote health and wellbeing.

Capacity building involves the development of sustainable skills, organisational structures, resources and commitment to health improvement to prolong and multiply health gains many times over.

Figure 6: Building capacity to promote health



Implementing strategies from each of the key action areas should build the combined ability of the agency or partnership to:

1. Deliver appropriate program responses to particular priority health issues, including the establishment of minimum requirements in structures and skills (**strengthening agency/system infrastructure**).
2. Continue to deliver, transfer and adapt a particular program through a network of agencies, or to sustain the benefits achieved (**program maintenance and sustainability**).
3. Strengthen the generic **problem-solving capability of organisations and communities** to be able to develop innovative solutions, learn through experience and apply these lessons.⁸⁴

Below is a brief explanation of each key action area and a menu of possible strategies. The examples have been adapted from the documents *A framework for building capacity to improve health*⁸⁵ and *A framework for strengthening health promotion in community health*.⁸⁶ Examples of process evaluation indicators have also been suggested to measure the success of these strategies.

§ Toolkit: For further information on specific indicators to help measure the success of these strategies see *Indicators to help with capacity building in health promotion (2000)* from NSW Health⁸⁷, downloadable from <http://www.health.nsw.gov.au>

5.3.1 Organisational development

Organisational development focuses on strengthening organisational support for integrated health promotion within provider agencies. Examples of organisational development strategies are provided in the table below.

Agencies and alliances have developed and implemented policies and monitoring processes that ensure an appropriate proportion of funds are allocated to support integrated health promotion action.

Elements	Possible strategies
Policies and strategic plans	<ul style="list-style-type: none"> • Integrated health promotion principles and population health approaches are built into the core business of agencies and networks. • Agencies and alliances have developed and implemented policies and monitoring processes that ensure an appropriate proportion of funds are allocated to support integrated health promotion action. • Agency strategic plans involve key health promotion personnel and identify the network's/agency's commitment to and vision for integrated health promotion. • Integrated health promotion program delivery is guided by an ongoing strategic planning process and is documented in the PCP community health plan or agency's organisational health promotion plan.
Organisational structures	<ul style="list-style-type: none"> • Formal responsibility for health promotion is established within management positions and committees. • Integrated health promotion principles and specific roles are included in performance agreements and job descriptions at all levels of agencies and networks. • Specialist positions, such as health promotion coordinators, are established to lead organisational change practice and to support other staff in the delivery of integrated health promotion programs. • Work practices are monitored to ensure appropriate time is allocated to integrated health promotion program delivery. • Orientation programs related to the determinants of health and integrated health promotion practice are available to all new staff and board members. • Staff and organisational audits are undertaken periodically to better understand capacity to undertake integrated health promotion programs and to guide workforce training programs. • Structures are established to support all staff involvement in strategic planning for integrated health promotion program delivery and transparency in resource distribution.

Senior managers are active members of health promotion network meetings and steering committees for integrated health promotion programs.

<p>Management support and commitment</p>	<ul style="list-style-type: none"> • Systems are developed to support service and organisational commitment to integrated health promotion. • Mainstream line management positions and accountabilities for integrated health promotion are established within agencies and networks. • Senior managers are active members of health promotion network meetings and steering committees for integrated health promotion programs. • Line management responsibilities are created between the health promotion coordinator and senior management.
<p>Recognition and reward systems</p>	<ul style="list-style-type: none"> • Formal feedback and acknowledgement systems for those undertaking integrated health promotion programs are established. • Staff performance appraisal processes monitor staff involvement in direct care services and integrated health promotion programs.
<p>Information systems – quality improvement, monitoring, evaluation and dissemination</p>	<ul style="list-style-type: none"> • Reporting systems are implemented to accurately identify the role, time taken and type of integrated health promotion action undertaken by staff. • Evaluation is planned, uses a mix of methods and is resourced as a part of the planning process. Evaluation strategies that measure process, impact and outcomes are planned and implemented systematically. • Dissemination strategies are implemented to effectively communicate the findings from evaluation processes. Processes are established to integrate these learnings into future planning cycles.
<p>Information resources</p>	<ul style="list-style-type: none"> • Information and evidence-based resources (for example, health status, risk factors, national goals and targets, literature reviews and information about effective practice) are available and accessible to support integrated health promotion program management. • Access to health promotion material, quality practice tools, the Internet and databases is negotiated and shared through the PCP member agencies and other program partners.

Organisational and staff values, that are underpinned by integrated health promotion principles, are encouraged and upheld within the workplace.

Informal organisational culture	<ul style="list-style-type: none"> • Staff are familiar with the determinants of health and their relationship with disease priorities. • Organisational and staff values, that are underpinned by integrated health promotion principles, are encouraged and upheld within the workplace.
Process indicators	<p>A number of reach process indicators could be considered for organisational development depending on the focus of the program plan:</p> <ul style="list-style-type: none"> • The number of agency management/staff participating in funded integrated health promotion activities (counted only once per annum). Information based on actual participation records such as diary notes and meeting papers. • The number of agency management/staff planning to or implementing health promoting workplace policy/organisational culture activities. • The number of agency management/staff planning to or implementing policies, plans and/or management support mechanisms for integrated health promotion activities in their agencies/organisations. • The number of agency management/staff using integrated health promotion recognition systems, integrated health promotion activity monitoring and evaluation systems, consistent information resources and best practice integrated health promotion tools.

5.3.2 Workforce development

Workforce development is the development of the integrated health promotion skills and knowledge of the workforce. Examples of workforce development strategies include:

Elements	Possible strategies
On-the-job learning	<p>A range of opportunities is provided for people across agencies and networks to learn about integrated health promotion, including:</p> <ul style="list-style-type: none"> • health promotion committees • scholarships, traineeships or mentoring programs • secondments and job rotations • planning guides to support self-directed learning, participant implementation and management of projects • information-sharing initiatives.

Professional development opportunities/ continuing education/ tertiary studies	<ul style="list-style-type: none"> • Information is disseminated about graduate and postgraduate studies relevant to health promotion and support for participation is provided. • Staff participate in the development of skills-based courses, including core health promotion short-course skills courses, conferences, workshops, seminars and in-service programs on specific health issues.
Professional support and supervision systems	<ul style="list-style-type: none"> • Formal supervision is established, including mentoring or support arrangements for integrated health promotion work. These may be provided individually or in groups, and internally or externally. • Peer support systems, buddy systems or networks for people working on similar issues are established. • Access to specialist advice and support through networks and consultancies.
Performance management systems	<ul style="list-style-type: none"> • Integrated health promotion tasks are incorporated into regular performance appraisal or performance management systems using established indicators where possible. • Specific performance management guidelines are developed for use by team leaders, managers or coordinators in other parts of the health system for integrated health promotion work conducted by their staff. • Organisational and staff audits are periodically conducted to identify particular health promotion skills and gaps. • Opportunities for staff are provided to promote and showcase their achievements to management and boards.
Process indicators	<p>Reach: The number of staff within the agency participating in funded integrated health promotion workforce development activities (counted only once per workforce activity such as a continuing education course). Information based on attendance records and similar information.</p> <p>Participant satisfaction: The number of staff reporting that content of the workforce development activities is relevant, interesting and easy to understand.</p>

Opportunities for staff are provided to promote and showcase their achievements to management and boards.

5.3.3 Resources

This action area focuses on developing and ensuring that there are resources to support integrated health promotion and allocating them strategically. Examples of strategies include:

Resources are appropriately and transparently allocated for quality integrated health promotion program management. This allocation should be directed by the agency's organisational health promotion plan.

Elements	Possible strategies
Financial resources	<ul style="list-style-type: none"> Resources are appropriately and transparently allocated for quality integrated health promotion program management. This allocation should be directed by the agency's organisational health promotion plan. Further funding is actively sought and staff allocate time for developing submissions. Information about funding opportunities is disseminated within an agency and across networks to other partners so they may become engaged and interested in integrated health promotion.
Human resources	<ul style="list-style-type: none"> Core health promotion positions (for example, health promotion coordinator) or responsibilities are established to support program development and leadership within the agency of alliance. A base of advocates for integrated health promotion is built within and across agencies, particularly at senior management levels. Resources may be combined to purchase training and development for staff from a range of agencies or one agency could provide staff to train workers from other agencies.
Specialist advice	<ul style="list-style-type: none"> Access to appropriate expertise and allocation of resources is provided when required (for example, research and evaluation, planning, media and marketing, dissemination, documentation and workforce development).
Decision making tools and models	<ul style="list-style-type: none"> Tools and models, such as investment matrices, cost-benefit analyses and guidelines on effective interventions, are used to inform decision making on resource allocation.

Administrative and physical resources	<ul style="list-style-type: none"> • Clerical or administrative support, equipment, offices and meeting spaces are made available for integrated health promotion activities.
Process indicators	<ul style="list-style-type: none"> • The number of staff participating in the integrated health promotion strategy/program planning (each staff counted only once per annum per health priority). • The average staff resource commitment (time, action, financial/physical). Information based on actual participation records such as diary notes and meeting papers.

The final two key areas of the capacity building framework – leadership and partnerships underpin and support efforts in the three key action areas described above to reinforce and sustain change.

5.3.4 Leadership

A number of key characteristics of leadership are required to underpin work, by individual agencies and across agencies, in specific integrated health promotion programs. Leadership in integrated health promotion is centred on particular skills and beliefs, rather than a position of authority and, therefore, needs to be exercised at every level of a program, not just at the top. Specifically, leaders in integrated health promotion need to be able to:

- Create an environment that allows time for co-workers to understand and integrate the principles and practice of integrated health promotion into their work.
- Develop strategies to engage, mobilise and inspire managers and staff to support and implement integrated health promotion practice and principles.
- Clearly communicate the principles of integrated health promotion in a language suitable to the particular context.
- Be a strong advocate of the role that integrated health promotion can play within everyone's work, using effective marketing skills to interpret and communicate this message in a practical way that will suit a wide audience.
- Find ways to maintain momentum for integrated health promotion, particularly where there are competing pressures.
- Effectively draw on a wide range of workers and expertise from many different disciplines and sectors to enable the development of innovative health promotion interventions.

Leadership in integrated health promotion is centred on particular skills and beliefs, rather than a position of authority and, therefore, needs to be exercised at every level of a program, not just at the top.

