



# Community and Women's Health Services Information Resource

## Health Promotion Reporting 02-03 and Planning and Reporting 03-04

This information resource focuses on Health Promotion Reporting 02-03 and Planning and Reporting 03-04. This is as a consequence of the Department's new funding approach for Community and Women's Health and the Primary Care Partnership strategy. Further information can be obtained from Primary Health Knowledge Base - <http://www.dhs.vic.gov.au/phkb> under Health Promotion in Community Health or Women's Health.

### Introduction

Health Promotion is "the process of enabling people to increase control over, and to improve, their health."<sup>1</sup> Health is defined as "a complete state of physical, mental and social wellbeing, not merely the absence of disease or infirmity."<sup>2</sup>

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.

Strengthening health promotion planning and reporting in Community and Women's Health Services builds on the policy framework introduced through the PCP strategy. The expected outcomes of this strengthened approach are a greater focus on planned and integrated health promotion that will improve the health of local communities.

The impetus for this shift partly arises from the recognition that health promotion programs are increasingly important as core elements of responsible service delivery. Given the prominence of information related to the burden of

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<sup>1</sup> World Health Organisation 1986, *The Ottawa Charter for Health Promotion*, Geneva

<sup>2</sup> World Health Organisation 1958, cited by Wass, A. 2000, *Promoting Health: The Primary Health Care Approach*, Second edition, Harcourt Saunders, Sydney, p. 7.

disease, the need for the reorientation of the primary care system (to become more integrated and population focused) is also recognised.

## **Health Promotion in Community and Women's Health Services**

Health promotion is a key element of the primary health care service system. For agencies receiving Community Health, Women's Health, Innovative Health Services for Homeless Youth (IHSY), Suicide Prevention, Family and Reproductive Rights Education (FARREP) and Family Planning funding, health promotion is funded as the single activity - Health Promotion.

### **2002-03 Final Quarter Reporting Requirements for Health Promotion**

In 2002-03, Community and Women's Health Services were required, for the first time; to develop health promotion plans for priority areas. By 15<sup>th</sup> July 2003, agencies are required to report actuals against these plans. The reporting required is:

1. Quarterly data collection through SWITCH or AIMS.
2. Submission of the 2002-03 Organisational Health Promotion Report (see Appendix 3 for the Organisational Health Promotion Reporting Proforma).

### **2003-04 Planning and Reporting Requirements for Health Promotion**

For all funded health promotion activity in 2003-04:

- All agencies in receipt of health promotion funding will be required to develop and submit a health promotion plan that relates to 100%<sup>3</sup> of health promotion funds from the Community and Women's Health programs by 15<sup>th</sup> July 2003 (see appendix 4 for the 2003-04 Organisational health promotion planning proforma).
- Progress reporting should be provided to regional offices at the end of the second and fourth quarters
- Agencies will provide quarterly data collection through SWITCH or AIMS.

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<sup>3</sup> Sixty to seventy percent of funds should relate to identified health promotion priorities, while a further 30-40% of health promotion funds can be used to respond more flexibly to health promotion issues that are not identified as priority areas. This flexible component should be used for new and/or emerging issues that arise in the local community and for transitional changes happening within the organisation, to ensure future good practice in quality health promotion service delivery.

**Development and reporting against the 2003-04 Organisational Health Promotion Plan**

Agencies in receipt of Community and Women's Health program funding for health promotion are required to plan and document their health promotion service delivery for the financial year 2003-04. The 2003-04 Organisational Health Promotion plan proforma is attached (Appendix 4). There are some changes to the planning and reporting templates for 2003-04 from the templates used for 2002-03. These changes respond to issues identified by the sector and departmental staff.

Organisational health promotion program plans should draw their priority setting rationale from PCP Community Health Plans, Burden of Disease, Municipal Public Health Plans (MPHP) and relevant local needs assessments. This should include systematic analysis of the issues presenting to agencies in their direct service provision and draw on the views of consumers, carers and community members.

