

Health promotion priorities for Victoria 2007–2012

Report of 2006 consultation process and next steps

Acknowledgements

The publishers of this document wish to acknowledge the valuable contributions of the following:

- all who attended the consultation forums and those organisations that prepared and forwarded written submissions
- Ms Bernie Murphy, Mr Bernie Marshall (Deakin University) and Professor Helen Keleher (Monash University), for facilitating the consultation forums
- Professor Helen Keleher, Ms Nerida Joss and Ms Rebecca Armstrong, for providing thematic analysis of the data from all ten consultation forums
- staff from the Department of Human Services and VicHealth, for their participation in the consultation forums and contributions to this report.

Further information

Please contact:

Kellie Horton

Senior Project Officer, Health Promoting Systems

Health Promotion and Chronic Disease Prevention

Department of Human Services

email: Kellie.Horton@dhs.vic.gov.au

tel: 9096 5506

fax: 9096 9165

Published by the Victorian Government Department of Human Services, Melbourne, Victoria

© Copyright State of Victoria 2007

This publication is copyright, no part may be reproduced by any process except in accordance with the provisions of the *Copyright Act 1968*.

This document may also be downloaded from the Department of Human Services website at: www.health.vic.gov.au/healthpromotion

Authorised by the State Government of Victoria,
50 Lonsdale Street, Melbourne.

Contents

Acknowledgements	ii
Executive summary	iv
1. Introduction	1
2. Summary of consultation results and rationale for priorities	3
2.1 Summary of general comments	3
2.2 Health promotion priority issues	3
2.3 New priority—sexual and reproductive health	5
2.4 Other priority issues for consideration	7
2.5 Comments on health promoting systems	8
3. Health promotion priorities and next steps	11
Appendices	
Appendix 1: Consultation forums	12
Appendix 2: Regional snapshots	14
Appendix 3: Written submissions to the consultation process	17
Appendix 4: Priority setting—management group representation	18

Executive summary

The Rural and Regional Health and Aged Care Services (RRHACS) Division, Department of Human Services, and the Victorian Health Promotion Foundation (VicHealth) together make a significant investment in supporting quality health promotion programs and practice. This report documents the process undertaken by RRHACS Division and VicHealth to further strengthen health promotion in Victoria, through the development of statewide priorities for 2007–12. It also articulates early plans for implementing these priorities.

The first stage of the priority setting process was the development of a widely circulated discussion paper. The paper introduced a preliminary list of priorities, based on available population health data and supporting evidence. It outlined questions to stimulate discussion regarding the proposed priorities and provided readers with references for further information.

The second stage comprised a statewide consultation, held between February and May 2006. Ten consultation forums were conducted across regional and metropolitan Victoria. They were divided into two parts: the first concerning health promotion priorities and the second concerning the systems required to support them. A total of 567 people participated in the sessions and an additional 35 written responses addressing the consultation questions were received.

Criteria used to prepare and finalise the priority issues included:

- the significance of the issue's impact and scale
- the degree of health inequalities
- evidence indicating that the issue is amenable to change through health promotion and prevention action
- the strategic opportunities and capacity for RRHACS, VicHealth and/or other key stakeholders, now and over the next five years, to address these issues.

The consultation results established seven broad priority issues.

The seven priorities are:

1. promoting physical activity and active communities
2. promoting accessible and nutritious food
3. promoting mental health and wellbeing
4. reducing tobacco-related harm
5. reducing and minimising harm from alcohol and other drugs
6. safe environments to prevent unintentional injury
7. sexual and reproductive health.

The overarching aim of the health promotion priorities is to **improve overall health and reduce health inequalities**.

Neighbourhood Renewal sites were also confirmed as one of the priority settings for health promotion practice, from 2007–12.

A management group, comprising representatives from program areas across the department and VicHealth, has been established to oversee implementation and ensure integration across the priorities. More information on implementation planning will be published in 2007.

1. Introduction

Since 2000, quality health promotion approaches have featured in policy reforms led by the Rural and Regional Health and Aged Care Services (RRHACS) Division, Department of Human Services. Examples include the Primary Care Partnership (PCP) Strategy—particularly the Integrated Health Promotion Framework, municipal public health planning guided by *Environments for Health* and the Small Rural Health Services Strategy.