Case study: learnings from the PCP strategy⁸⁸

Building and working collaboratively is a developmental process. Moving to a model of integrated health promotion service delivery requires leadership and management support. PCP reporting since 2001 reveals a set of key markers in creating and supporting integrated health promotion service delivery across a catchment, including:

- Senior managers participating on health promotion committees/working parties.
- Senior managers advocating and understanding the importance of consumer participation strategies.
- The development of policies and procedures that enable consistent, quality integrated health promotion reporting and communication.
- Resource allocation for positions dedicated to health promotion coordination, either through one position for each alliance or through each member agency taking a lead role on different components of the integrated health promotion strategy.
- Resourcing of alliance networking and backfill of staff (where possible) to allow intersectoral and interagency alliances to function.
- Linkages between PCP integrated health promotion planning, overall PCP executive decisions and individual member agency planning. This must be supported by clear and active communication and dissemination strategies across and within each member agency.
- Flat management and governance structures with devolved, shared and transparent decision making, particularly in relation to resource allocation.
- Flexible work practices (including flexible working hours, the ability to work from home, flexible use of leave, and flexible policies relating to family and children at work).
- Support for staff to access professional development opportunities, such as relevant courses and conferences, mentoring opportunities, the Internet, libraries and subscriptions to primary health care and health promotion journals.
- Staff acknowledgement and reward systems for leadership and innovation.

5.3.5 Partnerships

An organisation's ability to work in a cooperative and integrated way will depend on its ability to initiate and sustain effective involvement with other partners. The elements of capacity building discussed in this chapter require building effective partnerships within the organisation and across primary health care services.

Partnerships and successful cooperative relationships involve:

- Developing a shared vision for the collective partnership and articulating measurable objectives and strategies agreed on by all partners. This will involve identifying the role of each partner in fulfilling these tasks and building continual quality improvement processes within the partnership planning.
- Investing time in developing trust among members of the partnership. This will also mean recognising that there will be ongoing changes in the partnership relationship as it matures; regularly identifying and re-evaluating the level of operation of the partnership; and respecting and valuing the emerging autonomy of the partnership.
- Supporting a person or persons from within the partnership (with dedicated time) to bring together key stakeholders to facilitate the development of shared goals and agreements, given the expectations and commitments of all partners and tasks.
- Recognising common and overlapping integrated health promotion goals of partner organisations and supporting these partners to become local champions in fulfilling such goals.
- Supporting ways in which integrated health promotion can be made relevant to the different goals of partners' organisations, and encouraging partners to extend their goals to embrace and value integrated health promotion.
- Recognising issues of experience and divergent models of integrated health promotion practice among health professionals (coming from a range of backgrounds, from clinical settings to community development practices), and using this diversity to support innovation in the development of interventions.
- Ensuring effective communication and information sharing among partners through regular and timely circulation of action notes and contact lists, for example, using communication strategies to inform the broader community and stakeholders in a positive and consistent way.

§ Toolkit: See *The partnerships analysis tool: for partners in health promotion (2003)*. This is a resource for establishing, developing and maintaining productive partnerships (developed by John McCleod on behalf of VicHealth). It is downloadable from <http://www.vichealth.vic.gov.au/rhadmin/articles/files/Partnerships.pdf>

6. Evaluation and dissemination

Evaluation in its simplest form is the process of deciding the worth or value of something. This process involves measurement, observation and comparison with some criterion or standard.⁸⁹

An evaluation may be conducted for a number of reasons including:

- being accountable to key partners and funding bodies
- ascertaining if things went as expected
- determining whether the program has achieved its goal and objectives (and if not, why not?)
- considering whether something was worth the effort or resources
- future planning and identifying opportunities for improvement
- securing additional or future funding
- fulfilling accreditation requirements and making continuous quality improvements
- contributing to the evidence base for quality integrated health promotion practice.


Programs with a mix of interventions lead to multiple outcomes at varying levels. Different levels of change (as represented in Figure 4) will occur according to different time scales, depending on the nature of the program and the type of social or health problem being addressed.⁹⁰

Evaluation should be conducted throughout the life of the program.

Evaluation should be conducted throughout the life of the program. The steps in evaluation planning were discussed briefly in Section 4.2.5. Planning of the overall program should involve the development of an evaluation plan. The evaluation plan sets out and links the goal, objectives and strategies for the program, along with the data collection methods for evaluation (see Table 3). Indicators are used to guide the collection of data that answer the evaluation questions. They show progress and health change and are used at all levels of evaluation. At the most basic level, there are three types of evaluation: process, impact and outcome evaluation (as illustrated in Figure 4).

Table 3: Linking planning steps to the levels of evaluation⁹¹

Program goal	<i>is measured by</i>	Outcome evaluation
Program objective	<i>is measured by</i>	Impact evaluation
Health promotion interventions and capacity building strategies	<i>is measured by</i>	Process evaluation

 **Toolkit:** What do we know ensures good practice in evaluating integrated health promotion programs?⁹²

- **Participation:** At each stage of the evaluation, those that have a legitimate interest in the program should be involved.
- **Multiple methods:** Evaluation strategies should draw on a variety of disciplines and, where possible, employ a range of information gathering methods.
- **Resourcing:** A minimum **10 per cent** of the total financial resources from the integrated health promotion program should be devoted to evaluation strategies.
- **Levels of evaluation:** There should be a mix of process, impact and outcome information used to evaluate integrated health promotion programs.
- **Capacity building:** Practitioners should be involved in workforce development opportunities to gain expertise in the evaluation of integrated health promotion programs.
- **Dissemination and Sharing:** Dissemination and opportunities for sharing information on evaluation methods used (for example, through conferences, workshops, the Internet and other methods) need to be actively supported.

Resources for evaluation and quality in integrated health promotion are listed in Section 7. Below is a description of each of the levels of integrated health promotion evaluation.

6.1 Process evaluation

This level of evaluation covers all aspects of implementing a program.

This level of evaluation covers all aspects of implementing a program. This means focusing on the implementation of interventions and capacity building strategies and reviewing documentation of the program reach and the capacity of the system to deliver quality integrated health promotion action.⁹³

More specifically, reach performance indicators for integrated health promotion should be reported for any health promotion interventions and capacity building strategies that are part of the integrated health promotion program. Reach is the number of key stakeholders, settings⁹⁴ or members of the community affected by the program. See Section 5 for further explanation of reach for every health promotion intervention and capacity building strategy.

? Checklist: the six main questions to be asked about the program during process evaluation⁹⁵

- What is the capacity of the key partners involved in the program to fulfil the program goals and objectives?
- Is the program reaching the target or interest group?
- Are all parts of the program reaching all parts of the target or interest groups?
- Are participants satisfied with the program?
- Are all activities of the program being implemented?
- Are all materials and components of the program of good quality?

The relationship between implementing interventions and capacity building strategies and seeing outcome change is often complex, can be difficult to trace, and is likely to take place over a period of time beyond the time-scale of most evaluation timetables.

6.2 Impact evaluation

Impact evaluation considers how a program will have an impact on people's health.⁹⁶ The relationship between implementing interventions and capacity building strategies and seeing outcome change is often complex, can be difficult to trace, and is likely to take place over a period of time beyond the time-scale of most evaluation timetables.⁹⁷

For these reasons, when assessing the effects of integrated health promotion programs, the more immediate changes in populations, individuals or their environments are considered. These changes are known as impacts and relate to judgements about whether the **objectives** of the program have been achieved.


Depending on the objectives of the particular program, impacts include improved:

- **Health literacy:** health related knowledge, attitudes, motivation, confidence, behavioural intentions and personal skills concerning healthy lifestyles, as well as knowledge of where to go and what to do to obtain health services.
- **Social action and influence:** the results of efforts to enhance the actions and control of social groups over the determinants of health, including community participation, community empowerment, social norms and public opinion.
- **Healthy public policies and organisational practices:** implementation of policy statements, legislation and regulations, resource allocation, supportive organisational practices and settings experiencing enhanced engagement with integrated health promotion programs.

Other impacts include those relating to **healthier lifestyles, more effective health services, and healthier environments**. However, it is important to note that these are considered 'second level' impacts that may emerge at a later stage than the more immediate impacts described above.

Specifically, second level impact changes also include:

- Personal behaviours, such as stopping smoking or increasing participation in physical activity, which may increase or decrease the risk of ill health. These are summarised as **healthy lifestyles**.
- Access to appropriate provision and use of health services, which is acknowledged as an important determinant of health status and is represented by **effective health services**.
- **Healthy environments**, which consist of the physical, economic and social conditions that can have a direct impact on health, as well as support healthy lifestyles (for example, work to improve access to fresh fruit and vegetables in remote areas and to create smoke-free public places).⁹⁸

 **Toolkit:** The companion resource to this practice guide called *Measuring health promotion impacts: A guide to impact evaluation for health promotion* (March 2003) fully explores impact evaluation and examples of indicators. The guide is included in Section 8 of this resource kit. It is also downloadable from www.dhs.vic.gov.au/phkb under Health Promotion publications and resources.


Outcome evaluation measures the long-term effects of the program and, therefore, the program goal for that priority issue.

6.3 Outcome evaluation

Outcome evaluation measures the long-term effects of the program and, therefore, the program goal for that priority issue. These effects are usually expressed as outcomes, such as mortality, morbidity, disability, quality of life and equity, reflecting the endpoint of integrated approaches. At the end of the evaluation process, it should be possible to:

- assess whether a program has achieved its program goal
- understand and define the important conditions required to ensure successful implementation (and therefore best practice in integrated health promotion action)
- determine if these conditions can be reproduced in different circumstances.

Further details specific to the reporting of integrated health promotion programs (based on the partnerships' or agency's evaluation processes) refer to the PCP community health plan implementation agreement and the community and women's health program guidelines at <http://www.dhs.vic.gov.au/phkb>

 **Toolkit:** The following provides information about the **data gathering methods** commonly used in these three levels of evaluation. For further information see also the companion resource, *Measuring health promotion impacts: A guide to impact evaluation for health promotion*, downloadable from www.dhs.vic.gov.au/phkb under Health Promotion publications and resources.

Qualitative methods include:⁹⁹

1. Focus groups

These are semi-structured discussions, usually with 6–8 participants, and led by a facilitator. There is usually a prepared list of broad questions, themes or areas to be covered in the discussion, which might or might not be shared with the participants at the start of the interview. The proceedings are recorded by a note taker or by audio taping with later transcription.

Applications: Useful in gathering in-depth information about an issue from a small group of people, particularly concerning their beliefs, attitudes and concerns. They are also often used to pre-test program materials and to identify issues for use in later quantitative survey work.

Strengths: They provide opportunities to ask for elaboration or explanation, giving in-depth information. Ideas can be shared and discussed. They are more efficient than one-on-one interviews and require a minimum of specialised skills to implement.

Limitations: Some people can dominate a group, so good facilitation skills are necessary. They can tend to be subjective and there is the potential for facilitator bias. They are not suitable for sensitive or personal issues where participants may be unwilling to discuss these in a group. The data can be difficult to analyse and the results cannot be generalised to a broader population.

2. In-depth interviews

Generally an unstructured or semi-structured interview schedule conducted one-on-one in person or via the telephone. The interviewer generally follows an outline, but has flexibility to vary questions.

Applications: Useful for investigating sensitive issues with a small number of people. They provide the opportunity to get an in-depth understanding of the issues, attitudes and language.

Strengths: They allow people to raise issues of concern or interest and to speak in their own words. The confidential environment allows for greater depth and for development of a sense of rapport, and avoids peer influence. The interviewer has the opportunity to probe responses and to explore new issues.