The plan, which should cover 100% of the health promotion expenditure, should articulate the organisational vision statement, priority issues for health promotion activity and provide supporting rationales for these priorities. For the priority issues, the plan should document problem definition, solution generation and a mix of interventions (of both individual and population wide health promotion interventions) supported by identified capacity building strategies, that contribute to achieving the goal and objectives stated for that health promotion priority (see appendix 1 for a definition of the interventions and capacity building strategies).

Agencies are required to estimate and report on **reach** as a process indicator. Reach is the number of key stakeholders, settings or members of the community affected by the health promotion program (see appendix 2 for more detail).

In 2003-04, in addition to reporting on reach, agencies are required to identify intended **impacts** as part of their planning process and report against these in 2003-2004. *The Guide to Impact Evaluation for Health Promotion* (December 2002) has been developed to assist agencies in identifying, planning and evaluating against impacts. The resource is downloadable from <http://www.dhs.vic.gov.au/phkb> under Health Promotion Publications and Resources.

The approach to health promotion will continue to emphasize the distinction between *planned* and *opportunistic* health promotion activities. Opportunistic health promotion (health promotion undertaken during a Primary Health Care Contact or Session) occurs as part of good practice in the provision of Allied Health, Counselling/Casework and Nursing Activities. Health promotion is an

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integral part of quality health care and, as such, service providers should ensure that a health promotion approach is incorporated into treatment.

### **Priority Issues and Target Population Groups for Health Promotion**

2003-04 plans for health promotion should reflect efforts to address locally determined health priority issues which complement those identified in the PCP Community Health Plans. These plans have taken into account all available data and have been developed in collaboration with the broad range of stakeholders in Primary Care Partnerships (including Community and Women's Health Services) to identify health and well being needs of their communities. This includes the development of a community profile that takes into account the broad range of factors that influence health and wellbeing.

Particular population groups that will be the focus of the health promotion service should be determined through the planning process and will depend upon the priority issue(s) being addressed. However, emphasis should be given to lower socioeconomic groups who have significantly poorer health status and to groups that are more difficult to reach.

### **Percentage of budget required to be planned and reported**

In 2003-04 agencies are required to submit an Organisational Health Promotion Plan that includes 100% of their health promotion budget from the Community and Women's Health Programs. Given the goal of integrated health promotion planning is to have an organisational plan, agencies are encouraged to include activity that is funded through other sources. In response to suggestions from the sector, an optional column in the proforma is provided for this to delineate funds from other sources.

The Community Health Unit requires agencies that receive health promotion funds through the Community and Women's Health Programs to allocate a minimum of **60-70% of the health promotion funds to planned work in priority areas.**

The remaining **30-40% of health promotion funds can be used more flexibly** to respond to health promotion issues that are not identified as priority areas. This flexible component should be used for new and/or emerging issues that arise in the local community and for transitional changes happening within the organisation, to ensure future good practice in quality health promotion service delivery. (Please refer to the Planning proforma for more details, Appendix 4).

Details of the planning for the flexible 30 - 40% can be found at Appendix 4. The reporting against the health promotion plan must include details of the way in which the flexible component was expended.

### **2003-04 Reporting Timelines**

- Agencies' health promotion plans for **2003-04** should be submitted to DHS Regional Offices by **15 July 2003**, using the outline and template shown in appendix 4.
- **Progress reports** on these program plans should be submitted to the DHS Regional Office by **15 January 2004**
- **Final reports** on the health promotion plans implemented in 2003-04 are due by **15 July 2004**.

The proformas for the progress and final reports for 2003-04 are currently being finalised. These will be forwarded to agencies as part of the 2003-2004 Community and Women's Health Program Guidelines.

Progress and final reports will assist in determining the effectiveness and efficiency of particular strategies and interventions so that effort is not wasted in the future and limited resources can be put to best use. Evaluation that service providers conduct and report will assist in building the evidence base for health promotion. The Department will disseminate learnings through the Primary Health Knowledge Base ([www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb)).

### **Supporting capacity building strategies**

The Department continues to support Primary Health Reform, including health promotion planning & reporting, through specific workforce development opportunities for agencies in 2002-03. Round three regional workshops on health promotion evaluation and monitoring are being conducted in March and April 2003.

