Upper Hume

Primary Care Partnership

Health Promotion Planning and Evaluation Framework

2002-2004

Women's Health Goulburn North East & Upper Hume
Community Health Service

On behalf of UHPCP June 2002

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Introduction

This Health Promotion Strategy for the *Upper Hume Primary Care Partnership* (UHPCP) outlines the framework within which health promotion work can be planned and evaluated. This is a three year strategy for 2002-2004.

Working together is integral to the success of health promotion. A series of workshops with UHPCP members was held to ensure the input of a broad range of health and community agencies, and to ground the framework. Each component has been agreed to by the membership. We believe that growing together in our understanding will increase the effectiveness of our work in health promotion.

An UHPCP vision statement already existed, having been written in November 2000. The process involved input from all PCP members. It was reviewed during this project and affirmed, and is currently being updated. Likewise, the Guiding Principles — which are those promoted by the Victorian Government (Aged Community and Mental Health, and Public Health 2000, p. 20) — were examined and affirmed by the UHPCP membership as relevant to our work. (See Appendix 1 for a detailed methodology.)

Through our work with UHPCP members over the past 18 months, it is clear that health professionals are often too pressured ***doing*** their work to devote time to reading and incorporating new approaches. The sheer volume of information about *health promotion*, *the social model of health*, *planning and evaluation methods* (amongst many other concepts and theories such as *capacity building* and *social capital*) can be overwhelming and inaccessible to busy workers. Because it is critical that on-the-ground workers have a sound understanding of these principles, simplified versions of key documents and a definition of terms (Appendix 2) are attached to this Health Promotion Strategy. These, together with Appendices 3 to 9, form a collection of useful worksheets and resources which will enable workers to quickly become familiar with the current context and practice of health promotion work.

This Health Promotion Strategy for UHPCP is a planning and evaluation framework. It is intended to help workers think through how we are working, who we are working with, and what we want to achieve. Because many workers in the health and community services field need to meet reporting requirements of the Department of Human Services (DHS), this framework has been based on DHS templates. The evaluation part of the cycle guides us to reflect on what we did achieve, what we learned, and what we should do with that new learning. The planning and evaluation cycle is indeed a spiral, where what we learn that is **new**, informs future work.

The cycle is also one of moving from the local to the global and back again; of basing our work on the current knowledge, then adding to this body of knowledge with our local findings. Through conference presentations and journal articles, we are in a position to influence policy as well as local service delivery. **We can change things!**

Vision

The people of the Shires of Indigo and Towong, the City of Wodonga and the Kiewa Valley are proactive and inclusive in achieving and sustaining health and well being (UHPCP, 2002)

Goals underpinning this health promotion strategy

Six goals for this health promotion strategy were identified in April 2001 by UHPCP members:

1. To increase the capacity of the UHPCP to deliver effective health promotion
2. To develop trust in partnerships
3. To develop inter-sectorial relationships
4. To develop an integrated approach to health promotion
5. To adopt a community development approach to health promotion
6. To be responsive and part of the community.

UHPCP members discussing goals and partnership issues.

UHPCP members considering guiding principles for health promotion.

Guiding principles for health promotion

Address the broader determinants of health, recognising that health is influenced by more than genetics, individual lifestyles and provision of health care, and that socio-environmental factors are critical.

Base activities on the best available data and evidence, both with respect to the need for intervention in a particular area and the likely effectiveness of the interventions chosen.

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-supporting environment.

Emphasise active consumer and community participation in processes that enable and encourage people to identify and positively respond to events, services and environments affecting their health.

Empower individuals to understand the impact of their environments and their health-compromising behaviours, accepting that individuals who exhibit risky or poor health-related behaviours should not be treated as blameworthy in most cases.

Explicitly consider difference in gender and culture in recognition that gender and culture lie at the heart of the way in which health beliefs and behaviours are developed and transmitted.

Facilitate intersectoral cooperation, understanding that while programs may be initiated by the health sector, partnerships must be actively sought with organisations that may not have an explicit health focus. (Aged Community and Mental Health, and Public Health 2000, p. 20)

To begin to apply these principles in your work, consider this checklist in relation to your project.

☑ Have we looked beyond the individual and beyond health services to society's role in determining a person's health and well being?

☑ Have we asked why is there a need for action and what actions are most likely to make a lasting difference.

☑ Is it easy for individuals and groups from different backgrounds and situations to participate and benefit?

☑ Can people have a say about what issues are addressed that affect their health and wellbeing and how they can make a difference for themselves?

☑ Will we provide support, information and skill development to enable people to learn what keeps them well and what makes them ill? (Avoid blaming the individual for their risky behaviours and choices.)

☑ Are we aware of the different issues that arise from our experience of being brought up as a man or a woman? Are we aware that the effect of gender differs according to the cultures we belong to?

☑ Have we brought together all concerned – individuals, families, community groups, government departments, industry, business and the media? Are we working in partnership?

☑ Have we considered attending professional development opportunities, such as:
DHS Short Course in Health Promotion
Gender training
Cultural awareness training
Health issue-specific training[1]

Identifying priorities

A written survey was conducted by email to identify the health promotion priorities of UHPCP member organisations and their partnership arrangements. Of the 26 member organisations (at that time) 20 responded. To supplement this, focus groups and interviews were held with four networks or representatives of the following sectors: education/youth; environment; sport and recreation; and a community safety committee. The questionnaire (Appendix 10) was also used as the interview schedule to ensure consistency in data collection. The full analysis is attached in Appendix 11)

Summary: Survey results suggest that members of UHPCP are choosing their health promotion priorities on the basis of sound evidence and addressing them with a variety of strategies covering all five of the most relevant health promotion interventions (described below). They are working with multiple partners representing a diverse range of organisations and community groups. Their target populations were equally diverse, covering many sections of the community. Respondents had plans to apply more strategies and to work with more partners in the future.

Just under three-quarters were completed by managers or CEOs. A quarter of respondents reported membership of more than one PCP.

[11] In the Upper Hume catchment, contact DHS, Women's Health Goulburn North East or Mungabareena Aboriginal Corporation for further information and/or referrals.

While 95% of the organisations had identified specific health promotion priorities within the past two years, many of these named two or three priorities.

A total of 45 priorities were identified by the 20 organisations. Over half fell within the national health promotion priorities. Most were around mental health (mentioned eight times), injury prevention (8) and CVD (8) with diabetes (3), asthma (3), cancers (2) mentioned less often.

Respondents were asked to choose a health promotion priority identified by their organisation and answer a range of questions in relation to just that priority.

Table 1 shows that for the chosen priority, almost three-quarters fell within the national health promotional priorities. Four respondents chose a mental health priority, four chose CVD, three chose injury prevention, and one each chose asthma and diabetes.

Table 1: Categories of health promotion priorities for first named HP priority:

	N	%
National Health Promotion Priorities	14	70
HP targeted to specific populations	3	15
Preventative health	1	5
Safety and personal safety	1	5
None identified	1	5
Total	20	100

Table 2 shows that over a third of organisations had chosen their health promotion priority because it had been identified as an issue through their own research or experience. Other reasons were because it was a departmental directive or National[2]/State priority; because of other data indicating its importance (e.g. ABS, BOD); or because it was core business.

Table 2: Reasons for choosing health promotion priorities

	N	%
Identified through own research or experience of agency	16	35
Departmental directive/ National, State HP priority	10	21
Identified through data sources, e.g. ABS, BOD, etc.	10	21
Core business of organisation	8	17
Other	3	6
Total	47	100

All 20 organisations noted at least one strategy they used to address the identified health priority. Most (18) identified two strategies, and almost half identified three. (The questionnaire only asked for three strategies.) A

[2] National Health Priority Areas are Cardiovascular health, Cancer control, Injury prevention and control, Mental health, Diabetes and Asthma.

total of 47 strategies were identified. When grouped into the seven health interventions, the great majority were *Health Education, Counselling and Skill Development* strategies. A quarter were *Organisational development* strategies. Around 10 per cent were *Community Action* strategies, and 4 per cent each were *Health Information* and *Social Marketing* strategies.

Thirteen agencies noted between one and three strategies that could be developed in the future to further address their identified health promotion priority. A total of 27 potential strategies were listed. About a third fitted within *Health Education, Counselling and Skill Development*, and a further third were *Organisational Development* strategies. Almost a quarter were *Community Action* strategies.

Examples of the kind of strategies are:

Health education, counselling, skill development
: Sporting activity; exercise program; peer education; GP training; individual support to target group; specialised programs.

Organisational development
: Partnership approach; single point of entry; multi-disciplinary team; connections within and between agencies; changes to funding.

Community action
: Support groups; lobbying; rural community development.

Social marketing
: High level promotion; theatre workshops.

Health information
: Information centre; information dissemination.

Respondents mentioned 14 different groups of people as particular groups they target for their health promotion work. Specific groups included Older people, Middle years people, Adults, Children, Young Rural Males, People with a disability, Individuals with a recognised disease, the Aboriginal community, Carers and Health professionals. In addition to this, many mentioned the community as a whole. There was a very even spread across the groups with the exception of Older people which was a target group for four organisations.

UHPCP members are currently working with a diverse range of partners. The survey asked for all the partners that organisations were working with on their identified health promotion priority, and the 20 respondents noted a total of 71 current partners. They were also asked who they would like to work with in the future. These were grouped into 13 categories as shown in Table 3.

Table 3: Proportions of partners - current and future (of UHPCP members who responded to the survey)

	Current		Future	
	N	%	N	%
Community agencies (e.g. Mungabareena, UMFC)	12	17	8	24
Community health	11	15.5	8	24
Specific peak body/group (e.g. Diabetes)	11	15.5	3	9
PCP, networks	5	7	3	9
Community groups (e.g. Church, Senior Cits, RSL)	9	13	2	6
Hospitals	4	6	2	6
GP/ GP divisions	3	4	2	6
Schools	2	3	2	6
Police, Courts	0	0	2	6
Other (target group, other referrals)	1	1	1	3
Local government	7	10	0	0
Government departments	5	7	0	0
Business	1	1	0	0
Total	71	100	33	99

While partners from Community Health and Community agencies are amongst the highest proportion of partners, respondents are keen to work with even more from these areas in the future. Others showing future growth are Schools, Police/Courts, GPs/GP Division, and PCP/Networks.

All 20 were currently working with at least one partner on the health priority they had identified. Two were working with six partners. The range is shown in Table 4 below:

Table 4: No. of organisations currently working with between one and six partners

	1 partner	2	3	4	5	6
No of organisations	20	16	10	7	6	2

Fourteen of the 20 respondents noted at least one other partner they would like to work with in the future. Table 5 shows the range:

Table 5:No. of organisations wanting to work with other partners in the future

	1 partner	2	3	4
No of organisations	14	8	5	1

Most respondents noted constraints limiting their capacity to work in partnership with other organisations. These included time restraints; the limited size of their workforce; or limited programs available in the specific health area; limited financial resources; lack of shared approach; and lack of opportunity. Other constraints included lack of local input into decision making of national priorities; the focus on targets by funding bodies; distance and communication difficulties.

Suggestions for what would make it easier to work in partnership included the need for better infrastructure funding or increased resources; continuing the PCP; improving network structures; building trust and communication in work; and developing a shared understanding.

The survey gives a clear indication that the members of UHPCP are active in partnership work and interested in extending this work – both within and outside of the PCP.

The interviews with workers outside the PCP (in the sectors of education/youth; environment; sport and recreation and a committee with broad community representation) indicate that although there was some sense of exclusion, these workers could see relevance in linking with the PCP, and displayed a keenness to work in partnership. The purpose of this snapshot of how the PCP is viewed from the outside was prompted by the Service Integration Matrix (Template b) which suggests the need to work with other sectors. It appears that UHPCP members can feel confident in seeking partnerships outside the PCP membership.

Partnership principles for successful collaborations

The following partnership principles were identified by UHPCP members at a workshop in August 2001, and by the four collaboration partners during the evaluation of the collaboration partnership. (See Case Study below.)

- Develop common understanding of key terms
- Create a shared vision for the way forward
- Accept where people and organisations are at, and their different priorities
- Aim to meet community needs and improve service delivery
- Break down barriers and build trust
- Increase understanding of services
- Make use of skills across agencies
- Ensure sustainability

Case Study – working in partnership

UHPCP contracted four member organisations to work together to complete a Service Planning Project. The work of this project fits within a Planning and Evaluation Cycle[3], which uses the headings of *Problem Definition*, *Solution Generation, Resource Mobilisation*, *Implementation*, and *Evaluation*. (This Planning and Evaluation Cycle is explained more fully in the next section. Here, we show how to apply the Planning and

[3] Nutbeam, D & Harris, E. (1998). *Theory in a Nutshell*. Sydney: National Centre for Health Promotion.

Evaluation Cycle to the ***process*** of doing a project (how the project was conducted).

This example illustrates some of the strengths and weaknesses of working in partnership.

PROBLEM DEFINITION
The problem to be addressed by working in partnership was that services have been fragmented and duplicated. While we know that better service integration improves the health service experience for people in our community, **working in partnership has difficulties** for services separated by distance and philosophy.

SOLUTION GENERATION
To help overcome the problems that are often part of working in partnership, the following **strategies were identified** by all the partners in a series of workshops:

☑Be clear about the project and its processes

☑Respond constructively to problems

☑Support other partners

☑Obtain early outcomes for the project – including external acknowledgement

☑Value the experience of working jointly

☑Show tolerance and goodwill!

☑Understand that diversity provides strength

☑Be persistent!