Limitations: Individual interviews are more expensive and time consuming than focus groups. The greater flexibility brings with it a broader range of responses and so can make data coding and analysis more complex than group interviews. The results cannot be generalised to populations. Interviewers need training to be effective and to avoid biased or leading questioning.

3. Open-ended survey questions

A mail or telephone survey where there is a standard set of questions that allows respondents to answer in their own words.

Applications: Open-ended questions allow for greater depth and exploration of issues or for explanation of answers to closed questions.

Strengths: Because all respondents answer the same questions, there is the potential to generalise to the population. Open-ended questions provide depth and have the potential to be quantified.

Limitations: While using a fixed set of questions allows for a level of generalisation, it removes flexibility. Analysis of responses can be time consuming and expensive.

4. Journals

Stakeholders record their activities, experiences, reactions or thoughts in a diary or journal, maintained for an agreed period, such as for the life of the program or for a designated section of it. Journals provide a detailed description of the selected aspect of the program and give ongoing documentation by the selected stakeholders.

Applications: They are used primarily for process evaluation, although some short-term change (impact) may be recorded.

Strengths: Journals can provide information that had not been expected or planned for. They provide an ongoing record of people's experiences with the program and can cause participants to be more focused and reflective in their involvement in the program. They can put other evaluation findings in context and are relatively inexpensive to prepare.

Limitations: They are time consuming to prepare and not everyone feels comfortable or confident in writing down their thoughts or observations. Observations are subjective. Analysis can be time consuming and therefore expensive.

5. Observation

Unobtrusive observation involves the researcher undertaking a low-ley observation of the activities in the program, without doing or saying anything to influence behaviours of those being observed. 'Participant as observer' involves the researchers taking a more active role with participants, engaging in the activities and processes, but known to be an evaluator.

Applications: Observation is useful for understanding the context without asking the participants to explain it. It offers an alternative perspective to data developed through interviews with participants. It may be used as a preliminary stage to further data collection, particularly where the researcher is from a different background.

Strengths: Observation provides data other than self-report and gives information on behaviour, non-verbal communication and the physical and social environment. The researcher/evaluator is immersed into the context of the program.

Limitations: Observation can be time-consuming and expensive and observers need significant training. It can be seen as intrusive by program staff and participants and can lead to role conflict in the researcher in terms of their participation in the activity of the program.

Quantitative methods include:

1. Surveys

A structured questionnaire can be distributed to many stakeholders in a relatively short time frame. Respondents select from a fixed set of responses to each question. All respondents address the same questions and the survey can be completed in person or by telephone, fax, mail, email or the Internet.

Applications: Standardised questionnaires are useful when you need to collect information that is quantifiable and can be generalised to the population.

Strengths: Because all respondents address the same questions and select from a fixed set of answers, the results can be generalised to the population (assuming your sample is representative). The standardised nature of the question minimises interviewer bias. It is possible to collect and process large amounts of information in a relatively short time.

Limitations: The fixed set of questions and responses mean that it is difficult to gain an in-depth understanding of the respondents' perspectives. Preparation of survey instruments can be complex, and analysis and interpretation of the data may require input from a statistician. This, together with the costs of distribution and collection of surveys, can make this an expensive method when applied to large samples.

2. Population statistics

Many sets of population data are collected by health and other agencies. These sets range from national data down to data at the local government level.

Applications: Such data allow comparison of the target population with the broader community. Data broken down to the local level are useful in needs assessment.

Strengths: Such data provide information about change on a broad scale and are useful if programs are aimed at a large population. They provide accurate and well-researched information and allow comparisons between local populations and the broader context. They are collected regularly by government and other agencies and are usually easily accessible. They are used by a number of agencies and services and so provide a base for networking and information sharing.

Limitations: Given the broad nature of the data sets, they are not particularly useful in evaluating individual integrated health promotion programs. The data are often collected at a level far broader than the target audience and so relating the data to the work of an agency can be difficult. Also, given their broad nature, they are often influenced by non-program factors.

3. Process tracking forms/reports

Collecting process measures in a standardised manner is a feature of some programs.

Applications: Tracking forms or records are useful to document the processes occurring in a program and to identify areas for improvement.

Strengths: Such forms can be easily incorporated into routine program activities and can be easy to design and use. They can provide accurate information on program processes and decisions.

Limitations: Completing tracking forms can be seen as an added task or a burden by some staff and it is difficult to ensure that they are always completed.

...many health promotion programs in the past were not disseminated widely or findings were disseminated prematurely, limiting the full evidence of effectiveness being recognised or shared.

6.4 Dissemination

Dissemination is the active, purposeful process of knowledge transfer. Like evaluation processes, dissemination requires resources, infrastructure and planning and is essential in the feedback link to informing future planning (see Figure 3, Section 4.1). Reviews of the dissemination processes for findings from health promotion practice indicate that these processes are complex, easily underestimated and often devoid of deliberate and systematic approaches. It is also noted that many health promotion programs in the past were not disseminated widely or findings were disseminated prematurely, limiting the full evidence of effectiveness being recognised or shared.¹⁰⁰

Key findings and learnings can be disseminated via a range of strategies, such as training through workshops, train-the-trainer and continuing professional education; communication through print; communication through video and computer technologies such as databases of good practice stories, library search systems and

websites; personal face-to-face contacts; consultancies; policies, administrative arrangements and funding incentives; committees and other decision-making structures; and collaborative applied research programs.

The stages of dissemination can be summarised as:

1. Providing and seeking information.
2. Persuasion about the relevance and applicability of the innovation or findings.
3. Making a decision to adopt the findings or try the innovation.
4. Changing practices and using the innovation.
5. Sustaining the changed practice.¹⁰¹

§ Toolkit: For further information on dissemination see two key Australian references called:

King, Hawe and Wise (1996) *From research into practice in health promotion: a review of the literature on dissemination*, Sydney. ISBN: 1 86451 228 8

Oldenburg B et al (1997) *The dissemination effort in Australia: strengthening the links between health promotion research and practice*, School of Public Health, Queensland University of Technology. Publication Identification No. 2182

Members of the Australian Health Promotion Association will be able to download these references from the Association's website at <http://www.healthpromotion.org.au>

The Department plays an active role in disseminating integrated health promotion practice examples, evidence and tools. See <http://www.dhs.vic.gov.au/phkb> under Health Promotion for further information. This guide also features a range of good practice examples from PCP funded health promotion programs. It is planned that more examples will be developed and disseminated as updates to the guide.

In 2003–04, the Department will also support the development and dissemination of good practice case studies. These will be disseminated in partnership with VCHA as part of the QIPPS initiative.

7. Useful resources and endnotes

Department of Human Services

- The Primary Health Knowledgebase promotes and supports effective exchange of information relevant to providers of primary health care services in Victoria. See the website at <http://www.dhs.vic.gov.au/phkb> under Health Promotion.
- The Public Health Branch, Rural and Regional Health and Aged Care Services, Department of Human Services, has responsibility for policy development, funding, monitoring and legislation in relation to a wide range of public health services. A range of publications are available from: <http://www.dhs.vic.gov.au/phd/>
- The Better Health Channel is the department's community-focused Internet site, which provides health and health services information. A range of information is available from: <http://www.betterhealth.vic.gov.au>
- The *Health promotion strategies bulletin* aims to facilitate information sharing, communication and dissemination of quality health promotion examples across the department and other major health promotion organisations, local service providers and community-based groups. Each edition is downloadable from: <http://www.dhs.vic.gov.au/phd/0007089/index.htm>

Other resources

Disclaimer

Below is a listing of further resources and websites. Please note that this resource list is provided for information purposes only. No claim is made as to the accuracy or authenticity of the content of the resources and websites.

Consumer and community participation

Arnstein, S., (1969), A Ladder of Citizen Participation, *Journal of American Institute of Planners*, Vol 57, No 4, pp 176–182.

Communitybuilders.nsw is an interactive electronic clearing house for everyone involved in community level social, economic and environmental renewal including community leaders, community and government workers, volunteers, program managers, academics, policy makers, youth and seniors.

<http://www.communitybuilders.nsw.gov.au/>

Community engagement in the NSW planning system has a website with a centralised source of reference material for anyone keen to improve the quality of community engagement in this system at local, regional or State levels. While it is NSW focused, it contains a broad range of tools to help with community engagement. <http://www.iplan.nsw.gov.au/engagement>

Consumer Focus Collaboration (2000) *Education and training for consumer participation in health care: resource guide and final report*, Canberra, Commonwealth Department of Health and Aged Care.

Consumer Focus Collaboration (2000) *Feedback participation and consumer diversity, literature review and annotated bibliography*, Canberra, Commonwealth Department of Health and Aged Care.

Consumer Focus Collaboration (2001) *Review of the existing models of reporting to consumers on health service quality*, Canberra, Commonwealth Department of Health and Aged Care.

Consumer Focus Collaboration (2001) *The evidence supporting consumer participation in health*, Canberra, Commonwealth Department of Health and Aged Care.

Consumers' Health Forum of Australia (1999) Fourth Edition, *Guidelines for consumer representatives: suggestions for consumer or community representatives working on committees*, Lyons (ACT): Consumers' Health Forum of Australia.

Department of Human Services (2000) *Community advisory committee guidelines and community advisory committees: an aid to community participation*, Victorian Government Department of Human Services, Melbourne. Downloadable from <http://www.health.vic.gov.au/consumer/index.htm> See also a range of publications related to the consumer information and participation program for Victoria's public hospitals at this site.

Department of Human Services (2002) *A supplementary report on primary care partnerships consumer, carer and community participation*, Victorian Government Department of Human Services, Melbourne. Downloadable from <http://www.dhc.vic.gov.au/phkb>

Department of Human Services (2003) *Building community partnerships: consumer, carer and community participation in primary care partnerships*, Victorian Government Department of Human Services, Melbourne. Downloadable from <http://www.dhc.vic.gov.au/phkb>

Department of Public Health, Flinders University and South Australian Community Health Research Unit (2000), *Improving health services through consumer participation: a resource guide for organisations*, Canberra, Commonwealth Department of Health and Aged Care.

The Health Issues Centre Inc. provides an email bulletin, a journal, resources, research and training related to consumer participation. See their website at: <http://www.vicnet.net.au/~hissues>

The National Resource Centre for Consumer Participation in Health (NRCCPH) is a:

- clearinghouse for information on consumer feedback and participation methodologies
- centre of excellence where people can seek advice and assistance to develop, implement and evaluate consumer participation methods and models
- centre for research and special projects on consumer participation topics.

For further information see their website at <http://www.participateinhealth.org.au>

SPICE Consulting (1998), *The kit: a guide to the advocacy we choose to do. A resource kit for consumers of mental health services and family carers*, Canberra: Mental Health Branch Commonwealth Department of Health and Family Services.