More broadly the Department has a number of strategies and resources to improve the health promotion capacity in Victoria that compliment the Primary Health Funding Approach. These include:

- The five-day Core Health Promotion Short Course.
- A series of evidence-based reviews and program planning guidelines on specific health issues and risk factors funded by the Public Health Division. These reviews are accessible at <http://www.dhs.vic.gov.au/phd/ebhp/>
- The Department's Regional Health Promotion Officers and Regional Advisors, who are a valuable resource for assistance and advice in this change process. Their contact details are listed below.
- *The Health Promotion Practice Guide 2003*: This document is currently being finalised and will be released in May. Its purpose will be to support the practice of key principles of health promotion and government policy

directions; and guide effective planning and management of integrated health promotion services. In the interim the Primary Care Partnership Draft Health Promotion Guidelines are available, downloadable from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb) (under Health Promotion Publications and Resources).

- *The Guide to Impact Evaluation for Health Promotion (December 2002)* downloadable from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb) under Health Promotion Publications and Resources.

For other information, refer the Primary Health Knowledge Base at <http://www.dhs.vic.gov.au/phkb> under Health Promotion in Community and Women's Health Services.

## Key Contacts

For further information regarding Health Promotion in Community and Women's Health Services, please contact:

### Community Health Policy

Paul Butler, Manager

Email: [Paul.Butler@dhs.vic.gov.au](mailto:Paul.Butler@dhs.vic.gov.au)

Phone: 9616 8397

### Women' Health Programs

Bernice Murphy, Manager

Email:

[Bernice.Murphy@dhs.vic.gov.au](mailto:Bernice.Murphy@dhs.vic.gov.au)

Phone: 9616 7724

### Planning and Development Unit

Julie Jenkin, Manager, Funding and Accountability Strategies

Email: [Julie.Jenkin@dhs.vic.gov.au](mailto:Julie.Jenkin@dhs.vic.gov.au)

Phone: 9616 1485

### Planning and Evaluation-Community Health Unit

Sue Heward, Health Promotion

Email:

[Susan.Heward@dhs.vic.gov.au](mailto:Susan.Heward@dhs.vic.gov.au)

Phone: 96168382

## Regional Advisors and Regional Health Promotion Officers Contacts Details March 2003

### ***Barwon South Western***

Andrea Tidey

Primary Health Portfolio Officer

Email: [andrea.tidey@dhs.vic.gov.au](mailto:andrea.tidey@dhs.vic.gov.au)

Phone: 5226 4747

Email: [keith.sutton@dhs.vic.gov.au](mailto:keith.sutton@dhs.vic.gov.au)

Phone: 5177 2576

Helen Walsh

Email: [helen.walsh@dhs.vic.gov.au](mailto:helen.walsh@dhs.vic.gov.au)

Phone: 5226 4735

Debbie Mitchell

Regional Health Promotion Officer

Email:

[debbie.mitchell@dhs.vic.gov.au](mailto:debbie.mitchell@dhs.vic.gov.au)

Phone: 5177 2610

### ***Eastern***

Jeff Herd

Manager Health

Email: [jeff.herd@dhs.vic.gov.au](mailto:jeff.herd@dhs.vic.gov.au)

Phone: 9843 6244

### ***Grampians***

Kate Serrurier

Primary Health Advisor

Email:

[kate.serrurier@dhs.vic.gov.au](mailto:kate.serrurier@dhs.vic.gov.au)

Phone: 5333 6019

Anita Thomas

Regional Health Promotion Officer

Email: [anita.thomas@dhs.vic.gov.au](mailto:anita.thomas@dhs.vic.gov.au)

Phone: 9843 6106

Leanne Clarke

Primary Health Advisor

Email: [leanne.clarke@dhs.vic.gov.au](mailto:leanne.clarke@dhs.vic.gov.au)

Phone: 5333 6087

### ***Gippsland***

Keith Sutton

Team Leader Primary/Mental Health

Rick Gervasoni

Regional Health Promotion Officer

Email:

[rick.gervasoni@dhs.vic.gov.au](mailto:rick.gervasoni@dhs.vic.gov.au)