RESOURCE MOBILISATION
To ensure a solid basis for the partnership, **the four partners developed guiding documents**:

☑A vision for the project

☑Expectations of the partnership

☑Risks and opportunities of working together

☑A combined workplan detailing timelines and joint responsibilities

☑A simple grievance procedure

☑An evaluation procedure.

IMPLEMENTATION
The **project was clearly defined** and a **lead agency role** was taken up by each agency in relation to a part of the project. A **contract** was written and a structure was put in place for the project as a whole, based on Labonte's (*ref*) concept of 'midwiving' a project. Each agency developed **fully detailed workplans** and **undertook the work**. Regular working group meetings were held for ongoing input.

EVALUATION
The **weaknesses** of working in partnership were identified as distance and time (issues of cost, efficiency, value for effort; no incidental networking); learning to collaborate; differing interpretations of concepts – e.g. what working in partnership means; different ways of working – focus on process or outcome; communication (new partners needed to go over old ground; further discussion needed around project).

The **strengths** were the opportunity to explicitly examine partnership processes; involvement of all partners; flexibility about meeting times and venues; task and process focus; feedback loop of what works and what doesn't; Trust in competence of other partners; Agreement on the importance of HP; HP became more identifiable and valued within organisations; boards became more knowledgeable about HP; skills and knowledge were gained by PCP members and are retained within the PCP.

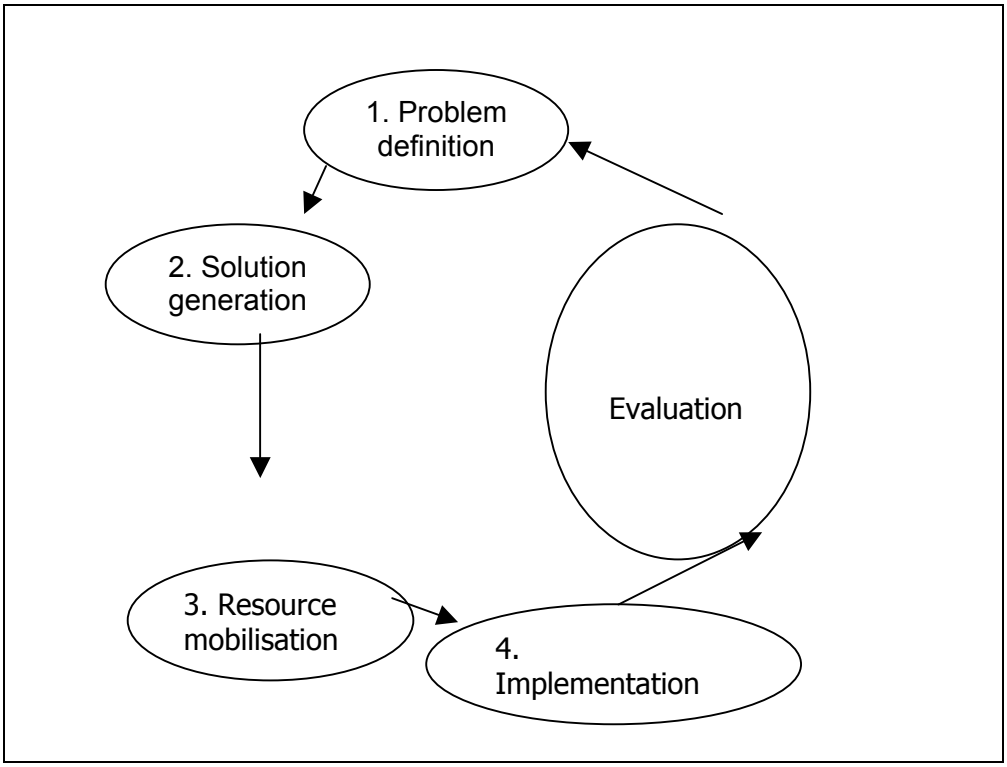
This example applies the planning and evaluation cycle to the ***process*** of the project – to reflect on ***how*** the work was undertaken.

The next section looks at how to apply the cycle to the project ***task*** – to ***what*** work was undertaken.

Planning and evaluation framework map!

There are many ways to plan and evaluate a project. However, the principles underlying sound planning and evaluation are basically the same. Because many health promotion workers are funded by the Department of Human Services, and required to submit Project Plans and Project Reports, this framework uses their templates[4] and preferred theories. The purpose of this section is to add some guidelines and examples to help you complete the templates. If you don't need to submit them to a funding body, **following this approach will, nevertheless, provide you and your agency with a well thought out project plan, and a thorough evaluation.** The framework[5] below, (used in the previous example), illustrates one planning and evaluation approach.

[4] Aged, Community and Mental Health, and Public Health (2000). *Primary Care Partnerships: Draft Health Promotion Guidelines*. Melbourne, Victoria: DHS.
[5] Nutbeam, D & Harris, E. (1998). *Theory in a Nutshell*. Sydney: National Centre for Health Promotion.



The creators of this framework (Nutbean & Harris, 1998, p. 12)) have suggested a useful way of thinking through project design and implementation. We have adapted the framework so that the Evaluation measures are:

- Reach (who, and how many, heard the message), and
- Impact (what has changed).

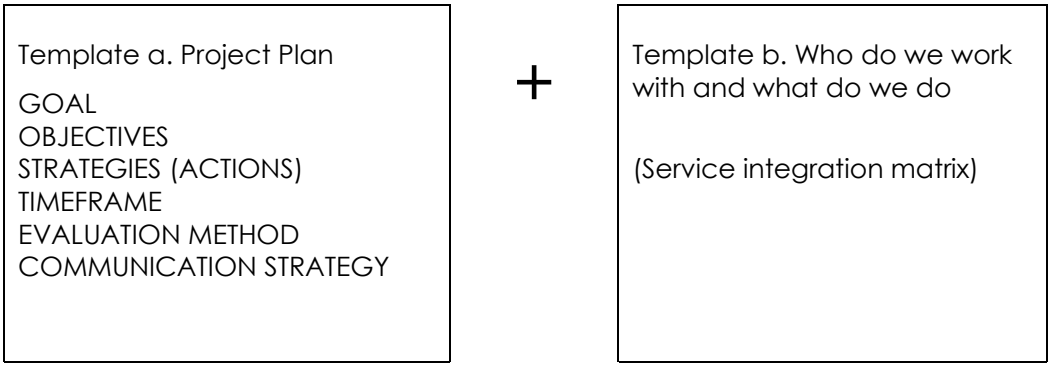
And, we have added a:

- Qualitative Evaluation section (to catch those aspects that can't easily be measured).

How the templates fit with the planning and evaluation cycle

The Department of Human Services have produced a number of templates to assist in gathering data and reporting. We have integrated the templates into the stages of the planning and evaluation cycle. **By following the steps outlined below to plan and monitor your project, you will have an ongoing, comprehensive record of what has happened through your work – all based on sound health promotion theory!**

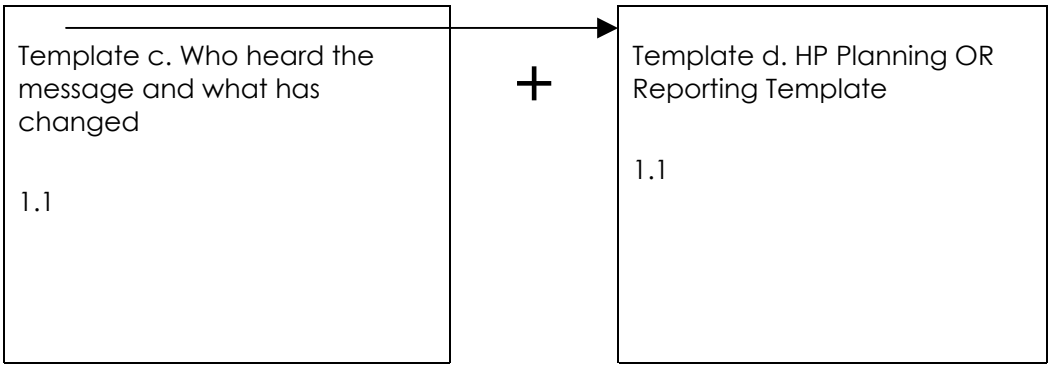
Under each of the headings below, a box suggests which template to start to fill in or add to. Although there are a number of crossovers, Template a (the Program Plan) captures **Problem Definition** and **Solution Generation**. Template b (Who we work with and what we do) captures **Resource Mobilisation**.



Template c (Who Heard The Message And What Has Changed) helps keep a record of the Implementation of the project, and gives some Evaluation measures.

Keep an eye on the cost-effectiveness of your project - or of individual strategies within it - by completing Template d (HP Planning or Reporting Template[6].)

You may prefer to have a broader overview by developing a budget for your project as a whole. To do this, consider the wages of the Project Workers; consumables (such as travel, accommodation, catering, guest speakers, conferences); on-costs; and administration contributions (telephone, photocopying, faxing).



Template e (what we've learnt from our work - achievements, challenges and issues) allows a deeper **evaluation**. Use it to outline how you will consider the project's successes or issues. Ideally, plan to meet with key stakeholders regularly throughout the project. Don't forget to consider issues of inclusiveness and diversity, and gender and equity.

[6] This is the only template that is required by DHS for funded projects.

Template e.
What we've learnt from our work - achievements, challenges and issues

(Or Narrative)

A range of resources – including our own experience - has been used to come up with a checklist under each heading to ensure you've thought about everything – including how you work collaboratively, gender and equity, and inclusiveness and diversity. In each of the steps below, ask:

- ✓ How does this affect women?
- ✓ How does this affect men?
- ✓ Who might not be included?
- ✓ How will you ensure that everyone has access?
- ✓ What broader social or cultural factors might be involved
- ✓ How might your own values, biases and assumptions affect the process?[7]

Step 1: Problem definition

Work out the best way to really hear from the local community what their issues are.

Locate epidemiological and demographic information, as well as data on community needs and priorities. UHPCP has distributed a health profile of the catchment to assist with this.

Check out formal data sources: Department of Infrastructure; Other Government Departments; Australian Bureau of Statistics; Burden of Disease; Division of GP data; Municipal Public Health Plans; PCP Health Profiles; Economic Development Corporations; Local Government Community Profiles; Peak Body Research.

[7] Dyson, S. (2001) *Gender and Diversity: A Workbook for an Equity Approach to Practice*. Frankston: Women's Health in the South East. Questions from pages 51, 75

Less formal sources: Existing research reports; local directories; local agency data; local and regional committees and networks; key individuals in the sector and in the community.

The problem definition checklist

- ✓ Have you spoken with key people, including community members, about needs and priorities?
- ✓ Have you looked at relevant data and information?
- ✓ Do you understand the bigger picture for your organisation, your partners, and for local, state and national government?
- ✓ Have you identified what contributes to the problem (socio-economic determinants; risk factors; etc.)
- ✓ Have you thought of where and how you can make a difference with the resources you have?
- ✓ Based on these, have you now decided which health issues are your priority?
- ✓ Start thinking how you can tell if you've made a difference (EVALUATION)?

Step 2: Solution Generation

Develop strategies using data (from Problem Definition above) and good practice models; identify statewide action and appropriate mix of interventions. Write a project plan specifying: the Goal; Objectives; Strategies (Actions); Timeframe; the Evaluation Method; and a Communication strategy.

Fill in …	***Template a – Project Plan***
	Transfer the Goal, Objectives and Strategies from Template a to ***Template d*** *if you need to complete a Program Plan for DHS.*

The solution generation checklist

- ✓ Do you know enough about your TARGET GROUP?
- ✓ Do you know what other work is being done in this field?
- ✓ Have you spoken with and arranged partners and practitioners?
- ✓ Have you included community members?

- ✓ What actions are you going to take (STRATEGIES)?
- ✓ Have you developed a timeframe?
- ✓ Have you based your approach on the social model of health (remember the Ottawa Charter and the Social Determinants of Health)?
- ✓ Are you thinking about how you will know if you meet your goals and objectives? (EVALUATION)

Step 3: Resource Mobilisation

Identify roles of stakeholders, including consumers and carers; allocate resources; and link with others to increase capacity to meet needs.

The resource mobilisation checklist

- ✓ Who's going to do what?
- ✓ Which of the 7 health promotion interventions do they fit under?
- ✓ Do you have the resources to do it?
- ✓ Are you thinking about how will you measure the reach (who heard the message) and impact (what has changed as a result) of your actions (EVALUATION)?

Fill in …	***Template b – Who we work with and what we do***
	If you can tick these, start filling in Template b

Step 4: Implementation

Put your project plan into practice:

- ✓ How will you keep stakeholders informed (both internally and externally)?
- ✓ How will you tell people what you've found out?
- ✓ Are decision making structures clear? Do they work well?
- ✓ Remember to monitor what's happening
- ✓ Are you aware of (and addressing!) emerging issues?
- ✓ Check out along the way how it's going and how people are feeling, e.g. talk to people, read feedback sheets, follow up with people who stop participating, (This informs evaluation).

- ✓ Are you reflecting on what's working and what isn't? (This informs evaluation).
- ✓ Be prepared to be flexible - make changes if necessary
- ✓ Remember to collect evidence. Document the achievements and the challenges (this informs evaluation).

	Template e – Qualitative evaluation worksheet
Fill in …	*Start filling in Template e either as an individual or as a group process.*

Step 5: Evaluation

	Template b – Who we work with and what we do ***Template c – Who heard the message and what has changed*** ***Template e - What we've learnt from our work - achievements, challenges and issues***
Fill in …	*Add to what you already have in Template b and start filling out Template c. This will provide quantitative evidence (the numbers!) to support the achievements of your project. However, it is also necessary to think in a qualitative way (what changes have occurred) about whether you have achieved what you set out to do, and how what you learned can lead to changes in planning future work. Template e will guide your thinking.*

Take evaluation to a higher level by considering how well your work meets the needs of a wide range of people. This is not to suggest that you need to be all things to all people. Instead, be aware of the principles of gender and equity, and diversity and inclusiveness (see Appendix 6).