Tatyo, M., Hirst, R., Murray, C and Verity, F. (1995) *The little purple book of community repping*, Kookaburra Press, Adelaide.

Victorian Department of Human Services (1999) *A guide to participation for older Victorian's*, Aged Care Division, Melbourne.

Health and wellbeing topics and population groups

Adolescent health

Evidence-based health promotion: resources for planning. No. 2 Adolescent health May 2000 downloadable from

<http://www.dhs.vic.gov.au/phd/ebhp/02adolescent.htm>

A database of articles related to adolescent health promotion (used to develop this evidence base review) is also available at: www.prometheus.com.au/teen/teen.html

The Australian Clearinghouse for Youth Studies (ACYS)

<http://www.acys.utas.edu.au/index.html> provides information and services for those working in the youth field. The site also offers a monthly online newsletter and extensive resources related to adolescent health.

The Gatehouse Project is a research project aimed at promoting emotional wellbeing of young people in schools. The project has been conducted by the Centre for Adolescent Health in Victorian secondary schools since 1996. See their website at <http://www.rch.unimelb.edu.au/gatehouseproject/>

Arthritis

Arthritis is now a national health priority area.

See the Department of Health and Ageing website on national health priority areas is at: <http://www.health.gov.au/pq/arthritis/index.htm>

Asthma prevention and management

National priority areas asthma website at

<http://www.dhs.vic.gov.au/phd/nhpa/asthma.htm>

Asthma Victoria at <http://www.asthma.org.au>

National Asthma Council Australia: <http://www.nationalasthma.org.au>

Victorian Asthma Health Educators Association: at

http://www.impagination.com.au/vahea/about_vahea.htm

Cancer prevention, early detection (including sun protection)

National Health Priority Areas cancer website at

<http://www.dhs.vic.gov.au/phd/nhpa/cancer.htm>

Victorian Cervical Screening Program

State Plan 2001–2004 downloadable from

<http://www.dhs.vic.gov.au/phd/cervicalcancer>

National program for the early detection of breast cancer: the Victorian program

December 2002 downloadable from <http://www.dhs.vic.gov.au/phd/breastcancer>

SunSmart campaign direction for 2000–2003 (Cancer Council of Victoria)

downloadable from <http://www.sunsmart.com.au/s/about/about.htm>

Cardiovascular disease

National health priority areas cardiovascular disease website at

<http://www.dhs.vic.gov.au/phd/nhpa/cardio.htm>

National Stroke Foundation <http://www.strokefoundation.com.au/>

Best practice guidelines for cardiac rehabilitation and secondary prevention 1999

downloadable from <http://www.dhs.vic.gov.au/phd/9905015>

The principles and practice of screening (1968)

http://whqlibdoc.who.int/php/WHO_PHP_34.pdf

National Heart Foundation of Australia at <http://www.heartfoundation.com.au/>

Australian Institute of Health and Welfare (2001) *Chronic disease and associated risk factors in Australia*, Australian Institute and Welfare, Canberra.

National Public Health Partnership (2001) *preventing chronic disease: a strategic framework – background paper*.

Childhood health and development

Best Start website at <http://www.beststart.vic.gov.au>

The health of young Victorians – October 1998 downloadable from

<http://www.dhs.vic.gov.au/phd/9709090>

The Positive Spin website looks at proactive approaches to the mental health of children and young people <http://www.positivespin.com.au>

Department of Human Services (2001) *Best start for children: summary of the evidence based underlying investment in the early years*, prepared by Centre for Community Child Health, Royal Children's Hospital, Melbourne.

(for child injury prevention see Injury prevention below)

Diabetes prevention and management

National health priority areas – diabetes mellitus website at

<http://www.dhs.vic.gov.au/phd/nhpa/diabetes>

National evidence based guidelines for the management of type 2 diabetes mellitus: primary prevention, case detection and diagnosis (2001) downloadable from:

<http://www.health.gov.au/nhmrc/publications/pdf/cp86.pdf>

American Diabetes Association (2002) *Position statement, screening for diabetes*, *Diabetes Care* 25:S21–S24, 2002.

Victorian Retinopathy Screening Development Program: summary report. Diabetic retinopathy screening: a planning tool and resource guide available from <http://www.dhs.vic.gov.au/phd>

The Eyes on Diabetes site is at: <http://www.eyesondiabetes.org.au>

A word document listing of asthma and diabetes projects (national and Victorian) downloadable from:

www.gpdv.com.au/ChronicDisease/Linkages/_Project%20Linkages%20for%20the%20website.doc

A list of HARP funded projects is at:

<http://www.health.vic.gov.au/hdms/harp/finalinsertsep02.pdf>

Diabetes Australia at: <http://www.diabetesaustralia.com.au/>

The International Diabetes Institute at

<http://www.diabetes.com.au/aboutidi/summary.htm>

Gay and lesbian health

Ministerial Advisory Committee on Gay and Lesbian Health website at <http://www.dhs.vic.gov.au/phd/macglh>

What's the difference? health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians downloadable from <http://www.dhs.vic.gov.au/phd/macglh/difference.htm>

Healthy ageing and specifically falls prevention

Making this the age to be in Victoria: a forward agenda for senior Victorians (2002) downloadable from <http://www.seniors.vic.gov.au/agenda>

Active living: getting better with age - activity options for older people website at <http://www.health.vic.gov.au/agedcare/active>

Evidence-based health promotion: resources for planning. No. 3 Falls prevention (2001) downloadable from <http://www.dhs.vic.gov.au/phd/ebhp/03falls.htm>

The articles, resources and information reviewed in the process of developing this evidence-based resource are also available in a database.

www.healthyageing.com.au/falls/falls.html

Preventing Falls Among Older People website at

<http://www.health.vic.gov.au/agedcare/maintaining/falls>

Healthy eating and weight

Public Health Nutrition website at <http://www.dhs.vic.gov.au/phd/nutrition>

A healthy balance - Victorians response to obesity (2002) downloadable from <http://www.dhs.vic.gov.au/phd/obesityforum/>

Eat well Australia: an agenda for action for public health nutrition 2000-2010 downloadable from <http://www.dhs.vic.gov.au/nphp/signal/natstrat.htm>

The Strategic Inter-Governmental Nutrition Alliance (SIGNAL) is a national partnership of government health authorities formed to coordinate action to improve the nutritional health of Australians. See their website with a range of publications at <http://www.nphp.gov.au/signal/index.htm>

(see also Body Image under Mental health Promotion)

Homelessness

Victorian Homelessness Strategy: executive summary-directions for change (2001) downloadable from <http://www.dhs.vic.gov.au/vhs/>

Illicit and licit drugs – harm minimisation

Victorian Alcohol Strategy: stage 1 (June 2002) downloadable from <http://www.dhs.vic.gov.au/phd/publications/alcoholstrategy.htm>

It's Our Drug Problem. Victoria's new drug initiative website at <http://www.drugs.vic.gov.au/>

Injury prevention

Victorian Injury Prevention Program website at: <http://www.dhs.vic.gov.au/injury/>

Taking injury prevention forward - strategic directions for Victoria (1994) downloadable: http://www.dhs.vic.gov.au/injury/downloads/injury_prev_strategic_directions.pdf

Evidence-based health promotion: resources for planning. No. 4 Child injury prevention (2001) downloadable from <http://www.dhs.vic.gov.au/phd/ebhp/04child.htm>

Koori and Indigenous health

Achieving improved Aboriginal health outcomes-an approach to reform (August 1996) downloadable from <http://koori.health.vic.gov.au/>

The Australian Indigenous Health Infonet is a dynamic resource, which makes published, unpublished and specially developed material about Indigenous health accessible to interested professionals and the community. Services provided via this website include a noticeboard, information about conferences, and a listserv. This site also provides a good set of Indigenous and health related links. See the website at: <http://www.healthinfonet.ecu.edu.au>

The Public Health Bush Book is an innovative Internet based resource, which provides practical support for people working as part of remote health care teams. It is a practical guide that resources community health workers to work with individuals, families groups and communities. See the website at http://www.nt.gov.au/health/healthdev/health_promotion/bushbook/bushbook_toc.shtml

Aboriginal and Torres Strait Islander Commission: <http://www.atsic.gov.au/>

Local government planning for health and wellbeing

Local Government Planning for Health and Wellbeing website at <http://www.dhs.vic.gov.au/phd/localgov/>

Municipal public health planning framework (2001) downloadable from
<http://www.dhs.vic.gov.au/phd/localgov/mphpf/index.htm>

Men's health promotion

Men's health promotion: developing an intersectoral strategic framework (2001)
<http://www.vichealth.vic.gov.au/default.asp?artid=316&tmid=247&level=2>

Mental health promotion

National health priority areas – mental health website at
http://www.dhs.vic.gov.au/phd/nhpa/mental_health.htm

Evidence-based health promotion: resources for planning. No. 6 Body image (2002)
 downloadable from

<http://www.dhs.vic.gov.au/phd/ebhp/06bodyimage.htm>

VicHealth mental health promotion plan foundation document: 1999–2002

http://www.togetherwedobetter.vic.gov.au/resources/pdf/Mental_Health_Foundation_Document.pdf

VicHealth mental health promotion plan 1999–2002

http://www.togetherwedobetter.vic.gov.au/resources/pdf/Mental_Health_Foundation_Document.pdf

Promoting Mental Health Network is a listserv for service providers who works or has an interest in the area of mental health promotion. Connect to the Yahoo group by following the links from:

<http://www.togetherwedobetter.vic.gov.au/resources/mhpromo.asp>

National action plan for promotion, prevention and early intervention for mental health (2000) downloadable from:

<http://www.health.gov.au/hsdd/mentalhe/mhinfo/ppei/nap2000.htm>

Promotion, prevention and early intervention for mental health: a monograph (Monograph 2000) downloadable from:

<http://www.health.gov.au/hsdd/mentalhe/mhinfo/ppei/monograph.htm>

Rowling L. et al. (eds) (2002) *Mental health promotion and young people: concepts and practice*, Published by McCraw Hill, Australia.

Multicultural health

A range of resources from the Victorian Office of Multicultural Affairs including *Access to information about government services among culturally and linguistically diverse audiences* (2001), *Valuing cultural diversity* (2002), *Victorian multicultural resources directory 2002–03* (3rd ed.) downloadable from
<http://www.voma.vic.gov.au> under publications

Action on Disability within Ethnic Communities Inc. (2003) *The better ethnic access to services kit: a resource for primary care partnerships*, Downloadable from www.dhs.vic.gov.au/phkb under PCP Strategy publications. A range of information is also available from the Action on Disability within Ethnic Communities website at:
<http://www.adec.org.au/>

The Centre for Culture Ethnicity and Health serves to enhance, develop and support the capacity of Victorian health care agencies and staff to provide high quality services to a culturally and linguistically diverse community. Check out their resources at <http://www.ceh.org.au>

The Ethnic Communities' Council of Victoria is the peak non-government body representing the views of ethnic communities throughout Victoria. See their website at: <http://www.eccv.org.au/>

The Health Translations Online Directory aims to:

- improve access to health information for people who speak languages other than English
- reduce duplication of translated information. Agencies are encouraged to register their translated health information on the directory
- enhance the sharing of translated health information. The directory is a web portal providing direct links to translated health resources.