## ***Community and Women's Health Services***

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Phone: 5333 6014

### ***Hume***

Neil Duggan  
Manager Primary Health Support  
Email: [neil.duggan@dhs.vic.gov.au](mailto:neil.duggan@dhs.vic.gov.au)  
Phone: 5722 0906

Debbie Lindsay  
Program Adviser-Community and  
Women's Health  
Email:  
[debbie.lindsay@dhs.vic.gov.au](mailto:debbie.lindsay@dhs.vic.gov.au)  
Phone: 57 611222

Susie Reid  
Regional Health Promotion Officer  
Email: [susie.reid@dhs.vic.gov.au](mailto:susie.reid@dhs.vic.gov.au)  
Phone: 5722 0631

### ***Loddon Mallee***

Anne Stanton  
Primary Health Advisor  
Email: [anne.stanton@dhs.vic.gov.au](mailto:anne.stanton@dhs.vic.gov.au)  
Phone: 5434 5536

Kristina Basile  
Regional Health Promotion Officer  
Email:  
[kristina.basile@dhs.vic.gov.au](mailto:kristina.basile@dhs.vic.gov.au)  
Phone: 5434 5585

### ***Northern***

Angela Soupourmas  
Primary Health Agency Liaison  
Officer  
Phone: 9412 2707

Steven Biggs  
Primary Health Advisor  
Email: [steven.biggs@dhs.vic.gov.au](mailto:steven.biggs@dhs.vic.gov.au)  
Phone: 9412 5441

Stephanie McAdam and Michelle  
Hollingworth  
Regional Health Promotion Officers  
Email:  
[stephanie.mcadam@dhs.vic.gov.au](mailto:stephanie.mcadam@dhs.vic.gov.au)  
[michelle.hollingworth@dhs.vic.gov.au](mailto:michelle.hollingworth@dhs.vic.gov.au)  
Phone: 9412 5316

### ***Southern***

Kelly Bridges  
Program Advisor  
Email: [kelly.bridges@dhs.vic.gov.au](mailto:kelly.bridges@dhs.vic.gov.au)  
Phone: 9213 2030

Lyn Wright  
Team Leader  
Primary Health  
Email: [lyn.wright@dhs.vic.gov.au](mailto:lyn.wright@dhs.vic.gov.au)  
Phone: 9213 2030

Melissa Losurdo  
Regional Health Promotion Officer  
Email:  
[melissa.losurdo@dhs.vic.gov.au](mailto:melissa.losurdo@dhs.vic.gov.au)  
Phone: 9213 2055

### ***Western***

Sally Richardson  
Primary Health Advisor  
Email:  
[sally.richardson@dhs.vic.gov.au](mailto:sally.richardson@dhs.vic.gov.au)  
Phone: 9275 7502

Shauna Jones and Karen Goltz  
Regional Health Promotion Officers  
Email:  
[shauna.jones@dhs.vic.gov.au](mailto:shauna.jones@dhs.vic.gov.au)  
[karen.goltz@dhs.vic.gov.au](mailto:karen.goltz@dhs.vic.gov.au)  
Phone: 9275 7362 (Shauna)  
9275 7336 (Karen)

## Appendix 1: Health Promotion Interventions and Capacity Building Strategies

In order to develop a systematic approach to integrated health promotion, a common planning framework<sup>4</sup> has been introduced for Health Promotion service delivery by Community & Women's Health Services. For 2003-04 this comprises of:

- An overall vision statement that reflect the principles and goals, which underpin each Agency's organisational health promotion plan.
- Priority issues and description of the 30-40% flexible component
- For each priority issue the program goal, objectives and the priority population groups that have been determined (*Problem Definition*).
- An appropriate mix of health promotion interventions (see definitions below), derived from the use of evidence based health promotion, good practice models, and data from relevant statewide action to address the identified program objectives (*Solution Generation*).
- Roles and responsibilities of the key stakeholders (including community, consumers and carers), and key capacity building strategies (see definitions below) required ensuring success (*Capacity Building-Support and Resources*).
- Evaluation and review processes including process and impact evaluation.