> "The result will be that instead of having some mainstream programs that are offered to a fairly homogenous group of people, and others that address the needs of marginalised groups, all programs will be strategically planned to be inclusive." (Sue Dyson, 2000)

Plan for the evaluation at the start of the project, and let it evolve as the project does.

The evaluation checklist

- ✓ Think about how you will know if you achieve your objectives
- ✓ How will you document your successes?
- ✓ Have you planned for reflection with key players throughout the project?
- ✓ Have you asked questions that will find out if the project worked differently for men and for women?
- ✓ Have you considered working with, for example, women's (and men's) health organisations to ensure gender is taken into account?
- ✓ How will you know if you reached everyone you wanted to?
- ✓ Did a range of people from different cultures and ages and gender participate? If not, why not? Who was missing?
- ✓ Will your evaluation plan let you find out what needs to change so that people of all backgrounds feel comfortable?

Template a. Project plan template

Rationale (from Problem Definition)

Program goal
(Copy to Template d)

Objectives
(Copy to Template d)

Strategies (Actions)
(Copy to Template d)

Timeline
(Copy to Template d)

Evaluation method

Communication strategy

Template a. Project plan - Falls prevention example

Rationale (from Problem Definition)

The need for falls prevention work was indicated from local and national data:

- Accidental falls consume 32% of total health system costs for unintentional injuries
- Of all unintentional injuries, falls are the major cause of DALYs (Disability Adjusted Life Years lost) in both men and women over 75
- Falls significantly affect quality of life for older people, triggering increased dependency, fear and frailty
- UHPCP in its first year had a focus on older people for joint service planning and delivery
- The three shires all have an ageing population.

Following the literature search on falls prevention, it was decided that the best value for effort would come from increasing physical activity opportunities for older people (including strength training and Tai Chi). Increased physical activity is known to positively affect diabetes, cardiovascular disease, osteoporosis, amongst other illnesses, as well as helping to reduce weight and increase strength. The lack of opportunities for physical activity for older people in the PCP catchment meant that there could be big health gains by implementing simple programs. This is the principle of the 'best bang for your buck'!

Program goal

To reduce the number of injuries caused by falls in older people (65+, Koories 40+)

Objectives

1. To increase the level of awareness of falls risk factors and falls prevention strategies in older people.
   2. To increase the capacity of the UHPCP organizations to reduce the incidence of falls injury within the target group.

Strategies (Actions)

For objective 1: Talks to Community Groups (20); Radio interviews (6, including one in Melbourne); Two newspaper articles in the newspaper of each of the 7 major towns.
For objective 2: August 22 Seminar attended by service providers and

community groups; Establish sectorial reference groups (e.g. Allied Health, LGAs, HACC, Community Health Workers)

Timeline

From July 1, 2001 until June 30, 2002. Detailed timelines were prepared. Falls prevention work has been funded for a further 12 months.

Evaluation method

Consultation – focus groups

With groups: the Project Worker filled in the evaluation form as groups were unable to do it for themselves. At the beginning of each session, participants were asked what they knew about falls risk factors (as a pre-test). At the end of the talk, they were asked again to name these factors (post-test). They were asked what actions they intended to take to reduce their risk of falling.

The evaluation methodology was based on trialing this planning and evaluation framework.

A workshop was held at the beginning to track what was going on in falls prevention, and to allow a baseline to compare with what was offered at the completion of the project.

Communication strategy

Reporting through monthly meetings of Working Group 3 (a group of service providers from UHPCP membership).

Using the media to reach community members.

Using the GP Division Friday Fax – to all GPs in the catchment.

Template b. Who we work with, and what we do

This is the Service Integration matrix from the Draft Health Promotion Guidelines (DHS, 2000, Headings adapted August 2002). We have changed it around it make it easier to use on a computer and to print. This can be used as a planning tool to brainstorm who you might work with and what they might do. It can help evaluate your success in who you formed partnerships with.

			Screening, Individual Risk Assessment and Immunisation	**Social Marketing/ Health Information**	**Health Education, and skill Development**	**Organisational Development**	**Community Action**	**Economic Regulatory Activities**
Health Promotion Partners	Dept Human Services	Central Office	*Write the action done by each partner in these squares.*					
		(Specify) ……						
	PCP Members	Community Groups and Members						
		Community Health						
		Local Government						

			Screening, Individual Risk Assessment and Immunisation	Social Marketing/ Health Information	Health Education, and skill Development	Organisational Development	Community Action	Economic Regulatory Activities
		GP Division						
		Women's Health Service						
		Aboriginal Corporation						
		Other, please specify ……						
	Non-PCP Partners	Chemists						
		GPs						
		Other, please specify ……						

Template b. Who we work with and what we do - Falls Prevention example

This can be used as a planning tool to brainstorm who you might work with and what they might do. It can help evaluate your success in who you formed partnerships with. (Abbreviations are below the table.) This is just a sample to show how you might complete the table.

			Screening, Individual Risk Assessment & Immunisation	**Health Information**	**Health Education, Counselling and skill Development**	**Social Marketing**	**Organisational Development**	**Community Action**	**Economic Regulatory Activities**
Health Promotion Partners	Dept Human Services	Central Office		Provide quality consumer information through the Better Health Channel	Develop and disseminate effective practice guidelines	Facilitate the development of Statewide media campaigns	Develop policy directions, baseline indicators, data monitoring systems		
		Rural Housing Network	Review safety of public housing environments	Target information development for older people eg large print pamphlets	Facilitate skill development opportunities for all project members eg Evaluation and HP short course training	Tailor State and national campaigns for local opportunities	Develop data monitoring systems for local needs.	Provide community action group with training in grant writing/ data collection	
	PCP Members	Community Groups and Members		Ensure the availability of information: Help develop specific PA info	Advocate for health education and training opportunities to improve the provision of age appropriate PA opportunities and facilities	Provide local media opportunities to raise awareness of FP and PA for OP		Community groups to develop local activities eg reporting of" black spot" areas	Help develop policy supporting safe public environments
		Community Health	Conduct PA Screening and risk assessment and follow up.	Provide passive and active information to clients and through community settings in relation to PA and FPI	Run age/ability appropriate sessions on physical activity, strength training , Tai Chai, water exercises, healthy eating etc. Run awareness raising seminars.	Work as a community health media spokesperson. Work with action groups	Provide professional development courses for PCP staff	Support community action groups - support their participation in Community health Action Plans, and in HP activities	

			Screening, Individual Risk Assessment & Immunisation	Health Information	Health Education, Counselling and skill Development	Social Marketing	Organisational Development	Community Action	Economic Regulatory Activities
		Local Govt		Disseminate information through community settings on opportunities for PA	Support Health Ed and skill development activities eg provide access to venues and facilities. Educate outdoor council staff in access/safety issues for OP and the disabled	Provide opportunities for community groups to develop local media campaigns	Develop policies to improve reporting of Falls Black spots and policies to rectify.	Work with local businesses to improve safe access to facilities/shops/ businesses/org anisations	Change legis. to support Falls Prevention in public / private buildings. Integrate Strategiesto MPHPs.
		GP Division		Provide information to GP's on opportunities for PA by OP in the community	Provide motivational counselling and offer referral contacts to GP's	Work as media spokesperson Work with community action groups.	Provide professional development courses for PCP staff	Work as key speaker for community group activities and health professionals.	
		Aged Psychiatry	Conduct Screening, risk assessment and follow up in the proper use of medication	Provide opportunistic information to clients and carers re opportunities for PA and FP.	Provide motivational counselling, HE and SD opportunities and referral contacts to clients and carers	Work as a media spokesperson	Provide professional development courses for PCP staff		
		Mungabareena Corporation	Conduct Screening, risk assessment and follow up	Provide opportunistic information to clients re info on FP and PA for OP	Provide motivational counselling, HE and SD opportunities to clients and carers.	Work as a media spokesperson		Work as a key speaker for activities organised by communities groups/facilities and health professionals.	
		Vision Aust	Conduct Screening, risk assessment and follow up	Provide opportunistic information to clients re info on FP and PA for OP	Provide motivational counselling and offer referral contacts to clients/carers	. Work as a media spokesperson/ key speaker	policies/protocols	Advocacy	Implement award system for local businesses and councils that are vision impaired aware.

PA – Physical activity OP – Older people HP – Health Promotion HE – Health Education SD – Skils Development

Template c. Who heard the message and what has changed Template

The 'Falls Prevention' example that follows is slightly different to this Template, as it was completed during 2001 with an earlier version of the template. This is the revised one released in August 2002. (*See Appendix 2 for a description of each intervention.)

HP Intervention	Strategies	Who	Reach (who, & how many heard the message)	Impact Indicators (what has changed)
1. Screening*	1.1 (write strategies here) 1.2 1.3 …		Proportion of target group or number of people participating in screening, individual risk assessment & immunisation activities (counted only once per activity). Information collected through systematic staff estimates & participation records.	Proportion of people who undertake screening, risk assessment or immunisation following participation in the activity. Impact is assessed through sample surveys of the people participating in the activity, & reported as a percentage of total reach.
2. Social marketing /Health Info	2.1 2.2 2.3 …		Proportion of target group or number of people (counted as contacts) accessing or aware of funded social marketing/health information activities & resources. OR number of articles published & the population reach of the newspaper or newsletter. OR number of agencies participating in the development & dissemination of consistent information resources (from printed material to interactive technology).	Proportion of people reporting changed knowledge, attitudes, beliefs & behaviours following participation in social marketing strategies. Impact is assessed through social marketing surveys, & reported as a proportion of total reach. Proportion of people who report using health information to improve their health after accessing information. Impact is assessed through sample surveys of people accessing health information, & reported as a percentage of total reach.
3. Health education/ skills dev	3.1 3.2 3.3 …		Proportion of target group or number of people participating in funded health education & skill development (counted only once per activity such as a quit smoking course). Information based on actual participation records.	Proportion of people who report changed knowledge, attitudes, beliefs & behaviours following participation in the activity. Impact is assessed through relevant pre-post evaluation measures, & reported as a percentage of total reach.
4. Community action (for social & environmental change)	4.1 4.2 4.3 …		Proportion of target group or number of people participating in funded community action activities (counted as contacts). Information collected through systematic staff estimates.	Proportion of people who report independent & continued (sustainable) participation in a health-related priority area following implementation of community action strategies. Impact is assessed qualitatively following implementation & reported as a percentage of total reach.

HP Intervention	Strategies	Who	Reach (who, & how many heard the message)	Impact Indicators (what has changed)
5. Settings & supportive environments	5.1 5.2 5.3 …		No. of settings (such as schools, local businesses & sporting clubs) involved in creating a supportive health promoting environment. No. of stakeholders involved in economic & regulatory activities. Information gathered through staff estimates. No. of settings/Stakeholders involved in advocacy activities, including direct political lobbying(Each counted only once per annum per health priority).	Policies, service directions, priorities & practices integrated into health promotion principles. Political commitment, policy support, social acceptance & systems support for a particular goal.
6. Organisational development	6.1 6.2 6.3 …		No. of agency management/staff - participating in funded health promotion activities (counted only once p.a.). Information based on actual participation records such as diary & meeting notes. - planning to or implementing health promoting workplace policy/organisational culture activities. - planning to or implementing policies, plans, &/or management support mechanisms for health promotion activities in their agencies/organisations. - using health promotion recognition systems, health promotion activity monitoring & evaluation systems, consistent information resources &/or best practice health promotion tools.	Proportion of settings reporting the implementation of health-promoting practices following participation in health promotion activity. Impact is assessed through an organisational change survey, & reported as a proportion of total reach.
7.Workforce developments	7.1 7.2 7.3 …		No. of staff within the agency participating in funded health promotion workforce development activities such as on the job learning, formal professional development/ support & supervision/performance management systems (counted only once per workforce activity). Information based on attendance records & similar information.	
8. Resources	8.1 8.2 8.3 …		The number of key stakeholders participating in the health promotion planning (counted only once per annum per health priority) & the average stakeholder resource commitment (time, action, financial /physical). Information based on actual participation records such as diary notes & meeting papers.	

Template c. Who heard the message and what has changed — Falls Prevention

HP Intervention	No.	Strategies	Who	Reach (who heard the message?)	Impact Indicators (what has changed?)
1. Screening	1.1	Implement Home Assessment for Safety and Security (HASS) Program (see 5.1)			
2. Health Info	2.1	Talks to Community Groups (20)	PW	Possible reach 500.	Pre test and post test of existing awareness shows doubling of awareness. An estimated 75% state that they will make changes to improve their health as a result of attending the session. (Based on sample survey of 12 groups with average of 25 participants and carers in each group)
	2.2	Distribute HASS Information Booklet	HASS volunteers	All requested homes (approximately 200 over the 3 LGA / PCP catchment)	Increased knowledge of falls risks and general home safety (estimate 16% of catchment population or 60% of population aged 65+)
3. Health education/skills dev	3.1	August 22 Seminar	PW	Approx 45 participants (16 PCPs; 12 other agencies)	100% of PCP agencies working with older people report increased awareness of physical activity, strength training and balance improvement (e.g. tai chi) and all relevant agencies (5 hospitals, 7 CHS, 3 LGA HACC services, 5 Nursing Homes, 2Age Concern) have increased opportunities for older people to be physical activities (Estimated reach – around 400 people attending courses such as Walk and Talk, Strength Training, Gentle Exercise, Water Aerobics, Tai Chi)
	3.2	Lit search for best practice – research, conferences, seminars	PW	One worker attending- ripple effect throughout workforce in organization. Knowledge gained by PW informed seminar to 45 PCP members and other workers.	
	3.4	Peer leadership and agency staff training in Tai Chi	10 peer staff and 5 allied health	15 trained Tai Chi in Wodonga and surrounding communities.	Tai chi is now offered in five new settings. No Tai Chi for arthritis had been run prior to this. 100% of the 15 Tai Chi trainers report changed knowledge.