For 2004–06, health promotion priorities were set for community and women’s health services, PCPs and some statewide health agencies. PCP community health plans and funded agency health promotion plans were used to determine specific priorities.

The RRHACS Division and the Victorian Health Promotion Foundation (VicHealth) have significantly invested in supporting quality health promotion programs and practice. There is a mutual commitment to an evidence-based approach to health promotion policy setting, planning, implementation and evaluation. For this reason, the RRHACS Division and VicHealth set out to develop health promotion priorities for 2007–12.

The first stage of this process was the development of *Health promotion priorities for Victoria: a discussion paper* (‘the discussion paper’), which was widely disseminated. It introduced a preliminary list of priority issues, including:

- physical activity and active communities
- accessible nutritious food
- promoting mental health and wellbeing
- reducing and minimising the harm from tobacco, alcohol and illicit drugs
- preventing injury.

Criteria used to identify these priorities were:

- **significance of the issue’s impact and scale**—using Burden of Disease data and other supporting evidence
- **degree of health inequalities**—considering differential distribution of socioeconomic status and factors such as gender, ethnicity, and rurality
- evidence that these issues are **amenable to change**, through health promotion and prevention action
- the **strategic opportunities and capacity** for RRHACS, VicHealth and/or other key stakeholders (now and over the next five years), to address these issues.

These criteria were chosen because of their relevance to the vision, mission, aims and objectives of VicHealth and the RRHACS Division’s health promotion principles.

The discussion paper is available at:

<http://www.health.vic.gov.au/healthpromotion>

The focus of the discussion paper was clearly on midstream risk factors, using a social determinants of health lens. The information was drawn from a summary of available evidence of the known relationship between disease, midstream risk factors (such as smoking, physical activity and nutrition) and upstream broader determinants (including the social, physical, economic and environmental factors that are precursors to midstream risk factors).

The second stage of the process comprised a series of ten consultation forums¹, held across Victoria between February and May 2006.

The consultation process was an opportunity to examine the proposed list of priorities and other potential priorities, as well as look to the future and explore how health promotion can be managed and organised to achieve the best possible outcomes.

¹ See Appendix 1 for an overview of the consultation forums.

Information collected from the consultation forums, as well as written submissions, was collated and analysed to finalise the list of health promotion priorities.

The third stage of the process—now underway—establishes the management mechanisms for coordinating implementation actions. More information on this implementation planning will be available later in 2007.

This summary report of the process and subsequent results includes:

- a brief introduction (section 1)
- an outline of the consultation results (section 2)
- the health promotion priorities for 2007–12 and next steps—implementation planning (section 3)
- an overview of the consultation forums (Appendix 1)
- regional summaries for consultation results (Appendix 2)
- the list of organisations from which written submissions were received (Appendix 3)
- the health promotion priority setting management group (Appendix 4).

2. Summary of consultation results and rationale for priorities

This section summarises the results of the consultation forums and feedback from the written submissions and is based on the thematic analysis produced by Monash University. Actions proposed to address these consultation results are outlined in section 3.

For the most part, similar issues were raised in each consultation, so comments are aggregated and not specified according to region. However, Appendix 2 does give region-by-region snapshots.

2.1 Summary of general comments

Valuable information was derived from the consultation feedback, helping the department finalise the priority issues.

Participants were pleased that the department and VicHealth were working in partnership to develop priorities for 2007–12. The leadership demonstrated throughout the process was acknowledged, as was the commitment shown to an evidence-based approach to priority setting.

The focus on addressing health inequalities was universally endorsed. Participants supported the need to examine the social determinants of health, based on the best available evidence and integrated practice across sectors. There must also be an ongoing commitment to ensure that the workforce is able to plan, implement and evaluate evidence-based practice. A recommendation was made to develop a set of underpinning health promotion principles.

There was general support for the preliminary priority issues outlined in the discussion paper, with the exception of injury prevention. There was, however, substantial support for more work on the language used to describe some of the priority issues. More detailed information for each priority issue was requested, including better defined population groups and an understanding that different approaches will be required, depending on the life stage.