For more information and to register go to: <http://www.healthtranslations.vic.gov.au>

The multicultural communication website is a useful resource for health professionals working with communities from culturally and linguistically diverse backgrounds. The website offers a range of valuable resources including a directory of multicultural health promotion projects and research, a number of useful guidelines and an online catalogue. See their website at:

<http://www.mhcs.health.nsw.gov.au/>

The Victorian Multicultural Commission (VMC) promotes the participation of Victorians regardless of their ethnicity, culture and religious background in building a successful future. See their website at: <http://www.multicultural.vic.gov.au>

Victorian Interpreting & Translating Services (2000), *We speak your language: a guide to cross-cultural communication*, Melbourne. Downloadable from

<http://www.vits.com.au/>

Neighbourhood renewal

Neighbourhood Renewal – Growing Victoria Together November 2002 downloadable from <http://www.neighbourhoodrenewal.vic.gov.au/ooh/web/nrwsite.nsf/doclookup/publications?opendocument>

Oral health promotion

Promoting oral health 2000–2004: strategic directions and framework for action downloadable from <http://www.dhs.vic.gov.au/phd/9909034/vhps>

Evidence-based health promotion: resources for planning. No. 1 Oral health (2000) downloadable from <http://www.dhs.vic.gov.au/phd/ebhp/01oral.htm>

Physical activity

Active for Life website at <http://www.dhs.vic.gov.au/phd/activeforlife/index.htm>

Physical activity, active for life: the Victorian Government framework (2000) downloadable from <http://www.dhs.vic.gov.au/phd/activeforlife/publications.htm>

National Public Health Partnership (2001) *Promoting active transport: an intervention portfolio to increase physical activity as a means of transport*, Melbourne. Downloadable <http://www.nphp.gov.au/>

Reproductive and sexual health

Victorian HIV/AIDS Strategy (2002–2004) downloadable from http://www.dhs.vic.gov.au/phd/publications/hiv_strategy.htm

Victorian Hepatitis C Strategy (2002–2004) downloadable from <http://www.dhs.vic.gov.au/phd/hepc/strategy.htm>

Family Planning Victoria website at <http://www.sexlife.net.au/>

Rural health promotion

Rural Health Promotion Development Program - summary report (2001) downloadable from <http://www.dhs.vic.gov.au/phd/ruralpromo/index.htm>

Victorian Rural Human Services Strategy website at <http://www.dhs.vic.gov.au/vrhss/>

Rural and Regional Health Services Branch website at <http://www.dhs.vic.gov.au/rrhacs/ruralbranch.htm>

Tobacco control

Victorian tobacco action plan (2002) downloadable from <http://www.tobaccoreforms.vic.gov.au/actionplan.htm>

Quit Victoria website at: <http://www.quit.org.au/>

Vaccine preventable disease control

Victoria's immunisation policy (2001) and Beyond downloadable from <http://www.dhs.vic.gov.au/phd/immunisation/index.htm>

Women's health and wellbeing

Victorian women's health and wellbeing strategy:

- *Policy statement and implementation framework* 2002–2006
- *Annual action plan* 2002–2003

downloadable from <http://www.women.vic.gov.au>

Women's Health Victoria is an independent statewide women's health promotion, advocacy and information service run by women for women. See their website at <http://www.whv.org.au/>

Women's Health Australia website: <http://www.newcastle.edu.au/centre/wha/>

Women's Health West (2002) *A gender agenda: planning for an inclusive and diverse community*, ISBN: 0 9585404 4 6, Melbourne.

Planning, implementation and evaluation for health promotion

Baum, F. 1998, *The new public health: an Australian perspective*, Oxford University Press, Melbourne.

Bickman L. (1987) The functions of program theory, *New Directions in Program Evaluation*, (33) 5–18.

Central Sydney Area Health Service and NSW Health (1994) *Program management guidelines for health promotion*, State Health Publication, Sydney. ISBN 0 7310 90576 7 Downloadable from http://www.health.nsw.gov.au/public-health/health-promotion/pdf/prog_manage/FINALPMG.pdf

Commonwealth Department of Health and Family Services (1999) *The kit: A guide to the advocacy we choose to do*, Canberra.

Country Health Services Division, South Australian Health Commission (1996) *Understanding rural health needs: a manual for regional planning*, Adelaide.

Funnel S. (1997) Program Logic: an adaptable tool for designing and evaluating programs, *Evaluation Methodology*, July 5–17.

Green, L. W. and Kreuter, M. W. (1991) *Health promotion planning: an educational and environmental approach*, Second edition, Mayfield Publishing, Mountainview USA.

Harris, E., Wise, M., Hawe, P., Finlay, P. and Nutbeam, D. (1995) *Working together: intersectorial action for health*, Australian Government Publishing Service. Canberra.

Hawe, P., Degeling, D. and Hall, J. (1990) *Evaluating health promotion, a health worker's guide*, MacLennan and Petty, Sydney.

Infoxchange <http://www.infoxchange.net.au> is a very well designed and popular Victorian site. Its aim is to use information technology for social justice. The site provides information on services to agencies and individuals. Other elements include a community support services database and a weekly newsletter, *Infocasts*, of material relevant to health and welfare workers across Victoria.

Keating C. (2002) *An evaluation guide for community arts practitioners*, State Government of Victoria. Downloadable from the VicHealth website at <http://www.vichealth.vic.gov.au> under the Arts topic.

May, A., Crawford, J., Marconi, J. and Radoslovich, H. (1997) *Preparing the ground for healthy communities: a workforce development manual*, Rural Health Training Unit, Adelaide.

Naidoo, J. and Wills, J. (2000) *Health promotion foundations for practice*, Second Edition, Bailliere Tindall, Sydney.

National Public Health Partnership (2000) *Deciding and specifying an intervention portfolio*, Melbourne, Victoria. Downloadable from <http://www.nphp.gov.au/ppi/planning/intervpf/index.htm>

North Central Metropolitan PCP (2002) *Promoting a healthy life for our community: a guide to social marketing*, published by North Central Metropolitan PCP. Downloadable from <http://www.ncmpcp.org.au>

NSW Health and the Australian Centre for Health Promotion, Department of Public Health and Community Medicine, University of Sydney (2001) *Indicators to help with capacity building in health promotion*, Sydney. Downloadable from <http://www.health.nsw.gov.au/public-health/health-promotion/pdf/indicators/capbuild.pdf>

Nutbeam, D. and Harris, E. (1998) *Theory in a nutshell: a practitioner's guide to commonly used theories and models in health promotion*, National Centre for Health Promotion, Sydney.

O'Conner, M. L. and Parker, E. (1995) *Health promotion: principles and practice in the Australian context*, Allen and Unwin, Sydney.

Public Health Strategy Unit (1999) *Public health bush book*, Northern Territory Health Service, Darwin.

Radoslovich, Helen and Barnett, Kate (1998) *Making the move: health promoting health services*, South Australian Department of Human Services, Adelaide.

Roe, M. (1995) *Working together to improve health: a team handbook*, Centre for Primary Health Care, University of Queensland, Brisbane.

The Health Communication Unit (2001) *Introduction to health promotion planning*, Ontario Ministry of health, Ontario. Downloadable from <http://www.thcu.ca/infoandresources/publications/Planning.wkbk.apr01.pdf>

The Local Government Planning for Health and Wellbeing website at <http://www.dhs.vic.gov.au/phd/localgov> provides a range of publications and resources including the municipal public health planning framework (the direct link is <http://www.dhs.vic.gov.au/phd/localgov/mphpf/index.htm>)

The role of health promotion within integrated health systems by the Working Group on Integrated Health Systems, 1998: <http://www.utoronto.ca/chp/ihs.htm>

The South Australian Community Health Research Unit aims to develop healthy communities through research, training and consultation. The website provides access to a range of publications and profiles a number of innovative research projects, such as the Project Evaluation Wizard – a software tool aimed at supporting health professionals to develop project and evaluation plans. Information on publications about community-based health promotion planning and evaluation are also available at this website. <http://www.sachru.sa.gov.au>

Victorian Local Government Association consultation site <http://www.vlgaconsultation.org.au/>

Vinson, T. (1999). *Unequal in health: access to comprehensive health services and Unequal in life: the distribution of social disadvantage in Victoria and New South Wales*, Jesuit Social Services downloadable from <http://www.jss.org.au/research/reports.html>

Walker R. (2000) *Collaboration and alliances: a review for VicHealth*, Victorian Health Promotion Foundation. Downloadable from <http://www.vichealth.vic.gov.au/default.asp?artid=353&tmid=247&level=2>

Wass, A. (2000), *Promoting health: the primary health care approach*, Second edition, Bailliere Tindall, Sydney.

Women's and Children's Hospital (1994), *Guidelines for the development of written health information*, South Australia.

World Health Organisation (1978) *The Alma Ata Declaration*, Geneva. Downloadable from <http://www.who.int/hpr/NPH/docs/DeclarationAlmaAta.pdf>

World Health Organisation (1986) *Ottawa Charter for Health Promotion*, Geneva. Downloadable from <http://www.who.int/hpr/NPH/docs/OttawaCharterforHealthPromotion.pdf>

World Health Organisation (1997) *Jakarta Declaration on Leading Health Promotion in the Twenty-first Century*, Geneva. Downloadable from <http://www.who.int/hpr/jakarta.declaration.shtml>

World Health Organisation (1998) *Social determinants of health: the solid facts*, downloadable from http://www.who.dk/healthy-cities/Documentation/20010918_10

World Health Organisation (1998) *Health promotion glossary*, downloadable from <http://www.who.int/hpr/NPH/docs/HPGlossaryEnglish.pdf>

World Health Organisation Regional Publications (2001) *Evaluation in health promotion: principles and perspectives*, edited by I. Rootman et al., WHO regional publications. European Series; No. 92.

International websites and resources

International

The Department of Non-Communicative Diseases (NCD) Prevention and Health Promotion, WHO, works to reduce the incidence of NCDs and promote positive health and wellbeing, with a focus on developing countries. Their website gives full details of these initiatives. Go to <http://www.who.int/hpr/support.material.shtml>

United Kingdom

The Health Development Agency (HDA) identifies the evidence of what works to improve people's health and reduce health inequalities. In partnership with professionals, policy makers and practitioners, it develops guidance and works across sectors to get evidence into practice. See their website at <http://www.hda-online.org.uk>

HealthPromis is the national public health database for England, and is produced by the Health Development Agency. HealthPromis focuses on evidence-based public health, health promotion and health inequalities.