HP Intervention	No.	Strategies	Who	Reach (who heard the message?)	Impact Indicators (what has changed?)
4. Social marketing	4.1	Radio interviews (6, including one in Melbourne)	PW	Potential reach 5,000+ in target audience.	Estimated change in behaviour of 10% of listening audience (500). Estimated change in knowledge 80% (4500) Estimations in the absence of social marketing surveys (beyond the scope of project funding).
	4.2	Two newspaper articles in the newspaper of each of the 7 major towns	PW and CH workers	Potential reach 100% of target population who read newspapers. (Estimate this includes all older people who are able to read.)	Estimated change in behaviour of 10% of reading audience. Estimated change in knowledge 80% Estimations in the absence of social marketing surveys (beyond the scope of project funding).
5. Organisational development	5.1	Establish sectorial reference groups	PW	Three groups established -community health workers, allied health and HACC services. Average of 12 participants per group.	Improved service provision and knowledge of issues amongst workers relating to falls and the importance of PA for OP in the community. Better communication between agencies leading to improved services for community. The aim is for residential, community and hospital settings to implement improved practice around falls prevention.
	5.2	Implement Home Assessment for Safety and Security Program	PW, 3 LGAs, 4 agencies	3 LGAs in implementation stage. Estimated reach within 12 months is 200 homes. *Possible reach is all homes requested by target group in 3 LGAs (ongoing as agreement reached that LGAs auspice the program overseen by Local Safety Committees).	3 LGAs agree to uniform assessment of homes and promotion of uniform prevention strategies using HASS program. 100% commitment to conducting all requested home assessments of target group Increased knowledge of falls risks and general home safety (estimate 16% of catchment population or 60% of population aged 65+)
6. Community action	6.1	Support community action group in skill development and participation in Community health Action Plans and lobbying for appropriate PA training for carers	WHGNE, PW, 2 carer volunteers	8 women have undertaken an intensive education series of 7 full days. 2 women from the group advocated for strength training. To date 30 women from locations across the UHPCP catchment and Alpine Shire have expressed interest in undertaking the training.	25% of the carers attending the community action group training have advocated successfully to have strength training offered to carers.
7. Economic and regulatory activities					

*Definitions are in Appendix 2

Template d: Health promotion planning OR reporting template

(This is the revised version released in August 2002)

This Template may be used as a planning template, or as a reporting template. For a Planning Template, write in Estimates. For a reporting template, write in Actuals.

Program name
Program goal
Population group/s

Program objective	**Intervention/ Capacity Building Strategies (from Template c)**	**Estimated OR Actual Impacts (Qualitative and/or Quantitative) (Template c)**	**Estimated OR Actual reach (from Template c)**	**Timelines and By Whom (from Templates a and b)**	**Estimated OR Actual Staff Costs (including staff oncosts)**	**Estimated OR Actual Consumables**	**Estimated or Actual Total cost**
	1.1 1.2 1.3 …						
	2.1 2.2 2.3 …						
	3.1 3.2 3.3 …						
	4.1 4.2 4.3 …						

Program objective	Intervention/ Capacity Building Strategies (from Template c)	Estimated OR Actual Impacts (Qualitative and/or Quantitative) (Template c)	Estimated OR Actual reach (from Template c)	Timelines and By Whom (from Templates a and b)	Estimated OR Actual Staff Costs (including staff oncosts)	Estimated OR Actual Consumables	Estimated or Actual Total cost
	5.1 5.2 5.3 …						
	6.1 6.2 6.3 …						
	7.1 7.2 7.3 …						
	8.1 8.2 8.3 …						

Template d: Falls Prevention Health promotion reporting template

The 'Falls Prevention' example that follows is slightly different to the blank Template above (which is the revised one released in August 2002), as it was completed during 2001 with an earlier version of the template.

Program name Falls Injury Prevention

Program goal To reduce the number of injuries caused by falls

Population group/s Older people 65+ and Koories 40+

Program objective	**Interventions/ Capacity Building Strategies (from Template c)**	**Actual Impacts (Qualitative and/or Quantitative) (from Template c)**	**Actual Reach (who heard the message?)**	**Timelines and By Whom (from Templates a and b)**	**Actual Staff Costs (including staff oncosts)**	**Actual Consumables**	**Actual Total cost**
Objective 1: To increase level of awareness of falls risk factors and falls prevention strategies in target group	Implement Home Assessment for Safety and Security (HASS) Program			(see 5.1)			$0
	Talks to Community Groups (20)	Pre test and post test of existing awareness shows doubling of awareness. An estimated 75% state that they will make changes to improve their health as a result of attending the session. (Based on sample survey of 12 groups with average of 25 participants and carers in each group)	Possible reach 500.	PW - ongoing	2 hrs per talk @ $27.50 $1100	$800	$1900

Program objective	Interventions/ Capacity Building Strategies (from Template c)	Actual Impacts (Qualitative and/or Quantitative) (from Template c)	Actual Reach (who heard the message?)	Timelines and By Whom (from Templates a and b)	Actual Staff Costs (including staff oncosts)	Actual Consumables	Actual Total cost
	Distribute HASS Information Booklet	Increased knowledge of falls risks and general home safety (estimate 16% of catchment population or 60% of population aged 65+)	All requested homes (approximately 200 over the 3 LGA / PCP catchment)	HASS volunteers	In-kind	N/A	$0
	August 22, 2001 Seminar	100% of PCP agencies working with older people report increased awareness of physical activity, strength training and balance improvement (e.g. tai chi) and all relevant agencies (5 hospitals, 7 CHS, 3 LGA HACC services, 5 Nursing Homes, 2Age Concern) have increased opportunities for older people to be physical activities (Estimated reach – around 400 people attending courses such as Walk and Talk, Strength Training, Gentle Exercise, Water Aerobics, Tai Chi)	Approx 45 participants (16 PCPs; 12 other agencies)	PW	10 days @ $220 per day $2200	$1500	$3700

Program objective	Interventions/ Capacity Building Strategies (from Template c)	Actual Impacts (Qualitative and/or Quantitative) (from Template c)	Actual Reach (who heard the message?)	Timelines and By Whom (from Templates a and b)	Actual Staff Costs (including staff oncosts)	Actual Consumables	Actual Total cost
	Lit search for best practice – research, conferences, seminars		One worker attending- ripple effect throughout workforce in organization. Knowledge gained by PW informed seminar to 45 PCP members and other agency workers. Ripple effect further into community as workers used their new knowledge in their practice.	PW – by August 2001	20 days @ $220 $4400 Conference/ seminar costs $575	$800	$5775
	Peer leadership and agency staff training in Tai Chi	Tai chi is now offered in five new settings. No Tai Chi for arthritis had been run prior to this. 100% of the 15 Tai Chi trainers report changed knowledge.	15 trained Tai Chi in Wodonga and surrounding communities.	10 peer agency staff and 5 allied health staff by February 2002	40 hours @ $27.50 $1100	$250 x 15 leaders $3750 + $450	$5300
	Radio interviews (6, including one in Melbourne)	Estimated change in behaviour of 10% of listening audience (500). Estimated change in knowledge 80% (4500) Estimations in the absence of social marketing surveys (beyond the scope of project funding).	Potential reach 5,000+ in target audience.	PW	12 hours @ $27.50 $330	$80	$410

Program objective	Interventions/ Capacity Building Strategies (from Template c)	Actual Impacts (Qualitative and/or Quantitative) (from Template c)	Actual Reach (who heard the message?)	Timelines and By Whom (from Templates a and b)	Actual Staff Costs (including staff oncosts)	Actual Consumables	Actual Total cost
	Minimum of one newspaper article in the newspaper of each of the 7 major towns	Estimated change in behaviour of 10% of reading audience. Estimated change in knowledge 80% Estimations in the absence of social marketing surveys (beyond the scope of project funding).	Potential reach 100% of target population who read newspapers. (Estimate this includes all older people who are able to read.)	PW and CH workers	14 hours @ $27.50 $385 Plus in-kind from CH workers	$60	$445
	Establish sectorial reference groups	Improved service provision and knowledge of issues amongst workers relating to falls and the importance of PA for OP in the community. Better communication between agencies leading to improved services for community. The aim is for residential, community and hospital settings to implement improved practice around falls prevention.	Three groups established -community health workers, allied health and HACC services. Average of 12 participants per group.	PW	12 hours @ $27.50 $330	$830	$1160

Program objective	Interventions/ Capacity Building Strategies (from Template c)	Actual Impacts (Qualitative and/or Quantitative) (from Template c)	Actual Reach (who heard the message?)	Timelines and By Whom (from Templates a and b)	Actual Staff Costs (including staff oncosts)	Actual Consumables	Actual Total cost
	Implement Home Assessment for Safety and Security Program	3 LGAs agree to uniform assessment of homes and promotion of uniform prevention strategies using HASS program. 100% commitment to conducting all requested home assessments of target group	3 LGAs in implementation stage. Estimated reach within 12 months is 200 homes. *Possible reach is all homes requested by target group in 3 LGAs (ongoing as agreement reached that LGAs auspice the program overseen by Local Safety Committees).	PW, 3 LGAs and 4 agencies by December 2002	PW 60 hours @ $27.50= $1,650 In-kind contribution from LGA and other agency workers	$412.50	$2, 062.50
	Support community action group in skill dev and Partic in CH Action Plans & lobbying for PA training for carers	25% of the carers attending the community action group training have advocated successfully to have strength training offered to carers.	8 women have undertaken an intensive education series of 7 full days. 2 women from the group advocated for strength training. To date 30 women from locations across the UHPCP catchment and Alpine Shire have expressed interest in undertaking the training.	WHGNE, PW, 2 carer volunteers	5 hours @ $27.50 $137.50 In-kind from WHGNE and carer volunteers	$60	$197.50
							Total

Template e. What we've learnt from our work - achievements, challenges and issues

(This can be done as an individual reflection, or a group process. The questions are posed as a prompt. Feel free to adapt them!)

PROJECT TASK

Name of intervention

……

1. When you think about the project, what are the highlights for you?
2. What are three things that worked particularly well? (from your perspective and from participants' feedback)
3. What are three things that didn't work well?
4. If you were to do this again, what would you do differently?
5. What issues arose during this project/ work?
6. What lessons have come from it for future planning/ work?
7. Have you identified any gaps in terms of who is not attending / who the project is not reaching?
8. Did you facilitate inclusiveness and diversity? What needs to happen to make your project or work responsive to the needs of diverse groups? In the program? In your practice?
9. Did you aim for equity and gender sensitivity in your project or work? What needs to happen to increase responsiveness to the needs of men and women? In the program? In your practice?
10. What did you find out that was new or unexpected – about the health issue, or about the community or target group? What further research or work is needed? How do we add what we've learned to the body of knowledge?
11. Who were your partners in this project/ work (both formal and informal)?
12. Reflect on the process of working in partnership. How did it go? What were the enablers and the barriers? (Ask the first 6 questions again in relation to the process itself.)

Alternatively, use the outline offered by DHS for a Narrative:

Description of the project; Successes and unexpected outcomes; Enablers and barriers; Lessons learned and recommendations; Other comments.

Template e. What we've learnt from our work … Falls Prevention example

(Abbreviated!) Increasing the availability and the range of opportunities for older people to participate in physical activity gave the best results for our investment across a range of chronic diseases as well as Injury prevention – Falls Injury Prevention.

Successes and unexpected outcomes

Partnerships: The project achieved greater success through the positive input of community health and allied health workers. Through the UHPCP framework, **partnerships were easily formed** for this project as networking was already well established, and trust was well founded between members – especially those directly involved in this project.

Increased opportunities for physical activity: A major achievement of this project has been that all seven major towns in the catchment (as well as many hamlets, e.g. Eskdale and Bethanga) have taken up the challenge of initiating new opportunities for older people to become involved in Tai Chi, Strength Training, and a range of other physical activities. Trained local volunteers are now supporting these activities which will ensure the sustainability of this initiative. **These volunteers are now making a real difference to the health and well being of their community.**

The HASS Program: Adoption of Home Assessment for Safety and Security (HASS) program across PCP catchment. This has come about through the Wodonga Community Safety Committee, in partnership with the Towong and Indigo shires, the Police, CFA, DVA and Neighbour Watch program. **The positive outcome from this process is the sustainability of this initiative.**

The success of Tai Chi: Recruited and trained community members and agency staff to run Tai Chi for arthritis classes. The money to do this came through a partnership with Vic Health specifically for a program in Wodonga (Plaza Walking Group). Invitations were circulated through PCP and HACC best practice for agency staff and members of the community known to them. **The result has been cost effective, time effective and spread the availability of Tai Chi across other interested agencies and settings.** They have utilized the program not only for falls prevention but to help with pain management, Metal Health programs for Older People and Carers' in other towns, being Wangaratta, Tangambalanga Rutherglen and Bethanga. (etc. etc.!)