The definitions of the health promotion interventions and capacity building strategies have been updated in 2003 to reflect feedback from the sector. These are listed below:

Screening, Individual Risk Factor Assessment and Immunisation	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.
Social Marketing/Health Information	Social marketing involves programs designed to advocate for change and influence the voluntary behaviour of target audiences to benefit this audience and society as a whole. It aims to shift attitudes, changes peoples view of themselves and their relationships with others change lifelong habits, values or behaviours. It typically uses persuasive (not just information) and cultural change processes. It can involve raising public awareness about a health issue through use of mass media eg.

<sup>4</sup> Adapted from King, L. 1996, 'An outcomes hierarchy for health promotion: a tool for policy, planning and evaluation', *Health Promotion Journal*, vol. 6, no. 2, pp. 50-1; Nutbeam, D. 1996, 'Health outcomes and health promotion: defining success in health promotion', *Health Promotion Journal of Australia*, vol. 6, no. 2, pp. 58-60; Nutbeam, D. (2000), 'What makes an effective health promotion program?', in *Oxford Handbook of Public Health*, Oxford University Press.

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	<p>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.</p> <p>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.</p>
Health Education and Skill Development	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.
Community Action (for Social and Environmental Change)	Community action aims to encourage and empower communities (both geographic areas and communities of interest) to build their capacity to develop and sustain improvements in their social and physical environments.
Settings and Supportive Environments	<p>This includes:</p> <ul style="list-style-type: none"> <li>• Organisational development - which aims to create a supportive environment for health promotion activities within organisations, such as schools, local businesses and sporting clubs. It involves ensuring that policies, service directions, priorities and practices integrate health promotion principles.</li> <li>• 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.</li> <li>• Advocacy - which involves a combination of individual, peer and social actions designed to gain political commitment, policy support, structural change, social acceptance and systems support for a particular goal. It includes direct political lobbying.</li> </ul>
Organisational Development	<p>Strengthening organisational support for health promotion within provider agencies.</p> <p><b>Elements:</b></p> <ul style="list-style-type: none"> <li>• Policies and strategic plans</li> <li>• Organisational management structures</li> <li>• Management support and commitment</li> <li>• Recognition and reward systems</li> <li>• Information systems—monitoring and evaluation</li> <li>• Information resources</li> <li>• Quality improvement systems</li> <li>• Informal organisational culture</li> </ul>

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Workforce Development	Developing the health promotion skills and knowledge of the workforce. <b>Elements</b> <ul style="list-style-type: none"><li>• On-the-job learning</li><li>• Professional development opportunities/continuing education/ undergraduate and postgraduate studies</li><li>• Professional support and supervision systems</li><li>• Performance management systems</li></ul>
Resources	Ensuring and/or developing resources to support health promotion, and allocating them strategically <b>Elements</b> <ul style="list-style-type: none"><li>• Human resources</li><li>• Financial resources</li><li>• Information resources including research and specialist advice</li><li>• Decision making tools and models</li><li>• Administrative and physical resources</li></ul>

## Appendix 2: Process Evaluation-Reach

Process evaluation covers all aspects of the process of delivering a program. This means focusing on the evaluation of the health promotion actions and involves the documentation of the activities' reach, quality and capacity of the system to deliver quality health promotion action. More specifically, reach performance indicators for health promotion should be reported for any health promotion interventions and capacity building strategies that are part of the health promotion program. Reach is the number of key stakeholders<sup>5</sup>, settings<sup>6</sup> or members of the community affected by the health promotion program as follows:

- Screening, individual risk assessment and immunisation: Proportion of target group or number of people participating in screening, individual risk assessment and immunisation activities (counted only once per activity). Information collected through systematic staff estimates and participation records.
- Social marketing/Health information: Proportion of target group or number of people (counted as contacts) accessing or aware of funded social marketing/health information activities and resources. OR number of articles published and the population reach of the newspaper or newsletter. OR number of agencies participating in the development and dissemination of consistent information resources (from printed material to interactive technology).
- Health education, and skill development: Proportion of target group or number of people participating in funded health education and skill development (counted only once per activity such as a quit smoking course). Information based on actual participation records.
- Community action: Proportion of target group or number of people participating in funded community action activities (counted as contacts). Information collected through systematic staff estimates.
- Settings and Supportive Environments:  
The number of:
  - Settings (such as schools, local businesses and sporting clubs) involved in creating a supportive health promoting environment. It involves ensuring that policies, service directions, priorities and practices integrate health promotion principles. (each setting counted only once per annum per health priority).
  - Stakeholders involved in economic and regulatory activities (each stakeholder counted only once per annum per health priority). Information gathered through staff estimates.
  - Settings/Stakeholders involved in advocacy activities designed to gain political commitment, policy support, social acceptance and systems support for a particular goal. It includes direct political lobbying. (each stakeholder/setting counted only once per annum per health priority).