The database, which contains references and document links to books and journal articles, is aimed at health professionals, researchers, academics and policy makers. See their website at: <http://healthpromis.hda-online.org.uk/>

The Health Education Board for Scotland (HEBS) <http://www.hebs.scot.nhs.uk> is the National Centre for Health Promotion Expertise and a WHO collaborating centre. Working with professionals at the practice and policy level in Scotland, HEBS encourages an approach informed by reliable evidence of what is and is not effective for promoting health. Also includes HEBS research centre <http://www.hebs.scot.nhs.uk/researchcentre> which includes a useful listing of health promotion work groups and discussion lists.

Information about health promotion in Wales can be found at <http://www.hpw.wales.gov.uk/> This site has an interesting health promoter's tool, which evaluates written health promotion material and pamphlets.

Canada

CLICK4HP is a Canadian health promotion discussion list. Currently there are about 1000 members from across the world. Members of the mailing list regularly debate issues in contemporary health promotion, seek input regarding program development and evaluation and share useful reports, publications and resources. Many Australian health promotion practitioners are active participants of CLICK4HP.

To subscribe send an email to LISTSERV@YORKU.CA with the subject line blank and a message saying SUBSCRIBE CLICK4HP. This will be followed up with a confirmation email to your email. Alternatively you can join through the CLICK4HP website at <http://listserv.yorku.ca/archives/click4hp.html> Archives of previous information are also available at this address.

Health Canada hosts a comprehensive health promotion website <http://www.hc-sc.gc.ca/english/care/hpo.html> which links to their directories of resources, tools and programs. Also linked to this site is Health Promotion on-line http://www.hc-sc.gc.ca/english/for_you/hpo/index.html with current news and programs. The Health Canada population health approach web site provides a comprehensive range of reports, research documents, strategy papers and policy papers relating to population health. A number of useful links are also available on this website. <http://www.hc-sc.gc.ca/hppb/phdd/resources/index.html>

The Health Communication Unit <http://www.thcu.ca/infoandresources.htm> at the Centre for Health Promotion, University of Toronto, has an extensive listing of websites and list serves covering the topics of health promotion, planning, evaluation, health communication and policy development.

The Centre for Health Promotion at the University of Toronto overall site <http://www.utoronto.ca/chp/> gives links to a number of their programs and resources, including a WHO annotated bibliography of health promotion resources and the centre's own publications.

The Ontario Prevention Clearinghouse (OPC) is a not-for-profit agency working with groups and communities in Toronto, Canada. The website <http://www.opc.on.ca> provides a starting point for the services offered by the OPC as well as some great online publications and an excellent site of bookmarks and hot links. <http://www.opc.on.ca/hplinks/hp-links1.html>

Nova Scotia Health also provides a clearing house at the address <http://www.heart-health.ns.ca/hpc/> One site available through the Clearinghouse that is of particular relevance to health promotion is Nova Scotia's Best Practices in Health Promotion http://www.heart-health.ns.ca/hpc/best_practices.htm

The Tools of Change web site <http://www.toolsofchange.com> is founded on the principles of community-based social marketing and offers specific tools, case studies and a planning guide for health promotion. Many examples of best practice programs are also provided. The case study section is particularly useful and well designed.

The Canadian Centre for Policy Alternatives <http://www.policyalternatives.ca/> is an independent, non-profit research organisation. It aims to promote research on economic and social policy issues from a progressive point of view. The website provides access to a large number of research reports and policy papers.

USA

The Office of Disease Prevention and Health Promotion web site <http://odphp.osophs.dhhs.gov> provides access to key US Federal Government publications, reports and announcements.

The Center for Disease Control and Prevention <http://www.cdc.gov/> is the main US public health site and provides comprehensive information about a range of public health issues, includes access to data and statistics, publications, and links to other public health web resources.

The Society for Public Health Education <http://www.sophe.org> provides a comprehensive website and includes information about courses, online presentations, publications, journals and resources.

Measuring Community Success and Sustainability is an interactive workbook http://www.ag.iastate.edu/centers/rdev/Community_Success/about.html which aims to provide guidance to communities, non-government agencies and health professionals wanting to improve their understanding of the ways to gather information that details progress toward community-based outcomes.

The Public Health Grand Rounds <http://publichealthgrandrounds.unc.edu> website periodically assembles a panel of specialists in public health to provide current information about a specific public health issue and to assess the problem from their professional perspective, knowledge and experience. The goal of Public Health Grand Rounds is to promote a leadership-level national dialogue on public health issues of strategic significance.

European

The Health Promotion Research Internet Network (HPRIN) is based at the Karolinska Institute in Sweden <http://www.phs.ki.se/hprin/> and provides links to health promotion research centres, schools of public health and other Internet resources of interest. Searches can be conducted by geographical region, which provides a useful breakdown. The HPRIN also manages a mailing list for group discussions.

A new site being established is called Review of Health Promotion and Education Online <http://www.rhpeo.org>. The purpose and aim of the site is to improve the quality of health promotion and health education by publishing regularly a rating of recent articles that are relevant for development, implementation and evaluation.

Other national and interstate websites

Australian Capital Territory, Department of Health and Community Care:
<http://www.health.act.gov.au/> Specifically the ACT health promotion website at
<http://www.healthpromotion.act.gov.au>

Australian Institute of Family Studies is a Commonwealth statutory authority established in 1980 to promote the identification and understanding of factors affecting marital and family stability in Australia: <http://www.aifs.org.au/>

Australian Institute of Health and Welfare (AIHW) is Australia's national agency for health and welfare statistics and information: <http://www.aihw.gov.au/>

Australian International Health Institute works in partnership with leading corporations, governments and non-government organisations, providing extensive consulting and advisory services and tailored education and training in health promotion, health policy and systems development, and health care delivery: <http://www.aihi.unimelb.edu.au/>

Centre for Immigration and Multicultural Studies, Australian National University:
<http://cims.anu.edu.au/>

Centre for Health Program Evaluation <http://chpe.buseco.monash.edu.au>

Australian Department of Health and Ageing: <http://www.health.gov.au/>

National Public Health Partnership is a formal structure for the Commonwealth, State and Territory governments to develop a joint Australian intergovernmental agenda for public health into the next century: <http://www.nphp.gov.au/>

Northern Territory Health Service: <http://www.nt.gov.au/nths/>

NSW Public Health Division: <http://www.health.nsw.gov.au/public-health/>
 and specifically health promotion at <http://www.health.nsw.gov.au/public-health/health-promotion/>

Public Health Education and Research Program, which is funded by the Commonwealth Government to improve the quality of public health teaching at Australian universities: <http://www.hlth.qut.edu.au/ph/phep/>

Queensland Health: <http://www.health.qld.gov.au/>

South Australian Department of Human Services: <http://www.dhs.sa.gov.au/>

Tasmanian Department of Community and Health Services:
<http://www.dchs.tas.gov.au/home.html>

The Australian Centre for Health Promotion provides information about professional development courses; current research activity and a range of publications: <http://www.health.usyd.edu.au/achp>

The School of Public Health at the Queensland University of Technology <http://www.hlth.qut.edu.au/ph/links.jsp> provides an extensive listing of public health resources on the Internet. The listing is categorised under the headings of: useful sites; directories; search engines; health news; journals and newsletters; mailing list searching; Usenet newsgroups; Australian directories and interesting sites.

The Victorian Consortium for Public Health (VCPH) was established in 1993 and comprises four partners:

- The Faculty of Health and Behavioural Sciences, Deakin University (http://www.deakin.edu.au/handbook/postgraduate/health_and_behavioural_sciences/H747.php)
- The Faculty of Health Sciences, La Trobe University (<http://www.latrobe.edu.au/publichealth/courses/mph/MPHStudyProgram.html>)
- The Department of Epidemiology and Preventive Medicine, Monash University (<http://www.med.monash.edu.au/epidemiology/teaching/postgrad/ph/index.html>)
- The School of Population Health, The University of Melbourne (<http://www.sph.unimelb.edu.au/postgrad/index.html>)

The Consortium aims to support the enhancement of health in Australia and other countries through the development and implementation of high quality education, research, training and consultancy activities in public health:

<http://www.publichealth.vic.edu.au/AboutConsortium.html>

Western Australian Department of Health: <http://www.health.wa.gov.au/>

Professional associations and journals

Australian Journal of Primary Health

This journal focuses on the integration of theory and practice in primary health, utilising perspectives from a range of disciplines. The journal is published by the Australian Institute of Primary Care, Latrobe University. For further information contact the Institute at:

Phone: 03 9479 3700 Fax: 03 9479 5977

Email: ajph@latrobe.edu.au

Health Promotion International

Papers published in Health Promotion International highlight innovations from various sectors including education, health services, employment, legislation, the media, industry and community networks. Articles describe not only theories and concepts, research projects and policy formulation, but also planned and spontaneous activities, organisational change and social development:

<http://www.heapro.oupjournals.org/>

Public Health Association of Australia

The Public Health Association of Australia Inc (PHAA) provides a forum for the exchange of ideas, knowledge and information on public health. The association is also involved in advocacy for public health policy, development, research and training. Information related to the *Australian and New Zealand Journal of Public Health* is also available from this site. <http://www.phaa.net.au>

The Australian Health Promotion Association

This professional association is for people involved in the practise, research and study of health promotion. The Health Promotion Association's major objectives include providing opportunities for members' professional development, increasing public and professional awareness of the roles and functions of health promotion practitioners, and contributing to discussion, debate and decision making on health promotion policy and programs. Information related to the *Australian Health Promotion Journal* is also available from this site:

<http://www.vichealth.vic.gov.au/hpja/>

The International Union of Health Promotion and Education (IUHPE)

This is a leading global network working to promote health worldwide and contribute to the achievement of equity in health between and within countries. It draws its strength and authority from the qualities and commitment of its diverse network of members, and it has an established track record in advancing the knowledge base and improving the quality and effectiveness of health promotion and health education practice: <http://www.iuhpe.nyu.edu/index.html>

The Victorian Community Health Association (VCHA)

The VCHA is the peak representative body for the Victorian community health sector and is managed by a committee of management elected from and by its membership. The VCHA acts to strengthen the capacity of the sector to improve the wellbeing of the community through:

- membership driven policy development and strategic activity
- advocating for the application of primary health care principles
- facilitating the ongoing development of best practice in community health.