Enablers

Communication: Good communication between service providers about health promotion opportunities and services; Service providers need to know what is available in relation to physical activity opportunities for target group; Updated information about what activities are available is vital for referral opportunities; Local newspapers are still a very important local communication tool;Develop strategies to improve information exchange within local communities and surrounding major towns about health promotion opportunities and available services.

G.P Engagement: To be successful with GPs, health promotion opportunities need to be linked with existing projects run by GP Divisions. e.g. diabetes and physical activity.

"Try before you buy": The target group like a "try before you buy" approach i.e.: they like to experience the activity before committing. The lack of obligation enables them to feel more relaxed about trying something new. **(etc. etc.!)**

Barriers

Rural Isolation: Traditional communication links for older people in isolated rural towns and/or communities need to be rethought. The lack of banking services in small country towns means that older people no longer visit these towns regularly, because of this they are missing out on the informal /casual information exchanges that once occurred, because of this they no longer access community notice boards or posters in shops etc

Involvement of men: Men are still very difficult to engage in organised health promoting activities. Especially older males who live on farms and who have forgotten how to walk because they use a motor bike all the time??!!:

Inclusiveness and diversity: Further work will be undertaken this year to increase the participation of diverse groups within the catchment, particularly the involvement of the aboriginal community.

Lessons learned and recommendations

The community is at a contemplative stage in that they have a general awareness about the need to be physically active, but need appropriately targeted opportunities to participate. The work done by the falls project needs to be linked into the information management strategy to ensure current information about activities is available. We need to continue to promote within the service system new research knowledge about risk factors related to falls prevention eg vision loss. We will continue the falls prevention project for a further 12 months.

We need to develop strategies to improve the information exchange within local communities and surrounding major towns about health promotion opportunities and available services. Strategies are needed to improve communication and the engagement of the Koori community (etc. etc.!)

Any other comments?

The lack of a good public transport system really affects older people and the problems getting worse as the population ages; The implications of litigation and insurance and there impact on older people, volunteers and sporting groups is enormous. Something has to be done or all our hard work will go out the window!!!; We need an industry standard/general qualification, which is not too expensive or time consuming to get, for community workers/volunteers who facilitate under supervision exercise groups of various kinds for OP.

Appendix 1 — Methodology

Working in partnership was the driving force behind this project. We approached this project believing it was necessary to engage with other PCP members and other organisations beyond the PCP, and with the community.

Partnerships worked at several levels. Initially, much work was devoted to defining roles for each of the four agencies which collaborated to complete the Service Planning/Health Promotion Project (of which, this Health Promotion Strategy is one part). This focus on process ensured a sound approach to "how the work was done".

Following this, the emphasis moved to the project task, or "what was to be done". A series of workshops with the broader Upper Hume PCP membership was held. This ensured our growing understanding of different aspects of health promotion was shared across the broader UHPCP membership. Equally important, the knowledge we gathered was informed by our combined experience. At these workshops, the theoretical framework for health promotion was built.

In the first workshop, the vision, principles and shared objectives were agreed upon. In the second, issues relating to collaborative work in planning were explored. The third workshop presented the Program Logic method of Evaluation, and a session on evaluating through a gender lens. (See Table 1 below.)

A written survey was conducted to identify health promotion priorities and service planning processes. Of the 26 UHPCP member organisations, 20 responded. To supplement this, focus groups and interviews were held with four networks or representatives of the following sectors: education/ youth; environment; sport and recreation; and a community safety committee. The written survey was also used as the interview schedule to ensure consistency in data collection. Responses were coded and analysed using Minitab software. Thematic analysis was used for responses to the more complex open questions (using the techniques offered in NUDIST software).

The first health promotion priority identified at the start of the project was Falls Prevention. The Health Promotion Planning and Evaluation Framework was developed and tested in close consultation with Upper Hume Community Health Service which had lead agency responsibility for the Falls Prevention Pilot Project.

The framework has been guided by the current State Government directions. For example, wherever possible we have used Departmental proformas and preferred theories. In this Health Promotion Strategy, they have been simplified to ensure they are accessible and practical for on-the-ground workers.

Table 1: Organisational Development

Identify key service planning processes across UHPCP region in literature (facility to post on website)	**WHGNE**	100% agencies participating and agreeing to process
Combined work planning and evaluation of the hp collaboration	Process facilitated by WHGNE	100% partner agencies participating and agreeing to process
Vision, principles, shared objectives workshop (April 6, 2001)	WHGNE (with partner agencies)	Input from 100% Partner agencies on agenda Consensus on vision and objectives
Collaboration Workshop (August 22, 2001)	WHGNE (with partner agencies)	Input from 100% Partner agencies on agenda 80% participants report increased knowledge and understanding Consensus on key elements of partnerships
Presentation at AES International conference in Canberra	WHGNE	Input from 100% partner agencies on content
Evaluation workshop (February 13, 2002)	WHGNE (in collaboration with CHPE)	Jointly planned 80% participants report increased knowledge and understanding
Identify key service planning processes across UHPCP region - develop consultation tool and process - consultation mail out - telephone follow up -focus groups	**WHGNE**	Increased consideration of hp priority setting by all participating PCP member agencies. Increased awareness of PCP beyond PCP members
Document key service planning processes	**WHGNE**	Increased understanding of partnership and planning processes in UH.
Develop a draft framework to coordinate and evaluate health promotion, involving relevant agencies around one hp priority (Falls)	**WHGNE**	Several agencies working together around one hp priority
Circulate framework for comment to develop common understanding of good practice HP and to validate framework		90% of PCP partners
Produce final report and ongoing CB action plan	**WHGNE**	

Appendix 2 — Definitions

Community action (for social and environmental change) 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. [8]

Economic and regulatory activities. This action involves the application of financial and legislative incentives or disincentives to support healthy choices. These approaches typically focus on pricing, availability, restrictions and enforcement.

Evaluation is the process of determining the merit, worth and value of things, and evaluations are the products of that process.[9]

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

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 personal responsibility for actions affecting their health.

Health Promotion is "the process of enabling people to increase control over, and to improve, their health."[10] Health is defined as "a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity'"[11].

Impact evaluation measures the immediate effect of the programme (does it meet its objectives?)

Organisational Development for Health Promoting Practice is strengthening organisational support for health promotion within provider agencies through elements such as Policies and strategic plans, Organisational management structures, Management support and commitment, Recognition and reward systems, Information

[8]Except where noted otherwise, definitions are from Public Health Aged, Community and Mental Health (December 2000). *Primary Care Partnerships Draft Health Promotion Guidelines.* Melbourne: Victorian Government DHS. Some definitions were updated in August 2002 in a DHS Information Resource for Agencies.

[9] Scriven, M. (1991). *Evaluation thesaurus 4th Edition*. NY:Sage Publications.

[10] World Health Organisation 1986, *The Ottawa Charter for Health Promotion*, Geneva

[11] World Health Organisation 1958, cited by Wass, A. 2000, Promoting Health: The Primary Health Care Approach, Second edition, Harcourt Saunders, Sydney, p. 7.

systems—monitoring and evaluation, Information resources, Quality improvement systems and Informal organisational culture.

Outcome evaluation measures the medium and long-term effect of the programme (does it meet its goals?)

Process Evaluation Hawe et al. defines Process Evaluation as the activities of the program, programme quality and who it is reaching. However process evaluation is often a broader term which involves consideration of how the project or work has been implemented.[12]

Reach In this document, "Reach" has been used as the term to describe how many people heard the message.[13]

Resources refers to ensuring and/or developing resources to support health promotion, and allocating them strategically. This includes Human resources, Financial resources, Information resources including research and specialist advice, Decision making tools and models, and Administrative and physical resources.

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 more comprehensive 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.

Settings and Supportive Environments action aims to improve the living conditions and working conditions conducive to health. Fo example, it includes:

- Economic and Regulatory Activities – which 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 – which involves a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular goal. It includes direct political lobbying.

Social marketing involves programs designed to influence the voluntary behaviour of target audiences to benefit this audience and society as a whole. It typically uses persuasive (not just information) and cultural change processes. It can involve raising public

[12] Definition used in this document, as understood by writers.
[13] Definition used in this document, as understood by writers.

awareness about a health issue through use of mass media eg. advertising in newspapers, magazines, pamphlets, and fliers or on radio, television etc. at local, state and national levels. It may also involve a mix of promotional strategies including public relations and face-to face communications. (See Health Information under 'H')

Social Model of Health is a conceptual framework for thinking about health. Within this framework, improvements in health and wellbeing are achieved by directing efforts towards addressing the social and environmental determinants of health, in tandem with biological and medical factors. This definition of health highlights the importance of understanding health and disease burden within the personal, social and cultural context specific to the person or community whose health is being considered. It is not possible to decide how best to support the improvement of health without understanding this context.[14]

Stakeholders may include community leaders, provider representatives and agency staff.

Settings are specific physical locations such as schools and workplaces.

Workforce development is about developing the health promotion skills and knowledge of the workforce. This could include On-the-job learning; Professional development opportunities/continuing education/undergraduate and postgraduate studies; Professional support and supervision systems; and Performance management systems.

[14] Aged, Community and Mental Health Division 1998, *A Stronger Primary Health and Community Support System: Policy Directions*, Victorian Department of Human Services, Melbourne.

Appendix 3 — Improving people's lives: Can we do it?

The Health Promotion Capacity Audit (developed through UHPCP, by Upper Murray Health & Community Services 200) identified a range of areas that either support or detract from the ability to do health promotion well. In conclusion, complete this checklist to identify strengths and opportunities.

Is Management supportive?

- Is health promotion part of your organisation's day to day activities? ☐
- Managers have to report on health promotion achievements ☐
- Is there money and time allocated to health promotion? ☐
- Is health promotion in position descriptions:
    - For managers ☐
    - For workers at all levels ☐
- Is work in health promotion measured, eg. in performance reviews or workplans?
    - For managers/ For workers at all levels ☐
- There are ways the organisation shows its commitment to health promotion, e.g. health promotion meetings, resources, templates ☐
- Senior managers support or take part in steering committees for health promotion projects ☐
- Quality improvement systems for health promotion are in place ☐
- Workplace health promotion planning processes are in place ☐

Do you feel you can do it?

- I am suitably qualified and experienced ☐
- I have time for health promotion ☐
- I can be innovative and a leader in health promotion ☐
- I am aware of partners and networks that will help me ☐
- My project/activity is based on solid evidence ☐
- I am aware of how to report on my project/activity ☐

Have you talked to the community?

- Has the community had input into health promotion planning for your agency? Are they involved in:
    - Planning processes ☐
    - Policy development ☐
- Has the community had input into your project?
    - Have they helped identify the need ☐
    - Have they assisted with planning ☐
    - Are they involved in the project ☐
    - Will they help evaluate the project ☐

Appendix 4 — Identifying Expertise and Resources

The idea behind this information-gathering exercise is for you to create a database of expertise and resources, of organisations with expertise who could play a training or mentoring role with you in your role as a health promotion worker.

Contact key organisations and individuals and ask in relation to your project area:
What planning documents or frameworks do they know of which would be relevant?
What information and resources could they offer you, eg. in terms of speaking with workers, borrowing books, tapes, etc.?
Can they offer you training or mentoring?
Can they introduce you to networks that could be valuable?

Name of Organisation (think of both PCP members and non-members)	**Name of Contact person**	**Planning documents/ frameworks**	**Information & Resources - Human and Material**	**Training/ mentoring offered**	**Networks**
Women's Health (Example)		Women's Health Plan National Women's Health Plan Women's Health & Wellbeing Strategy	Library with specialist collections including evaluation and research – most available for loan Staff with expertise on gender analysis (make appointment to meet)	Help with setting up research or evaluation projects (mentoring) Group training Undertaking joint projects	WHAV WHS FV network
(Hypothetical example)	Local university		Extensive library … Staff with qualifications …	Accredited post-grad and under-grad units in research, planning, evaluation … In-house training …	

Appendix 5 — Evaluating with a gender lens!

How does someone's gender affect the way they experience health and health care?

While this question has an obvious relevance to women's health, all organisations deal with people, and people are gendered.

The link between gender and health is not universally recognised within the health sector. AT the start of last year, WHGNE was funded by the Victorian Government to develop a PCP Best Practice Project which would investigate the issue.

With just a few examples, the link between gender and health becomes clear.

Examples of gender differentiation in experience of health, and health services.

(1) A person walks into the outpatient department of their local hospital with an injury such as concussion, laceration, black eye. If it is a man with a black eye, we would probably assume he got it in a fight or playing sport (both of these may be seen to enhance his masculinity). If it is a woman with a black eye, we would probably assume she was hit by her partner in a domestic violence situation. By contrast to the man with a black eye, this is something to be ashamed of and to be hidden from society. So although it is the same physical injury – a black eye – how it happened, and the personal meanings may be very different for a man and a woman. (Dyson, 2001)

(2) Research tells us that a man who presents to his GP with a racing heart, will usually be sent for heart tests. A woman with the same symptom will usually be prescribed drugs for anxiety.

(3) Evaluation of health promotion messages show a strong gender bias. Advertisements showing blackened lungs being squeezed out had very little effect in terms of women giving up smoking. What was effective for women, were the ads showing a woman's face rapidly ageing as a result of smoking.

While these are simple and perhaps one-dimensional examples, the example of asthma illustrates how the influence of gender operates at a number of levels.