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<sup>5</sup> Stakeholders may include community leaders, provider representatives and agency staff.

<sup>6</sup> Settings are specific physical locations such as schools and workplaces.

- **Organisational development:** A number of reach process indicators could be considered for organisational development depending on the focus of the program plan:
  - The number of agency management/staff participating in funded health promotion activities (counted only once per annum). Information based on actual participation records such as diary notes and meeting papers.
  - The number of agency management/staff planning to or implementing health promoting workplace policy/organisational culture activities.
  - The number of agency management/staff planning to or implementing policies, plans, and/or management support mechanisms for health promotion activities in their agencies/organisations.
  - The number of agency management/staff using health promotion recognition systems, health promotion activity monitoring and evaluation systems, consistent information resources and/or best practice health promotion tools.
- **Workforce development:** The number of staff within the agency participating in funded health promotion workforce development activities (counted only once per workforce activity such as a continuing education course). Information based on attendance records and similar information. Depending on the focus of the program plan, workforce development activities may be more specifically articulated as: on the job learning, formal professional development/professional support and supervision/performance management systems.
- **Resources:** The number of key stakeholders participating in the health promotion strategy/program planning (each stakeholder counted only once per annum per health priority) and the average stakeholder resource commitment (time, action, financial/physical). Information based on actual participation records such as diary notes and meeting papers.

## Appendix 3

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# 2002 – 2003 Community and Women's Health Services Organisational Health Promotion Reporting Pro Forma

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### Introduction

The June reporting for 2002-03 involves 2 parts including the **Narrative and the Health Promotion Summary Reporting grid**. Both part 1 and 2 are **mandatory for each Priority issue** identified in your Agency's 2002-03 Integrated Health Promotion Organisational Plan.

### **Submission of June Reports**

The June report (including parts 1 and 2 for each priority area, compiled into one document) will be submitted to the relevant Regional office by 15 July 2003. The Agency CEO or Manager should sign off each report. The June report should be submitted to the relevant regional office electronically-by email, cd or disk (the region will forward an electronic copy to Michelle Lasek at Head Office [michelle.lasek@dhs.vic.gov.au](mailto:michelle.lasek@dhs.vic.gov.au))

## (Insert Agency Name) Integrated Health Promotion Organisational Plan-Reporting 2002-03

### PART 1 Narrative

Agencies are required to submit a narrative section for Priority issues identified in their 2002-03 Integrated Health Promotion Organisational Plan. Use the prompts below to guide this narrative.

- 2002-03 priority setting process eg. What was the rationale that the priority was based on? How was the process based on population health and wellbeing data provided in the PCP Community Health Plan, Burden of Disease, Municipal Public health plans and relevant local needs assessments? In setting organisational health promotion priorities what was the decision-making process?
- Problem definition process eg. Was the goal, objective and selection of target population group realistic?
- Consumer and community participation eg. How were the key population groups involved in developing/implementing and participating in the priority?
- Solution generation process eg. Was the mix and balance of interventions (including both individual through to population interventions) appropriate to achieving the goal and objectives stated for the priority area?
- Planning for and conducting evaluation strategies eg. What was difference, how was changed observed? What were the evaluation processes? From the evaluation are there any implications for future priority setting processes?
- Capacity building eg. Were there enough resources- time, infrastructure, personnel and community participation to achieve the goal and objectives? What were the enablers and barriers? If not do these need to be developed or should different interventions, objectives even program goal be planned for?
- Any other comments?