<http://www.vcha.org.au/>

Australian Health Promoting Schools Association:

<http://www.hlth.qut.edu.au/ph/ahpsa/>

Quality, evidence and effectiveness in health promotion

A comprehensive review of the health status of Victorians was undertaken, quantifying the contribution to the burden of disease in 1996 of mortality, disability, impairment, illness and injury arising from 176 diseases, injuries and risk factors (with this burden projected to 2016):

<http://www.dhs.vic.gov.au/phd/bod/index.htm>
<http://www.dhs.vic.gov.au/phd/bod/mortality.htm>
<http://www.dhs.vic.gov.au/phd/bod/morbidity.htm>

Davies J. and MacDonald G editors (1998) *Quality, evidence and effectiveness in health promotion: striving for certainties*, published by Routledge. For further information see <http://www.routledge.com>

Evidence for Policy and Practice Information Coordinating Centre:
epi.ioe.ac.uk/EPPIWeb/home.aspx

National Health Service Centre for Reviews and Dissemination (NHS-CRD) is a sibling organisation to the Cochrane Centre. Most reviews focus on health care to support England's National Health Service but some reviews do examine health promotion and disease prevention www.york.ac.uk/inst/crd

Rural and Regional Health and Aged Care Services Divisions (2002) *The Victorian ambulatory care sensitive conditions study*, Victorian Government Department of Human Services, Melbourne. Downloadable from www.dhs.vic.gov.au/phd/acsc

The Campbell Collaboration: Focuses on the effects of social and educational policies and practice www.campbellcollaboration.org

The Cochrane Health Promotion and Public Health field
www.vichealth.vic.gov.au/cochrane

The Effective Public Health Practice Project (EPHPP) is a key initiative of the Public Health Research, Education and Development (PHRED) program. It is jointly funded by the Canadian Ministry of Health and Long-Term Care and the City of Hamilton, Social and Public Health Services Department.
www.city.hamilton.on.ca/sphs/ephpp/ephppSumRev.htm

The evidence of health promotion effectiveness: shaping public health in a new Europe, A report for the European Commission (2000). Not available electronically but can be ordered at www.iuhpe.nyu.edu

The Health Development Agency – research and evidence:

- www.hda-online.org.uk/html/research/reviews.html Also within this site there are various other useful sites
- www.hda-online.org.uk/html/research/effectiveness.html
- www.hda-online.org.uk/evidence/
- www.phel.gov.uk/

The Health Inequalities Research Collaboration (HIRC). Research in Australia and overseas has shown that people who experience social and economic disadvantage tend to be sicker and die younger than others. The goal of the collaboration is to enhance Australia's knowledge of the causes of and effective responses to health inequalities, and to promote vigorously the application of this evidence to reduce health inequalities in Australia. www.health.gov.au/publth/hirc/index.htm

The Victorian Government (Australia) is committed to supporting evidence-based practice in the planning and implementation of effective health promotion action. The practical use of evidence promises better health outcomes by informing practitioners, program planners and funding bodies as they develop and select health promotion strategies, methods and activities. The following four documents initiate the series:

- Evidence-based health promotion: resources for planning. No. 1 Oral health www.dhs.vic.gov.au/phd/ebhp/01oral.htm
- Evidence-based health promotion: resources for planning. No. 2 Adolescent health www.dhs.vic.gov.au/phd/ebhp/02adolescent.htm
- Evidence-based health promotion: resources for planning. No. 3 Falls prevention www.dhs.vic.gov.au/phd/ebhp/03falls.htm
- Evidence-based health promotion: resources for planning. No. 4 Child injury prevention www.dhs.vic.gov.au/phd/ebhp/04child.htm
- Evidence-based health promotion: resources for planning. No. 6 Body image www.dhs.vic.gov.au/phd/ebhp/06bodyimage.htm

The Prevention Dividend Project is a Canadian initiative designed to provide some leadership in the critical, but underdeveloped, application of economic evaluations. By providing clear evidence of the relationship between **costs and consequences**, the project is showing that economic evaluations can help demonstrate the value or return on investment on early interventions and prevention programs. <http://prevention-dividend.com/en/welcome/>

Social determinants of health, health inequalities and social capital

Acheson, D. (1998), *Independent inquiry into inequalities in health*, The Stationary Office, England.

Berkman, L. and Kawachi, I. eds (2000), *Social Epidemiology*, Oxford University Press, New York.

Harris, E., Sainsbury, P. and Nutbeam, D. eds (1999) *Perspectives on Health Inequity*, Australian Centre for Health Promotion, Sydney.

Cox, E. (1995), *A Truly Civil Society*, ABC Books, Sydney.

Kawachi, I., Kennedy, B., Lochner, K. and Prothrow-Smith, D. (1997), Social capital, income inequality and mortality, *American Journal of Public Health* vol. 87, no. 9, pp. 1491–8.

Kawachi, I., Kennedy, B. and Wilkinson, R. eds (1999), *The society and population health reader – income, inequality and health*, The New Press, New York.

Labonte, R. (1998), *A community development approach to health promotion: a background paper on practice, tensions, strategic models and accountability requirements for health authority work on the broad determinants of health*, Research Unit on Health and Behaviour Change, University of Edinburgh, Edinburgh.

Marmot, M. and Wilkinson, R. (1999), *Social determinants of health*, Oxford University Press, Oxford.

National Health Strategy (1992), *Enough to make you sick: how income and environment affect health*, Melbourne.

National Health Strategy (1993), *Healthy participation: achieving greater public participation and accountability in the Australian health care system*, Melbourne.

People Together Project and the Victorian Local Governance Association (2000), *The Power of the Community*, Victorian Local Governance Association, Melbourne.

Pope, Jeanette (2000) *Social capital and social capital indicators – a reading list*, Public Health Information Development Unit, University of Adelaide, Adelaide.

UK Government (1998), *Independent inquiry into inequalities in health*, The Stationery Office, London.

Vinson, Tony (1999), *Unequal in Life: The distribution of social disadvantage in Victoria and New South Wales*, Ignatius Centre for Social Policy and Research, Jesuit Social Services.

Winter, I. ed. (2000) *Social capital and public policy in Australia*, Australian Institute of Family Studies, Melbourne.

World Bank Social Capital for Development website at <http://www.worldbank.org/poverty/scapital/whatsc.htm>

Statewide health promotion agencies and journals

The Statewide health promotion organisations: a partnership resource for local agencies (2002) is a directory, produced in response to the recommendation of both statewide and local agencies. It provides a map of statewide health promotion functions, defines the activities of each organisation and provides a point of contact for health promotion.

See the website: <http://www.dhs.vic.gov.au/phd/statehealthpromo/index.htm>

VicHealth is committed to enhancing the health promotion role at both the partnership and agency level by funding innovative health promotion initiatives and supporting capacity building activities.

See VicHealth's website at <http://www.vichealth.vic.gov.au>

Endnotes

1. Acute Health Division (2001) *Emergency demand management: a new approach*, Victorian Department of Human Services, Melbourne. Downloadable from <http://www.dhs.vic.gov.au/ahs>
2. Press release 'Prevention is better than cure – you can count on it' (April 7 2003) Senator the Hon Kay Patterson, Minister for Health and Ageing. Downloadable from <http://www.health.gov.au/mediarel/yr2003/kp/kp03039.htm>

3. International Union for Health Promotion and Education (2000), *The evidence of health promotion effectiveness: shaping public health in a new Europe*, Report for the European Commission, Brussels.
4. World Health Organisation (1986), *The Ottawa Charter for Health Promotion*, Geneva.
5. Adapted from Himmelman A. (2001) On coalitions and the transformation of power relations: collaborative betterment and collaborative empowerment, *American Journal of Community Psychology*, vol. 29, no. 2 as quoted in *The partnerships analysis tool: for partners in health promotion* (2003), developed by John McCleod on behalf of VicHealth. It is downloadable from <http://www.vichealth.vic.gov.au/rhadmin/articles/files/Partnerships.pdf>
6. Walker R. (2000), *Collaboration and Alliances: A Review for VicHealth*, Melbourne.
7. Adapted from three sources including: Debra Parkinson, Jane Archbold and Dee Baskinski (2002) *Upper Hume PCP health promotion planning and evaluation framework*, Prepared on behalf of the Upper Hume PCP member agencies (Downloadable from <http://www.dhs.vic.gov.au/phkb> under PCP good practice stories); Department of Human Services (2003) *Core health promotion skills short course – trainers manual*, State Government of Victoria: Melbourne; Primary Health Care in Action (2003) *Community and Women’s health services integrated health promotion training resources*, delivered on behalf of the Department of Human Services, Melbourne.
8. At the time of writing this case study, strategies addressing the needs of Koori people have not yet been fully implemented.
9. Aged, Community and Mental Health Division (2000), *Going forward: Primary Care Partnerships*, Victorian Department of Human Services, Melbourne.
10. The second key deliverable for PCPs is improving service coordination. A case study linking the two deliverables is described in Section 6.2. For more information regarding service coordination see www.dhs.vic.gov.au/phkb under Primary Care Partnerships.
11. Department of Human Services (2003) *Community and women’s health services information resource health promotion reporting 02–03 and planning and reporting 03–04*, Victorian Government Department of Human Services, Melbourne. Downloadable from <http://www.dhs.vic.gov.au/phkb> under Health Promotion in Community and Women’s Health.
12. Australian Labor Party (2002) *Victorian Labor’s 2002 Policy Platform: Listens then acts – Labor’s plan for building a stronger and fairer community in Victoria*. Downloadable from http://www.vic.alp.org.au/dl/Chapter_4.pdf
13. World Health Organisation (1986), *The Ottawa Charter for Health Promotion*, Geneva.
14. Department of Human Services (2001) *Environments for Health*, Victorian Government of Human Services, Melbourne. Downloadable from <http://www.dhs.vic.gov.au/phd/localgov/mphpf/index.htm>

15. Department of Human Services (2003) *Community health plans and municipal public health plans information resource*, Victorian Government of Human Services, Melbourne.
16. Consumer Focus Collaboration (2001) *The evidence supporting consumer participation in health* Canberra: Commonwealth Department of Health and Aged Care.
17. Victorian Health Promotion Foundation (1999), *VicHealth strategic directions 1999–2002*, Melbourne.
18. Department of Human Services (2002) *Statewide health promotion organisations: a partnerships resource for local agencies*, Victorian Government of Human Services, Melbourne. Downloadable from <http://www.dhs.vic.gov.au/phd/statehealthpromo/index.htm>
19. Aged, Community and Mental Health Division, *Going forward*, op. cit.
20. Aged, Community and Mental Health Division (1998), *A stronger primary health and community support system: policy directions*, Victorian Department of Human Services, Melbourne.
21. World Health Organisation 1958, cited by Wass, A. (2000), *Promoting health: the primary health care approach*, Second edition, Harcourt Saunders, Sydney, p. 7.
22. Victorian Department of Health and Community Services (1991), *Promoting health and preventing illness in Victoria*, Melbourne.
23. Roe, M. (1995), *Working together to improve health: a team handbook*, Centre for Primary Health Care, University of Queensland, Brisbane.
24. Adapted from Labonte, R. (1998), *A community development approach to health promotion: a background paper on practice, tensions, strategic models and accountability requirements for health authority work on the broad determinants of health*, Health Education Board of Scotland, Research Unit on Health and Behaviour Change, University of Edinburgh, Edinburgh.
25. Adapted from Labonte, R. (1998), op. cit.
26. Marmot, M. (1999), 'The solid facts: the social determinants of health', *Health Promotion Journal of Australia*, vol. 9, no. 2, pp. 133–9.
27. Marmot, M. and Wilkinson, R. (1999), *Social determinants of health*, Oxford University Press, Oxford.
28. World Health Organisation (1999), *Reducing inequalities in health: proposal for health promotion policy and action*, Consensus Statement, Health Documentation Services, Copenhagen.
29. Comino, E. and Howell, S. (2000), The facts, in Harris, E., Sainsbury, P. and Nutbeam, D. (eds), *Perspectives on health inequity*, Australian Centre for Health Promotion, Sydney.
30. International Union for Health Promotion and Education (2000), *The evidence of health promotion effectiveness: shaping public health in a new Europe*, Report for the European Commission, Brussels.