(4)Asthma is more common in boys than girls during early childhood. The prevalence equalizes between the genders during adolescence then switches to a female predominance in adulthood. The level of parental involvement in care giving, well being indicators and resilience levels differs for males and females. The Family Law Court in Victoria report incidences where access has been influenced by the fathers' lack of capacity to manage their child's asthma. Asthma Victoria has been approached by Family Law Courts to provide education for fathers to

improve their capacity to manage asthma. There is still gender bias in current research practice. One example is research which looks at 'patterns of family responsibility' but uses only mothers in the research. There are important gender related considerations for the health professional when dealing with asthma patients and their caregivers. For example, adolescent girls may be less compliant with tobacco avoidance, and less likely to quit due to concerns about weight gain. In adolescent males there can often be a denial of symptoms that can lead to under treatment and perhaps under diagnosis. There is anecdotal evidence that Doctors and other practitioners make gender assumptions about the role of carer. They could play a major role in all aspects of the asthma management.

By way of explanation for gender difference:

> We are born with biologically sexed bodies,and depending on what society we grow up in, we give each gender social and cultural meaning. As humans we are historical beings, we are not born in nature, we are born in societies, in a world culturally construed with laws, norms, values, symbols, and collective commitments. All cultures have forms of gender training, and all institutions, governments, schools, churches, families, [reiterate this gender training]. A woman in today's society can behave differently to a woman living a century ago. A woman in Australia can behave differently to a woman in another country. A woman of a particular socio-economic standing can behave differently to someone from a different strata. Gender is socially contructed.

So, how do we turn this new awareness - this theoretical understanding - into a way to make health services better for women and men?

One way is to evaluate through a gender lens.

Over the past decade or so, delivery of health services has moved from a provider-centred approach towards a user-centred approach. The measurements for success have moved away from counting the number of people seen, procedures undertaken, or professional activities towards more qualitative attempts to measure client satisfaction, and the broader effect on the health of the community.

So if the **focus of the evaluation** is the way an institution is managed, the **objective** may be to *identify institutional strategies that best respond to male and female users' rights, needs and possible options*. The **strategy** may be (1) to examine the organisation to see what promotes or impedes a gender-aware approach to health care and (2) to identify changes that we can make on personal, interpersonal and institutional levels. **Performance indicators** could be identified to measure the effects of these changes

There are perhaps two key messages that we want to be taken up by the health sector:

(1) that providers' personal and professional practices are developed in an institutional context, which either impedes or promotes progress, and

(2) that improvement depends on efforts that range from the receptionist's attitude, to the program's design and management, and through to state, national and international policies.

References:

International Planned Parenthood Federation's (IPPF) Proposal for Institutional Evaluation and Family Health International (FHI). URL:http://www.fhi.org

Dyson, S. One example given at training workshop, Benalla, 2001.

Appendix 6 — Gender and diversity framework

From Dyson, S. (2001). *Gender and Diversity: a workbook for an Equity Approach to Practice*. Frankston: WHISE.

See page 5 for diagram. Our apologies that this cannot be included here.

Appendix 7 — Useful resources and websites

Nutbeam, D. & Harris, E. (1998) *Theory in a Nutshell*. University of Sydney: National Centre for Health Promotion.

Defines theory and outlines two theories and three models to explain how to bring about change. A *Health Promotion Planning and Evaluation Cycle* is given in seven steps: *Problem definition* or redefinition (theory helps identify what are targets for intervention); *Solution generation* (theory helps to clarify how and when change can be achieved in targets for intervention); *Resource mobilisation* (theory indicates how to achieve organisation change and raise community awareness; *Implementation* (theory provides a benchmark against which actual can be compared with ideal program); *Impact assessment and Intermediate outcome assessment* (theory defines outcomes and measurements for use in evaluation; and *Outcome assessment*. (p. 12)

This book contains a very useful table on the use of theory in program planning and evaluation (p. 17). Planning phases (problem identification, solution planning, mobilizing resources, implementation and evaluation) are cross referenced with tasks and possible uses of theory.

A theory of organisation change is described as having four stages; Awareness raising, Adoption, Implementation and Institutionalisation (p. 58).
A model for effective Intersectoral action is outlined suggesting that three factors are necessary for success: (1) an understanding of the context, (2) an assessment of the infrastructure and (3) a planned approach to action and sustainability. Two case studies are presented under the headings Necessity, Opportunity, Capacity, Relationship and Action (p. 63).

Health Development Section, Public Health Division, DHS (2000) *Evidence-based Health Promotion: Resources for Planning No. 2 Adolescent Health*.

Seven recommendations are made to increase the effectiveness of HP interventions: Invest strategically to advance evidence-based practice; Invest in strong implementation; Request behavioural outcomes; Employ more than one HP strategy; Target multiple risk factors; Seek sustained intervention; and Identify and reward evidence-based practice. (pp. 19-20)

Baum, F. (1999). The New Public Health: An Australian Perspective. Melbourne: Oxford University Press.

This is a comprehensive text covering all aspects of the New Public Health that encompasses Public Health, Health Promotion, Primary Health Care, Community Health services and Social Health. Baum sees the term New Public Health "to be a useful all-embracing term. It signifies an interest in the broad range of social, economic and political activities implied in the Ottawa Charter and a commitment to community participation. Health promotion is one of the key aims of the New Public Health. Community health and primary health care are key strategic areas within the health sector (P. 512).

The section on qualitative research methods is particularly useful when planning and designing research.

Hawe, Dedgling & Hall (1994) Evaluating Health Promotion: A Health Workers Guide. Sydney: MacLennan & Petty Pty. Limited.

This book offers guidelines for quality evaluation, which will lead to better interventions. The design and layout are simple and provide a comprehensive common-sense guide to the evaluation process, using well-chosen examples to illustrate the key steps.

Part 1 discusses the approaches to evaluation, needs assessment, planning, process evaluation, impact and outcome evaluation.

Skills needed are discussed in Part 2 as are methods of surveying, questionnaire design, reviewing literature, running focus groups, choosing measures and seeking help.

Labonte, R. & Reid, E. (1997) Power, Participation and Partnerships for Health Promotion. Melbourne: VicHealth,

In the first chapter Reid discusses the role of health promotion in social change, about giving people power over the conditions of their own health and the necessity for changes in the practice of health promotion.

Labonte considers power relations in health promotion and Fields of Wellbeing (p. 15). He gives consideration to Risk Conditions, in particular Psychosocial and Behavioural risk factors, and the power relations that are central to participation and partnership practice. Chapter 3 offers power and empowerment exercises and the useful tables.
Chapter 4 looks at the value of health promotion and public participation in policy making giving a comprehensive outline of the benefits.
o Public participation directly improves the health and well being of many people by overcoming their isolation and perceived powerlessness.
o Participation can help mobilise community actions on issues that are more relevant to people's lives, and, can lead to improved policy decisions affecting the deeper determinants of health (risk conditions).
o Provides a building base for a "whole of governance" approach to solving problems (p. 42)

The three Phases of Collaboration, Problem setting, Direction-setting and Implementation are examined in the section relating to moving from participation to partnership.

Chapter 5 focuses on a Story Dialogue Method for Health Promotion Knowledge Development and Evaluation with Figure 2 (p. 71) clearly demonstrating the Steps in the Story Dialogue Method and its uses.

Owen, J. & Rogers, P. (1999). Program Evaluation: Forms and Approaches. 2nd Edition. St. Leonards NSW: Allen & Unwin

This Evaluation textbook offers clear guidelines on the fundamentals of evaluation and includes discussion about
· the why
· the what
· the planning,
· development of questions
· the application
· key players and resources and
· codes of behaviour
· Proactive, clarificative, interactive including action research, monitoring and impact evaluation.

It is interspersed with many figures and tables offering practical examples of projects where the proposed techniques have been used.

Patton, M.Q. (1997) Utlilzation-Focused Evaluation: The New Century Text, Edition 3. Thousand Oaks, California: Sage Publication

Patton approaches evaluation in a theoretical and practical manner. The how, what and why is supported by examples and anecdotes with a major focus on making evaluation useful. He comments on the increasing significance in the importance of evaluation in the private and independent sectors as well as the government. Corporations, philanthropic foundations and non-profit organisations are increasingly turning to evaluation for help in enhancing their organisational effectiveness (p. 15).

"Utilization-focused evaluation emphasises that what happens from the very beginning of a study will determine its eventual impact long before the final report is produced" (p. 20).

Patton uses "Exhibits" to précis the information in each section
For example: Guiding Principles for Evaluators are "exhibited" as:
Systematic Inquiry
Competence
Integrity/Honesty
Respect for People
Responsibilities for General and Public Welfare (p. 21).

The evaluator's role is to actively involve the primary intended users in the process for generating their evaluation and thereby ensuring that the evaluation questions are clearly understood and relevant for the intended use by the intended user. "Focusing an Evaluation" offers alternatives to goal based evaluation and discusses the challenges involved and the role of implementation analysis.

Appropriate Methods are discussed in Part 3 with credibility, use and validity being emphasised and Part 4 concentrates on realities and practicalities with a focus on power, politics and ethics.

Asking questions about impact-that's evaluation. Gathering data- that's evaluation. Making judgements-that's evaluation. Facilitating their use-that's evaluation. Putting all those pieces together in a meaningful whole they want to know and can use about a matter of importance. Now that's really evaluation! (Halcolm, in Patton p. 371)

Websites

Australian Bureau of Statistics
www.abs.gov.au

Victorian Department of Human Services
www.dhs.vic.gov.au

Victorian Health Promotion Foundation
www.vichealth.vic.gov.au

Victorian Burden of Disease Study: Morbidity
www.dhs.vic.gov.au/phd/9909065/index.htm

Victorian Burden of Disease Study: Mortality
www.dhs.vic.gov.au/phd/9903009/index.htm

Australian Burden of Disease and Injury Study
www.aihw.gov.au/publications/health/bdia/index.html

National Health and Medical Research Council
www.health.gov.au/nhmrc/

Australian Institute of Health and Welfare (AIHW)
www.aihw.gov.au

Social Health Atlas of Australia
www.publichealth.gov.au/atlas.htm

City of Wodonga
www.wodonga.vic.gov.au

Indigo Shire
www.indigoshire.vic.gov.au

Australasian Evaluation Society Inc.
www.aes.asn.au

Towong Shire
www.towong.vic.gov.au

Australian Institute of health and Welfare (2000). *Australia's Health 2000.* Canberra
www.aihw.gov.au/publications/health/ah00/index.html

Health Canada (1996) *Guide to Project Evaluation: A Participatory Approach*
www.hc-sc.gc.ca/hppb/familyviolence/html/1project

Australian Association for Social Research
www.socialresearch.org.au

Appendix 8 — Sample planning & evaluation sheets

In the following pages, you will find samples of feedback sheets collected from a variety of projects and sources including the Falls Prevention Project, Celebrating the Age We Are (Women's Health East, 1999), the Health Promotion Short Course (State Govt. of Victoria, 2001) and Women's Health Goulburn North East.

(i) Group Evaluation Form

Falls prevention and Physical Activity Information Session

Group Date

Can you tell me some things that may cause you to fall?

Please indicate with a cross (x) the level of knowledge of the group prior to this session.

Very poor	Poor	Reasonable Good	Very Good

Please indicate with a cross (x) the level of knowledge of this subject after this session.

Very poor	Poor	Reasonable Good	Very Good

Name something you might do as a result of attending this session that may prevent you having a fall.

(ii) Weekly evaluation sheet

Had you heard about this activity before? Yes No

Have you participated in this activity prior to today Yes No

Do you think you might continue this activity in future? Yes No

(iii) Final Evaluation Sheet

How many sessions did you attend?

Have you started any new activity as a result of attending this program?
Yes/No

If the answer is Yes, please elaborate

Have you recommenced any activity as a result of attending this program? Yes/No

Is there anything else that you are doing or have done as a result of these sessions? Yes/No. If Yes, please elaborate.

What did you find most valuable about the sessions?

What did you find least valuable about the sessions?

What did you enjoy most about the sessions?

What did you enjoy least about the sessions?

During the program, what was the most important source of information for you? Please rate the following from 1 (least important) to 4 (most important).

Printed material
Facilitators/speakers
Other women during the sessions
Time spent with other women during lunch

(Women's Health East, 1999, Celebrating the Age We Are)

(iv) Feedback sheet

Date & Place of workshop

1. Describe an idea that developed during the training that affected you personally.

2. Comment on a concept or proposal that caused confusion, raised doubts, or that you rejected for whatever reasons.

3. What topics and methods explored in the sessions are related in some way to your own work?

4. What topics or methods have nothing to do with your work, or were irrelevant to you?

5. In which topic or method were you most interested? Why?

6. Did the workshop satisfy your expectations for learning? Why or why not?

7. What suggestions do you have to improve the workshop?

(Dyson, 2001)

(v) Evaluation sheet

We would appreciate your feedback about the workshop. This Evaluation sheet will only take a few minutes to complete. Thank you for your thoughts and time in completing this form.

1. What aspects of the workshop did you find valuable?

2. What aspects were not useful or valuable to you?

3. How could the workshop have been improved?

4. Please indicate if you agree or disagree with these statements by circling the appropriate word:

(a) this workshop provided a good opportunity for me to have input into the Project

Agree Don't know Disagree

(b) my contribution was valued by the group

Agree Don't know Disagree

Appendix 9 — How to get all the theory without doing all the reading

Upper Hume
Primary Care Partnership

‘Your first book on health promotion – how to get all the theory without doing all the reading!’

Women's Health Goulburn North East and Upper Hume Community Health Service
2002

The simplest version of this book!

1. **Talk to people**
2. **Hear their issues**
3. **Understand the context**
4. **Challenge your own assumptions**
5. **Work out the best approach**
6. **Work at different levels**
7. **Evaluate**

Introduction

This resource is a *practical guide* for people *working to improve the wellbeing of people and their communities. It is relevant if you work in any number of* settings including community health, local government, community group, education, recreation, media, industry or business.