**Part 2: (Insert Agency Name) Health Promotion Summary Reporting Grid**

<b>Program Goal:</b>	
<b>Population Target Group/s:</b>	

<b>Objective 1:</b>						
<b>Health Promotion Interventions &amp; Capacity Building strategies<sup>7</sup></b>	<b>OPTIONAL Actual Impacts<sup>8</sup> &amp;/or Quantitative</b>	<b>Actual<sup>9</sup> Reach</b>	<b>Timelines &amp; by whom<sup>10</sup></b>	<b>Actual Staff Costs</b>	<b>Actual Consumables Costs</b>	<b>Total cost</b>
Screening, individual risk assessment and immunization						
Social marketing /Health information						
Health education and skill development						
Community action						
Settings and Supportive Environments						
Organisational Development						
Workforce Development						
Resources						
<b>Total Budget per Objective</b>						
<b>Total Budget per Program Goal</b>						

<sup>7</sup> Please refer to the document *Health Promotion Resource- Community and Women's Health Services March 2003*. It can be downloaded from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb), which describes these interventions and strategy types. An appropriate mix of interventions and strategies should be documented, to address the stated objective (solution generation and capacity building in part 1 above). Agencies are only required to fill in interventions/strategies that were implemented; all other interventions/strategies categories can be deleted.

<sup>8</sup> **Actual Impacts** (Qualitative &/or Quantitative): Agencies were encouraged to identify intended impacts as part of their planning process but are not required to report against them in 2002-2003. This is optional for 2002-03 but important for 2003-04 planning.

<sup>9</sup> **Actual Reach**: Planning requires the development of process indicators for each priority. However, the Department only one type of process indicator-Reach to be reported on. For further information please refer to the document *Health Promotion Resource- Community and Women's Health Services March 2003*. It can be downloaded from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb).

<sup>10</sup> **Timelines & By Whom**: Timelines of when implementation occurred and who in the agency carried out the action.

## Appendix 4

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# 2003 – 2004 Community and Women's Health Services Organisational Health Promotion Plan Pro Forma

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### Introduction

The Organisational Health Promotion planning requirement for 2003-04 involves 3 mandatory components including:

Part 1: Agency vision and priority setting process and description of the 30-40% flexible component

Part 2: Outline

Part 3: Health Promotion Summary planning grid.

Both part 2 and 3 are **required** for each Priority issue identified from part 1 (priority setting process)

In 2003-04 Agencies are required to submit an Organisational Health Promotion plan that includes **100%** of their health promotion budget from the Community and Women's Health Programs. Given the goal of integrated health promotion planning is to have an organisational plan, rather than a plan for funds from one program area, agencies are encouraged to include activity that is funded through other sources. An optional column in part 3 is provided for this.

The Community Health Unit requires agencies that receive health promotion funds through the Community and Women's Health Programs to allocate a minimum of **60-70%** of the health promotion funds to planned work in priority areas. The remaining **30-40%** of health promotion funds can be used more flexibly to respond to health promotion issues that are not identified as priority areas.

The 60-70% (minimum) of the budget being allocated to priority issues (identified in part 1) will need to be documented in part 2 (outline for each priority) and part 3 (summary grid for each priority) using this 2003-04 Organisational health promotion plan proforma.

The remaining 30-40% of the budget can remain as a flexible component. This flexible component should be used for new and/or emerging issues that arise in the local community and for transitional changes happening within the organisation, to ensure future good practice in quality health promotion service delivery. Part 1.3 in the 2003-04 Plan proforma requires each agency to give a brief statement about the possible areas that this 30-40% will address (if known).

Parts 2 and 3 of the proforma are not required to be completed for this flexible component of budget, however the reporting proforma will require a 100% budget reporting, including this flexible component.

### **Submission of the Organisational Health Promotion planning requirement for 2003-04**

The Organisational Health promotion plan (With all components compiled into one document) will be submitted to the relevant Regional office by 15 July 2003. The Agency CEO or Manager should sign off each report. The June report should be submitted to the relevant regional office electronically-by email, cd or disk (the region will forward an electronic copy to Michelle Lasek at Head Office email: michelle.lasek@dhs.vic.gov.au).