31. Draper, R. quoted in Restrepo, H. (2000), *Increasing community capacity and empowering communities for promoting health*, Draft Technical Paper, Fifth Global Conference on Health Promotion, Mexico.
32. Marmot M. (1999) op,cit.
33. Putnam, R. (1993), *Making Democracy Work*, Princeton University Press, Princeton, New Jersey.
34. Baum, F., Palmer, C., Modra, C., Murray, C. and Bush, R. (2000), 'Families, social capital and health', in Winter, I. (ed.), *Social Capital and Public Policy in Australia*, Australian Institute of Family Studies, Melbourne.
35. Berkman, L. and Syme, S. (1979), 'Social networks, host resistance, and mortality: A nine-year follow-up study of Alameda County residents', *American Journal of Epidemiology*, vol. 109, no. 2, pp. 186–203.
36. Kawachi, I., Kennedy, B., Lochner, K. and Prothrow-Smith, D. (1997), 'Social capital, income inequality, and mortality', *American Journal of Public Health*, vol. 87, no. 9, pp. 1491–8.
37. Baum, Palmer, Modra, Murray and Bush, op. cit.
38. Kawachi, I., Colditz, G., Ascherio, A., Rimm, E., Giovannucci, E., Stampfer, M. and Willet (1996), 'A prospective study of social networks in relation to total mortality and cardiovascular disease in men in the USA', *Journal of Epidemiology and Community Health*, vol. 50, pp. 245–51.
39. Gillies, P. (1998), 'Effectiveness of alliances and partnership for health promotion', *Health Promotion International*, vol. 13, no. 2.
40. Baum F. (1999) *The role of social capital in health promotion: Australian perspectives*, Keynote address at the 11th National Health Promotion Conference, Perth May 1999.
41. Baum F. (1999), op. cit.
42. Cox, E. 1995, *A Truly Civil Society*, ABC Books, Sydney.
43. Minkler M. (1990) 'Improving health through community organization'. In K. Ginz, F.M. Lewis and B.K. Rimer, (Eds) *Health behavior and health education: theory, research and practice*. San Francisco: Josey Bass.
44. Department of Human Services (2003) *Core health promotion skills short course – trainers manual*, State Government of Victoria: Melbourne.
45. World Health Organisation (1978) *Declaration of Alma Ata*. Geneva: World Health Organisation.
46. Wass A (2000) *Promoting health: the primary health care approach*, second edition, Harcourt Saunders, Australia.
47. World Health Organisation (1986), op. cit.
48. World Health Organisation (1986), op. cit.
49. World Health Organisation (1997), *The Jakarta Declaration on Health Promotion in the Twenty-First Century*, Geneva. The declaration was adopted at the Fourth International Conference on Health Promotion, Jakarta, Indonesia, July 1997.

50. Wass, A. (2000), *Promoting health: the primary health care approach*, Second edition, Harcourt Saunders, Sydney.
51. Nutbeam, D., Wise, M., Bauman, A., Harris, E. and Leeder, S. (1993), *Goals and Targets for Australia's health in the year 2000 and beyond*, Department of Public Health, University of Sydney, Sydney.
52. Commonwealth Department of Human Services and Health (1994), *Better health outcomes for Australians: national goals, targets and strategies for better health outcomes in the next century*, Australian Government Publishing Service, Canberra.
53. For further information related to the national health priority areas visit the website: <http://www.health.gov.au/pq/arthritis/index.htm>
54. National Health and Medical Research Council (1996), *Promoting the health of Australians: a review of infrastructure support for national health advancement. summary report and recommendations*, Australian Government Publishing Service, Canberra.
55. National Public Health Partnership (1997), *Public health in Australia: the public health landscape—person, society, environment*, Melbourne.
56. National Public Health Partnership (2000), *Integrated public health practice: supporting and strengthening local action*, Draft Discussion Paper, Melbourne.
57. Australian Labor Party (2002) *Healthy communities: Labor's plan for seniors and community health*, downloadable from http://www.vic.alp.org.au/policy/healthy_communities.html
58. Department of Premier and Cabinet (2002) *Growing Victoria Together*, Victorian Government, Melbourne Downloadable from <http://www.growingvictoria.vic.gov.au> or available from Information Victoria at 356 Collins Street Melbourne 3000 by calling 1300 366 356.
59. Glanz, K. (1996), Achieving best practice in health promotion: future directions, *Health Promotion Journal of Australia*, vol. 6, no. 2, pp. 25–8.
60. Adapted from King, L. (1996), An outcomes hierarchy for health promotion: a tool for policy, planning and evaluation, *Health Promotion Journal*, vol. 6, no. 2, pp. 50–1; Nutbeam, D. (1996), Health outcomes and health promotion: defining success in health promotion, *Health Promotion Journal of Australia*, vol. 6, no. 2, pp. 58–60; Nutbeam, D. (2000), What makes an effective health promotion program?, in *Oxford handbook of public health*, Oxford University Press, Sydney.
61. The structure and content of the information contained in this section are adapted primarily from Nutbeam (2000), op. cit.
62. Adapted from 3 sources including: Parkinson D, Archbold J and Baskinski D (2002) *Upper Hume PCP health promotion planning and evaluation framework*, Prepared on behalf of the Upper Hume PCP member agencies. Downloadable from <http://www.dhs.vic.gov.au/phkb> under PCP good practice stories; Department of Human Services (2003) *Core health promotion skills short course – trainers manual*, State Government of Victoria: Melbourne; Primary Health Care

in Action (2003) *Community and Women's health services integrated health promotion training resources*, delivered on behalf of the Department of Human Services, Melbourne. Input also acknowledged from the Centre for Culture and Ethnicity.

63. Parkinson D. (2002), op.cit.
64. National Public Health Partnership (2000) *Deciding and specifying an intervention portfolio*, National Public Health Partnership, Victoria. Downloadable from <http://www.nphp.gov.au/ppi/planning/intervpf/index.htm>
65. Nutbeam (2000), op. cit.
66. South Australian Community Health Research Unit (2000), *Evaluation workshop session 1, Mid North Regional Health Service*, Adelaide.
67. Parkinson D. (2002), op. cit.
68. Nutbeam (2000), op. cit.
69. South Australian Community Health Research Unit (2000), op. cit.
70. Parkinson D. (2002), op. cit.
71. Nutbeam (2000), op. cit.
72. Parkinson D. (2002), op. cit.
73. Adapted from Department of Human Services (2003) *Core health promotion skills short course – trainers manual*, State Government of Victoria: Melbourne.
74. Department of Human Services (2003), op. cit.
75. Adapted from Deakin University (2002) *Health promotion program planning and evaluation course material*, Faculty of Health & Behavioural Sciences, School of Health Sciences, Melbourne.
76. Department of Human Services (2003), op. cit.
77. The service coordination tool templates are designed to support local service coordination practice by facilitating a consistent and shared approach to data collection and the sharing of consumer information. For further information see *Service coordination implementation information resource* September 2002 downloadable from <http://www.dhs.vic.gov.au/phkb>
78. Department of Human Services (2003), op. cit.
79. Department of Human Services (2003), op. cit.
80. Department of Human Services (2003), op. cit.
81. Hawe, P., Noort, M., King, L. and Jordens, C. (1997), 'Multiplying health gains: the critical role of capacity-building within health promotion programs', *Health Policy*, vol. 39, pp. 29–42.
82. Health Promotion Strategies Unit (1999), *A framework for building capacity to improve health*, NSW Health, Sydney.
83. Adapted from Hawe et al., quoted in Health Promotion Strategies Unit, op. cit.

84. Adapted from Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B. (2000), *Indicators to help with capacity building in health promotion*, NSW Health, Sydney.
85. Health Promotion Strategies Unit (1999), *A framework for building capacity to improve health*, NSW Health, Sydney.
86. Keleher, H. and Marshall, B (2002) *A framework for strengthening health promotion*, Deakin University, Geelong, Victoria downloadable from <http://www.deakin.edu.au/hbs/hshp/projects.htm>
87. Hawe, P., King, L., Noort, M., Jordens, C. and Lloyd, B. (2000), *Indicators to help with capacity building in health promotion*, NSW Health, Sydney.
88. Adapted from Hoodless M., Evans F. and Flanagan K (2001) *Upper Hume Primary Care Partnership: health promotion capacity review*, Rural Health Innovations for the Upper Hume PCP, Victoria, and PCP health promotion reporting to the Department.
89. South Australian Community Health Research Unit (2000), op. cit.
90. International Union for Health Promotion and Education (2000), *The evidence of health promotion effectiveness: shaping public health in a new Europe*, Report for the European Commission, Brussels.
91. Adapted from Hawe, P., Degeling, D. and Hall, J. (1990), *Evaluating health promotion: a health workers guide*, MacLennan and Petty, Sydney.
92. Adapted from WHO Europe (1998) *Health promotion evaluation: recommendations to policy-makers*, Report of the WHO European Working Group on Health Promotion Evaluation, Denmark.
93. Hawe, P., Degeling, D. and Hall, J. (1990), *Evaluating health promotion: a health workers guide*, MacLennan and Petty, Sydney.
94. Stakeholders may include community leaders, provider representatives and agency staff; Settings are specific physical locations such as schools and workplaces.
95. Department of Human Services (2003), op. cit.
96. Nutbeam, D. (1996), 'Health outcomes and health promotion: defining success in health promotion', *Health Promotion Journal of Australia*, vol. 6, no. 2, pp. 58–60.
97. International Union for Health Promotion and Education (2000), *The evidence of health promotion effectiveness: shaping public health in a new Europe*, Report for the European Commission, Brussels.
98. International Union for Health Promotion and Education (2000) op. cit.
99. Department of Human Services (2003), op. cit.
100. King, Hawe and Wise (1996) *From research into practice in health promotion: a review of the literature on dissemination*, Sydney. ISBN:1 86451 228 8.
101. NSW Health and Australian Health Promotion Australia (2003), Workshop material used for the Effective Information Dissemination Strategies Workshop, Department of Human Services, Melbourne January 2003.

8. Other information

This section is for practitioners to insert other information, such as the *Measuring health promotion impacts: A guide to impact evaluation for health promotion* (a companion document also developed by the Department), the PCP's or agency's organisational health promotion plan or the current reporting pro formas.