In this guide[15] we summarise the key points about:

- What guides our beliefs and understanding in promoting health and wellbeing (Section 1)
- What determines our health and wellbeing (Section 2), and
- How to make change (Section 3)
- What do we actually do, and how do we know if we've made a difference (Section 4)

We acknowledge the health and wellbeing of people is influenced by and includes every aspect of a person's life. This means it is important for us to work with individual people in the community, groups and organisations to create the changes needed for ongoing improvement in the heath and wellbeing of women, men and children of all ages and from different backgrounds.

This resource is drawn from, but not limited to, the DHS booklet 'Primary Care Partnerships – Draft Health Promotion Guidelines'. Details of this booklet and other resources are listed at the end.

Section 1: What guides our beliefs and understanding about health promotion?

DEFINITION	***'Health is a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity.'***
	World Health Organisation

This view of health means we consider the broad social factors contributing to health and wellbeing, rather than just looking at physical or biological factors. It recognises how fundamental conditions and resources such as peace, shelter, education, food, income, social justice and equity are necessary for a person's health and wellbeing. **Social Model of Health** (**) is a term used for this broader understanding of health.

The current understanding and commitment to health promotion by the Victorian State government is based upon the definition developed at the first *World Health Organisation International Conference for Health Promotion* held at Ottawa, Canada in 1986. The **Ottawa Charter** was formed at this conference and defined health promotion as:

DEFINITION	***'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 health lifestyles to wellbeing.***
	Ottawa Charter World Health Organisation 1986

The Ottawa Charter outlines five areas for action which have proven to work best when used in combination. The table overleaf gives an example beside each area for action:

Ottawa Charter: **Five areas for action**	**Example:** **Promoting Physical Activity**
Build healthy public policy	Council put in safe walking paths with toilets
Create supportive environments	Walking groups
Strengthen community action	Encourage input and participation in walking
Develop personal skills	Learning new skills, e.g. tai chi, bushwalking, yoga
Reorient health services	Raise awareness amongst health workers of the importance of physical activity for people from all backgrounds and ages

Other international and national conferences have endorsed and built upon the Ottawa Charter. The Jakarta 1997 Conference acknowledged the importance of the responsibilities of the broader community and governments for promoting the health and wellbeing of people and made these additional responses:

- Promote social responsibility for health
- Increase investments for health development
- Consolidate and expand partnerships for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

Section 2: What Determines Our Health and Wellbeing?

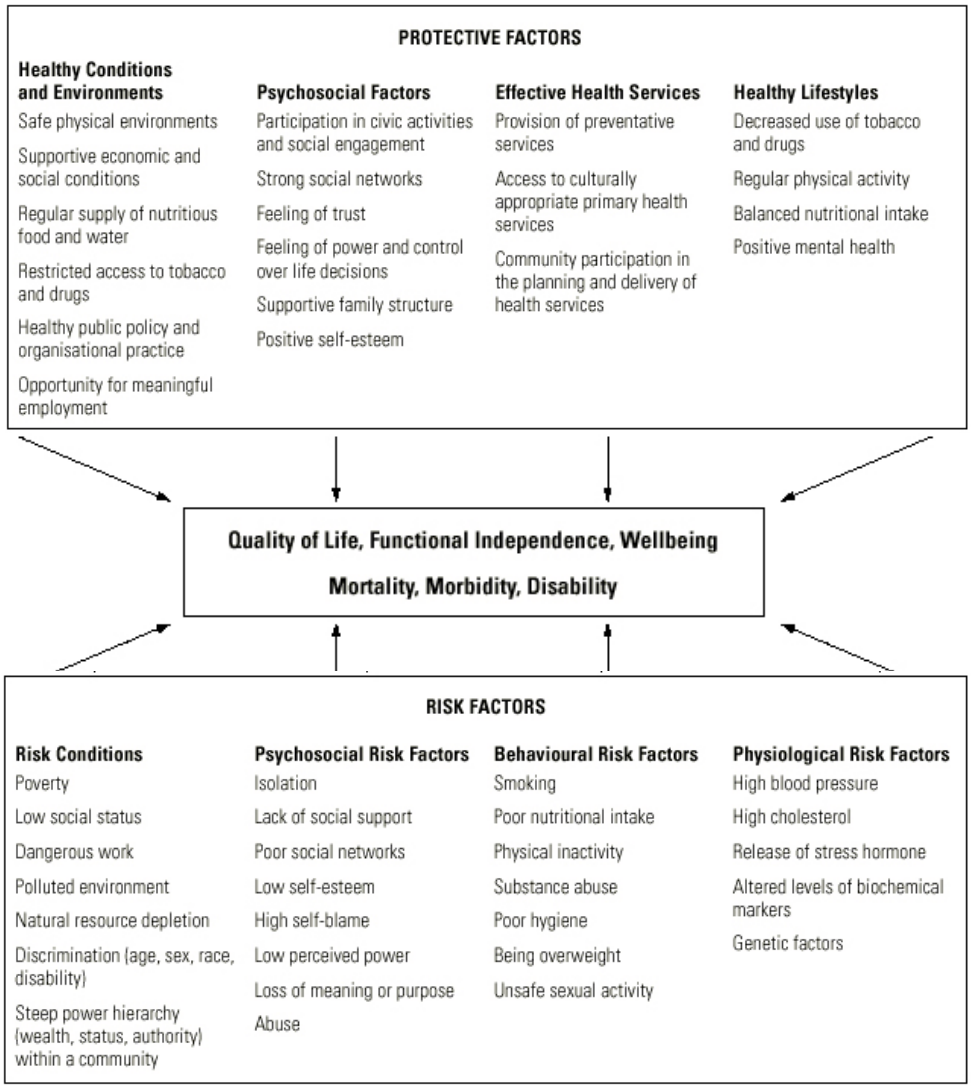
A person's health and wellbeing includes everything about their life.
These include the food we eat, where we live, the work we do, the friendships we have and the level of support we receive. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to health. Health promotion action aims to improve these conditions.

People's health status and needs differ enormously.
Health promotion action aims to reduce these differences and ensure all people have equal opportunities and resources to achieve their fullest health potential. Women, men and children from all cultural backgrounds backgrounds must have opportunities to make healthy choices. For this to happen, people need a supportive environment, access to information and life skills.

There is a relationship between people's living and working situations and their health and wellbeing.
For example, a person's life expectancy or a person's quality of life, sense of wellbeing and ability to actively participate in the community is likely to be increased if that person has an adequate income. Health Promotion action aims to ***strengthen communities*** – by putting effort into supporting the ways people come together and participate in a community. By doing this, we help build a resource often called '**social capital'.**

Figure 3 shows how the health and well being of an individual is influenced by the presence or absence of risk factors (such as poverty, isolation, smoking) and protective factors (such as safe environment, connection with friends and family, appropriate and accessible health services). It is important therefore to shift the focus from the individual and look at ways to influence change in the structural causes of ill health. In making decisions and policy about health, social conditions must be taken into account. Remember to look at the big picture.

Figure 1: The Determinants of Health



Guiding Principles of Health Promotion[16]

Address the broader determinants of health
Don't just look at the individual, but look more broadly at society's role in determining a person's health and well being.

Base activities on the best available evidence
Find answers as to why there is a need for action and what actions are most likely to make a lasting difference.

[16] (adapted from PCP Draft HP Guidelines, p. 20)

Act to reduce social inequities and injustice
Ensure individuals and groups from different backgrounds and situations benefit from living, learning and working in an environment that promotes health.

Emphasise active participation by individuals and the community
Ensure people have a say about what influences their health and wellbeing and what would make a difference.

Empower individuals
Provide support, information and skill development to help people understand what keeps them well and what makes them ill, and support them in making decisions about their health and wellbeing.

Explicitly consider differences in gender and culture
Recognise that we all understand our lives through our experience of being brought up as a man or a woman, and that differs according to the cultures we belong to.

Work in collaboration
Bring together all concerned – individuals, families, community groups, government departments, industry, business and the media. Work in partnership.

Section 3: How to Make Change

Taking a holistic approach

To make a difference in the long term, we must grapple with a number of questions. To help think about this more, ask yourself these questions, e.g. in relation to a health issue such as depression, HIV Aids or your own current project.

- How can we create supportive environments around this issue?
- How can we strengthen the community?
- How can we influence public policy on this issue?
- How can we foster collaboration between different organisations, government departments and community groups on this issue? Who needs to be involved?
- How can we make it easy for people to make healthy choices?
- What are some examples of actions already happening in your own community in relation to this issue?
- What are some of the organisational barriers preventing your ability to adopt a broader approach to this issue?
- How are personal values and professional attitudes likely to affect a socio-environmental approach to health promotion?

Health promotion approaches and interventions

Another way of looking at the work we do is by understanding different approaches. There are 3 main approaches to promoting health:

Medical
- improving physiological risk factors
eg high blood pressure, early cancer detection, immunisation

Lifestyle
- improving *behavioural risk factors*
eg smoking, diet, physical inactivity, stress management

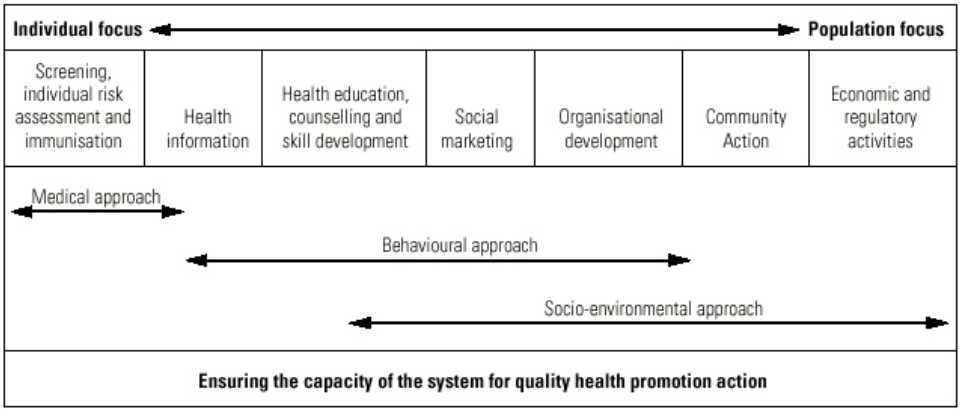
Socio-environmental
- responding to the broader, environmental and structural causes of ill health by understanding the link between a person's living and working conditions and their health – *(addressing the risk conditions and psychosocial risk factors*), e.g. poverty, unemployment, powerlessness, isolation and stress

The three approaches are most effective and powerful, when used in combination.

The 7 Health Promotion Interventions (Actions)

The State government has identified 7 interventions with clear definitions to ensure a consistent understanding of health promotion within Departmental programs. This is necessary to assist with funding, accountability and planning of programs. (See Figure 2 below)

Figure 2: Health promotion interventions



Descriptions of the 7 Interventions

1. Screening, Individual Risk Factor Assessment and Immunisation

- a systematic way of finding out who is at risk of developing a specific disease. It can include finding out about a person's lifestyle, or the risks to physical, emotional or mental health and wellbeing.

At a local level, screening is done by a range of professionals including general practitioners, nurses or staff at community based programs including alcohol and drug agencies, mental health outreach and community health staff.

Screening, immunisation and assessments about risk factors are best carried out at a local level as part of a planned program that is linked with a range of programs and services in a community. This will ensure there is opportunity for further health information or appropriate referrals, coordination of services and links to State or National policy and programs

EXAMPLE		***Screening for pap smears or skin cancer*** ***Immunisation for measles, tetanus or influenza*** ***Risk assessment tools, e.g. working with older community members to assess their physical environment for the risk of falls***

2. Health Information

aims to improve people's knowledge about what affects and determines their health and wellbeing and what services and support is available to improve and maintain health and wellbeing.

In an ideal situation, all people, no matter what their background or situation, will know where to find information about their health and wellbeing and who to approach for further information, treatment or support.

The question for health promotion workers – is how can we make sure people have the information they need to make informed choices about their health and wellbeing? We need to find ways to ask people!

EXAMPLE		*The answers will mean being creative about written material, telephone information services, use of videos, internet or finding ways to use local networks and link information sessions to existing group activities*

3. Health Education, Counselling and Skills Development

planned sessions in a group setting or one-to-one to improve knowledge and ability of people to make changes.

Settings include community health centres, schools, workplaces, general practices, and recreational venues or in the streets. It is important for such activities to be coordinated at the local community level to avoid duplication and promote consistency of information.

EXAMPLE		***Healthy cooking classes, personal financial budgeting skills or development of peer education programs***

4. Social Marketing -

- a planned program aimed at informing and educating individuals, groups or populations so people become aware of the need to make to changes to their behaviour. Social marketing can be directed at systems and social structures, such as schools and workplaces, for example in encouraging alcohol-free social events.

affecting groups of people as well as individuals and planners, policy makers or organisational structures can be just as much the focus of social marketing.

Social marketing at a local level may link with statewide, national or even international campaigns and involve a range of activities that are planned and evaluated.

EXAMPLE		***TAC have chosen to use TV and radio advertisements, and billboards to increase use of seatbelts and to reduce drink driving.***

5. Organisational Development

- aims to create a supportive environment for health promotion activities to take place within a variety of settings such as: schools, community health centres, local government, industry and sporting clubs.

This means the structures, policies and training programs or organizations are supportive for people to make decisions and plan activities that promote health and wellbeing.

EXAMPLE		***A health promotion program may choose to assist local schools to develop healthy eating school policies.***

6. Community Action

(for social and environmental change)

- aims to empower communities (both geographical and communities of interest) to build their capacity to create and maintain change to improve social and physical environments.