## Integrated Health Promotion Organisational Plan 2003-04

### **Part 1: Agency vision, priority issues and description of the 30-40% flexible component**

1.1 Articulate overall organisational vision statement that reflects health promotion principles.

1.2 Identify the organisational priority issues for health promotion activity and provide supporting rationales for these priorities.

1.3 Give a brief description of the possible areas that 30-40% (maximum) of the health promotion budget will address. This flexible component covers *new and/or emerging issues* that arise in the local community and *transitional changes* happening within the organisation, to ensure future good practice in quality health promotion service delivery.

### **Part 2: Outline**

Given each of the Priority issues identified from part 1 outline the:

#### **2.1 Problem Definition**

- Program Goal
- Program Objectives
- Target Population Groups

#### **2.2 Solution Generation**

- Use evidence based health promotion and good practice models
- Identify relevant Statewide action
- Identify the appropriate mix and balance of both individual and population wide health promotion interventions

#### **2.3 Capacity Building-Support and Resources**

- Identify the roles and responsibilities of the key stakeholders, including community, consumer and carer representatives.
- Assess and allocate appropriate resources
- Identify key capacity building strategies required to ensure success

2.4 Plan for Review and Evaluation including process (reach indicators must be included) and impact evaluation.

**Part 3: Health Promotion Summary planning grid: To summarise this planning process including budget details (for each priority issue).**

<b>Program Goal:</b>	<i>(links with Priority Issue column in Switch reporting)</i>
<b>Population Target Group/s:</b>	<i>(links with Population Group column in Switch reporting)</i>

<b>Objective 1:</b>				
<b>Estimated Impacts (Qualitative &amp;/or Quantitative) for Objective 1</b>				
<b>Health Promotion Interventions &amp; Capacity Building strategies<sup>ii</sup></b>	<b>Estimated<sup>iii</sup> Reach</b>	<b>Timelines &amp; by whom<sup>iv</sup></b>	<b>Estimated Budget from C&amp; WH program<sup>v</sup></b>	<b>OPTIONAL Estimated Other Funding sources<sup>vi</sup></b>
Screening, individual risk assessment and immunisation				
Social marketing /Health information				
Health education and skill development				
Community action				
Settings and Supportive Environments				
Organisational Development				
Workforce Development				
Resources				
<b>Total Budget per Objective</b>				
<b>Total Budget per Program Goal</b>				

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**Explanatory Notes for the 2003-04 Organisational Health Promotion Planning Proforma**

<sup>i</sup> Estimated Impacts (Qualitative &/or Quantitative): Planning requires the development of impact indicators to measure the achievement of program objectives. Agencies are required to identify intended impacts as part of their planning process and report against these in 2003-2004. Please refer to the document *A Guide to Impact Evaluation in Health Promotion December 2002* can be downloaded from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb) under Health Promotion Publications and Resources.

<sup>ii</sup> Agencies are only required to fill in interventions/strategies that are planned for; all other interventions/strategies categories can be deleted. Please refer to the document *Health Promotion Resource- Community and Women's Health Services March 2003*. It can be downloaded from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb) This document describes these interventions and strategy types.

<sup>iii</sup> Estimated Reach: Planning requires the development of process indicators for each program. However, the Department only one type of process indicator-Reach to be documented in the health promotion summary grid. Please refer to the document *Health Promotion Resource- Community and Women's Health Services March 2003*. It can be downloaded from [www.dhs.vic.gov.au/phkb](http://www.dhs.vic.gov.au/phkb)

<sup>iv</sup> Timelines & By Whom: Timelines for implementation need to be identified as well as whom in the agency is responsible for carrying out the action.

<sup>v</sup> Estimated Costs (Staff and consumables): Where possible include the estimate cost per intervention/strategy. Also include total cost per objective and total overall cost per program goal.

<sup>vi</sup> OPTIONAL Estimated Other Funding sources: To support the concept of having an Organisational HP planning process Agencies have the option of including actual cost derived from other funding sources. When reporting against the plan it is not mandatory to report on the activities funded from elsewhere, this column allows the Agency to also have a better understanding of how much quality health promotion services cost.