This means action to strengthen social networks, support community groups and make it possible for people to participate in making decisions about the programs and services for people. By

community, we mean both geographical and communities of interest – cultural, sporting and recreational, workplace, local government areas.

These actions help to strengthen communities and build social capital which leads to ongoing improvements in health and wellbeing of community members.

EXAMPLE		***Community members are involved in decision making about issues affecting their health and wellbeing – such as planning for services. Self-help or support groups for people experiencing specific health problems***

8. Economic and Regulatory Activities

- ***actions with a focus on policies and regulations*** about costs, availability, restrictions and enforcement of laws to give incentive or disincentives to support people making healthy choices.

Settings include local governments, hospitals, schools, workplaces, community bodies and industry and media.

EXAMPLE		***Local business is encouraged to make changes by offering an award for employers supporting stress management, healthy eating or complying to regulations about responsible alcohol service or cigarette sales.***

To help us think about the type of activities we might do within each health intervention, here are some examples. This also links back to the guiding principles and the Ottawa Charter.

Building health policy

- Advocate to government for change to regulations to reduce advertising for availability of unhealthy products
- Organise a lobbying or media campaign around an issue, such as better public transport
- Support stricter enforcement of key regulations (eg laws on noise, cigarette sales etc.)

Creating supportive environments: physical and social

- Work with local gym to establish ways to be more appropriate for older women
- Work with local schools to provide safe, harassment-free environment

Strengthening community action

- Establish a support group for people in particular situations eg those with HIV Aids
- Set up training course in management of community organizations
- Set up action group to tackle a particular issue (eg

Developing personal skills

- Run an education session for local schools about ways for schools to take action to support the emotional and social health of their students
- Run a peer education program to train community members to educate others

Reorientating health services to be more preventative and health promoting

- Share responsibility for promoting health by working with a broad range of groups, professionals and governments
- Continue research to encourage ongoing learning by workers and ensure the service provision is relevant
- Provide cultural awareness training for workers to ensure they sensitive and respectful.

Building capacity for health promotion work to continue

- Help communities develop resources and skills
- Make sure organizations, teams and individual workers have the resources, skills, knowledge and policies to carry out quality planning, implementation and evaluation of health promotion programs.

This means making sure there is money and people available to do health promotion and providing opportunities for ongoing training for workers including volunteers and key community members.

Working collaboratively

- Take the initiative in inviting other key people and groups to help in understanding the problem and finding solutions.
- Develop a shared vision with clear goals and roles for each partner
- Invest time in developing trust between partners
- Recognise issues about different experience and ways of working
- Find ways to encourage good communication and information sharing

Encouraging Community Participation

- Ensure processes are open so people can easily see your goals.
- Find ways to make it easy for everyone to be involved
- Make sure information is shared
- Encourage people to learn how to communicate with each other
- Foster respect and acceptance of difference between people

Promoting and Marketing your Programs

- Use local newspaper, TV programs to promote your program and increase awareness of health issues
- Link into networks and encourage community members to pass on information

In addition, there is a range of ways we can organise the focus of our work:

- Health Issues – mental health, heart disease, diabetes, oral health
- Lifestyle factors – physical activity, tobacco, safe sex initiatives
- Settings approaches – healthy schools, workplaces, hospitals
- Population approaches – blue collar workers, single parents, same-sex attracted youth, older people living alone)

Remember:

- Improved health and wellbeing for individuals, communities will occur if interventions are used in combination.
- All interventions must be planned and evaluated each intervention.

- All interventions have a part to play in making a difference.

(Prepared by Dee Basinski, Susie Reid and Debra Parkinson, Women's Health Goulburn North East, and Upper Hume Community Health Service, 2002. Adapted from Aged, Community and Mental Health, and Public Health (2000). *Primary Care Partnerships: Draft Health Promotion Guidelines*. Melbourne, Victoria: DHS, together with other sources.)

Appendix 10 — Questionnaire

During 2001, UHPCP has been working on a collaborative approach to Falls Prevention. The purpose of this survey is to help UHPCP identify the next health promotion priority.
If emailing back to Women's Health Goulburn North East (whealth@whealth.com.au), please complete this form by deleting the options that do not apply.

1. Name of agency or organisation you are representing

.....

2. Position held within the organisation
❑ CEO/ Director ❑ Manager ❑ Worker ❑ Volunteer

3. Please give a brief description of your organisation's role (including target group, geographic area covered, etc.)

.....

4. Is your organisation a member of more than one PCP
❑Yes (Please specify) ❑No ❑Don't Know

.....

5. Has your organisation identified any health promotion priorities over the past two years (e.g. cardiovascular disease, mental health)? ❑Yes ❑No ❑Unsure

If yes, please list:

1. .....

2. .....

3. .....

If the UHPCP could offer to pay its members to offer health promotion training / mentoring to other UHPCP member organisations, would your organisation be interested in:

(a) **offering** training or mentoring in **health promotion** ❑Yes ❑No ❑Unsure
(b) **receiving** training or mentoring in **health promotion** (unpaid) ❑Yes ❑No ❑Unsure

(c) **offering** training or mentoring in **planning & evaluation** ❑Yes ❑No ❑Unsure

(d) **receiving** training/mentoring in **planning & evaluation** (unpaid) ❑Yes ❑No ❑Unsure

(e) participating in a self-help network on **health promotion** (unpaid) ❑Yes ❑No ❑Unsure

(f) participating in a self-help network on **planning & evaluation** (unpaid) ❑Yes ❑No ❑Unsure

For **two health promotion priorities** identified by your organisation, please answer questions 6 and 7. *(To save space, the repeated question is not included in this Appendix*)

6. Health Promotion Priority 1 (*Please name*) .....

(a) Could you indicate why this was chosen as a health promotion priority (*tick as many as are applicable*)

- ❑ Departmental directive/ National/ State health promotion priority
- ❑ Core business of organisation
- ❑ Identified through data sources, such as Australian Bureau of Statistics, Dept. of Infrastructure, Burden of Disease, agency- or sector-specific data, etc.
- ❑ Identified through own research or experience of the agency
- ❑ Reaction to incident or media coverage
- ❑ Other (please specify) .....

(b) Please list any activities or strategies developed to address this health promotion priority.

1. .....

2. .....

3. .....

(c) Please list any other suggested activities or strategies that you feel **could be developed** in the future to further address this health promotion priority.

1. .....

2. .....

3. .....

(d) What particular groups are targeted (if any)?

.....

(e) Please list any agencies or organisations that you currently work with in addressing this health promotion priority.

1. .....

2. .....

3. .....

4. .....

5. .....

(f) Please list any agencies or organisations that you would **like to** work with in further addressing this health promotion priority.

1. .....

2. .....

3. .....

4. .....

5. .....

(g) What constraints, if any, limit your organisation's capacity to work in partnership with other organisations?

.....

(h) What would make it easier for you to work in partnership?

.....

Feel free to add any further comments. Results from this survey will be collated, together with results of a survey of non PCP member organisations. This research will inform the development of the draft Health Promotion Planning and Evaluation framework, which will be presented to the UHPCP at a workshop on May 14.
Thank you for participating in this survey. *Please email back to Women's Health Goulburn North East, whealth@whealth.com.au, or post to WHGNE, PO Box 853, Wangaratta, 3676, by* ***Friday February 8, 2002****. Phone Debra Parkinson on 03 57 223 009 for more information.*

Appendix 11 — Detailed survey results

Twenty PCP member organisations responded to the survey. Just under half were completed by Managers, a quarter by CEOs, and just over a quarter by workers.

A quarter of respondents reported membership of more than one PCP.

95% of the organisations had identified specific health promotion priorities within the past two years (only one of the 20 had not).

While the great majority of respondents (95%) named at least one health promotion priority that had been identified by their organisation, three quarters named two, and over half named three.

A total of 45 priorities were identified by the 20 organisations. As shown in Table 2, over half fell within the national health promotion priorities. Most were around mental health (mentioned eight times), injury prevention (8) and CVD (8) with diabetes (3), asthma (3), cancers (2) mentioned less often.

The specific populations targeted accounted for 12% of priorities and included such groups as men, women, children and families, young people, older women, carers, Aboriginal people and people with a disability.

Table 2: Categories of health promotion priorities for all three identified HP priorities:

N=60	N	%
National Health Promotion Priorities	32	53
HP targeted to specific populations	7	12
Preventative health	1	5
Safety and personal safety	5	8
None identified	15	25
Total	60	103

Respondents were asked to choose a health promotion priority identified by their organisation and answer a range of questions in relation to just that priority.

Table 3 shows that for the chosen priority, almost three-quarters fell within the national health promotional priorities. Four respondents chose a mental health priority, four chose CVD, three chose injury prevention, and one each chose asthma and diabetes.

Table 3: Categories of health promotion priorities for first named HP priority:

	N	%
National Health Promotion Priorities	14	70
HP targeted to specific populations	3	15
Preventative health	1	5
Safety and personal safety	1	5
None identified	1	5
Total	20	100

A total of 47 reasons were given for the choice of this priority. (The question allowed more than one reason to be given.) Table 4 shows that a third chose their priority as a result of their agency's own research or experience. The other reasons were fairly evenly divided between Departmental directives or National/State priorities, Other data sources, or because it was the core business of the organisation.

Table 4: Reasons for choosing health promotion priorities

N=	N	%
Identified through own research or experience of agency	16	35
Departmental directive/ National, State HP priority	10	21
Identified through data sources, e.g. ABS, BOD, etc.	10	21
Core business of organisation	8	17
Other	3	6
Total	47	100

All 20 organisations noted at least one strategy they use to address the identified health priority. Most (18) identified two strategies, and almost half identified three. (The questionnaire only asked for three strategies.) A total of 47 strategies were identified. Table 5 shows that when grouped into seven health interventions (Draft Health Promotion Guidelines), The great majority were *Health Education, Counselling and Skill Development* strategies. A quarter were *Organisational development* strategies. Around 10 per cent were Community Action strategies, and 4 per cent each were Health Information and Social Marketing strategies.

Table 5: Strategies currently used to address health promotion priorities

N=47	N	%
Health information	2	4
Health education, counselling, skill development	27	57
Community action	4	9
Social marketing	2	4
Organisational development	12	26
Total	47	100

Thirteen agencies noted between one and three strategies that could be developed in the future to further address their identified health promotion priority. A total of 27 potential strategies were listed. Table 6 shows about a third fitted within Health Education, Counselling and Skill Development, and a further third were Organisational Development strategies. Almost a quarter were Community Action strategies.

Table 6: Strategies to be developed in the future

N=47	N	%
Health information	1	4
Health education, counselling, skill development	8	30
Community action	6	22
Social marketing	3	11
Organisational development	9	33
Total	27	100

Examples of the kind of strategies are:

Health education, counselling, skill development
: Sporting activity; exercise program; peer education; GP training; individual support to target group; specialised programs.

Organisational development
: Partnership approach; single point of entry; multi-disciplinary team; connections within and between agencies; changes to funding.

Community action
: Support groups; lobbying; rural community development.

Social marketing
: High level promotion; theatre workshops.

Health information
: Information centre; information dissemination.

Respondents mentioned 14 different groups of people as particular groups they target for their health promotion work. Specific groups included Older people, Middle years people, Adults, Children, Young Rural Males, People with a disability, Individuals with a recognised disease, the Aboriginal community, Carers and Health professionals. In addition to this, many mentioned the community as a whole. There was a very even spread across the groups with the exception of Older people which was a target group for four organisations.

UHPCP members are currently working with a diverse range of partners. The survey asked for all the partners that organisations were working with on their identified health promotion priority, and the 20 respondents noted a total of 71 current partners. They were also asked who they would like to work with in the future. These were grouped into 13 categories as shown in Table 7 below.

Table 7: Proportions of partners - current and future (of UHPCP members who responded to the survey)

	Current		Future	
	N	%	N	%
Community agencies (e.g. Mungabareena, UMFC)	12	17	8	24
Community health	11	15.5	8	24
Specific peak body/group (e.g. Diabetes)	11	15.5	3	9
PCP, networks	5	7	3	9
Community groups (e.g. Church, Senior Cits, RSL)	9	13	2	6
Hospitals	4	6	2	6
GP/ GP divisions	3	4	2	6
Schools	2	3	2	6
Police, Courts	0	0	2	6
Other (target group, other referrals)	1	1	1	3
Local government	7	10	0	0
Government departments	5	7	0	0
Business	1	1	0	0
Total	71	100	33	99

All 20 were currently working with at least one partner on the health priority they had identified. Two were working with six partners. The range is shown in Table 8 below:

Table 8: No. of organisations currently working with between one and six partners

	1 partner	2	3	4	5	6
No of organisations	20	16	10	7	6	2

Fourteen of the 20 respondents noted at least one other partner they would like to work with in the future. Table 9 shows the range:

Table 9:No. of organisations wanting to work with other partners in the future

	1 partner	2	3	4
No of organisations	14	8	5	1

Sixteen respondents noted constraints that limit their capacity to work in partnership with other organisations. Of these, more than a third mentioned time restraints, another third mentioned the limited size of their workforce. Other constraints mentioned were limited programs available in the specific health area; limited financial resources; lack of shared approach; lack of opportunity.

Where respondents noted more than one, subsequent constraints included lack of local input into decision making of national priorities; the focus on targets by funding bodies; distance and communication difficulties.

Eleven respondents suggested nine factors which would make it easier to work in partnership. Three noted the need for better infrastructure funding or increased resources. Other factors were continuing the PCP, improving network structures, building trust and communication in work, developing a shared understanding, more community education, wider recognition of mental health issues, and location of service within the community.

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