Particular population groups were raised as a priority, including:

- Aboriginal and Torres Strait Islanders
- women
- injecting drug users
- people experiencing homelessness
- people from low socioeconomic status groups

- people with a disability
- gay, lesbian, bisexual, transgender and intersex Victorians
- people from culturally and linguistically diverse (CALD) communities.

It was also recognised that all priorities are multi-dimensional and relate closely to each other, particularly when viewed through the lens of the social determinants of health.

Participants also recommended that acknowledging *place*—defined by geography or community of those most disadvantaged—was important. Throughout the entire consultation process, it was clearly stated that Neighbourhood Renewal sites will remain as a priority setting for health promotion practice throughout 2007–12.

2.2 Health promotion priority issues

Specific issues were raised in relation to each of the preliminary priority issues, as outlined below.

Physical activity and active communities

There was significant support for this priority issue. Past and current regional programs were acknowledged, as was the evidence base already available.

There was, however, lack of agreement about the title of this priority issue, particularly the words ‘active communities’. There was agreement that this priority needed to be framed around the social determinants of physical activity, including strategies to address transport and income.

There was recognition that this priority area is multi-dimensional, with obvious links to nutrition, mental health and general wellbeing (particularly, social connectedness).

Several regions discussed the need for a targeted approach, with reference made to particular population groups including Aboriginal and Torres Strait Islanders, women, children and people from CALD communities.

Accessible and nutritious food

There was general support for this priority, but considerable discussion regarding its title. Most agreed that the proposed title was ambiguous. The meaning of 'accessible' was debated and the issues associated with the priority were deemed to be greater than those defined by this term. Alternative titles were suggested, including: 'accessible food for all'; 'accessible nutritious food'; 'healthy eating and healthy weight'; 'promotion and increased access to nutritious food'; 'healthy eating'.

There was agreement that this priority needed to be framed around its determinants—transport, income, socioeconomic status, density of fast food outlets and television advertising. Some participants were concerned about the absence of sustained action on health education and skill development in the areas of food choice and preparation, and the need for continued investment to address mid-stream risk factors. Participants saw the need for a more targeted approach, focusing on life stages and on disadvantaged groups.

Action on oral health and disease was another common area for discussion. Some participants proposed oral health as a separate priority, while others advocated for it to be considered under 'accessible and nutritious food'.

Promoting mental health and wellbeing

This issue was identified by most as the number one priority. There was considerable discussion about the need to clearly frame it using the social determinants of health.²

There was confusion about whether this priority focuses on people with mental illness, or on the whole population. Areas of interest under this priority included social connectedness, depression, self-esteem, stress, bullying, family and intimate partner violence. There was significant discussion about identifying vulnerable groups—including children, young people, older people, women and CALD groups.

Reducing and minimising harm from tobacco, alcohol and illicit drugs

Despite overall support for these areas, there was disagreement over grouping them under one priority. Different approaches were seen to be necessary, with limited benefits in putting them together.

Tobacco was often seen as a stand-alone priority issue, given its significant impact on the burden of disease. The Commonwealth of Australia has also ratified the Framework Convention on Tobacco Control. This international treaty imposes wide-ranging obligations on all parties to adopt and implement specific tobacco control measures. At a national level, the *National Tobacco Strategy 2004-09* provides clear objectives and directions—see the strategy at www.nationaldrugstrategy.gov.au

The term 'illicit' was highlighted, as it does not cover all forms of drugs. Suggested alternatives were 'illegal use of drugs', 'other drugs' or 'other substances'. There was also concern about the terms 'minimising' and 'reducing'—alternative titles suggested included 'addressing the harm from tobacco, alcohol and other drugs'; 'decreasing and minimising the harm from tobacco, alcohol and other drugs'; 'minimising the harm from, and reducing the use of tobacco, alcohol and other substance abuse'.

There was general agreement that this priority issue should include other substances, particularly prescription drugs. Significant links between this priority and others were raised, particularly alcohol-related injury and mental health.

Preventing injury

Consultation feedback suggested mixed support for 'preventing injury' as a stand-alone priority, especially given the links between alcohol, intentional injuries and mental health. Those who felt this *should* be a stand-alone priority believed that it was too broad and needed refining. Injury morbidity and mortality are commonly divided into intentional and unintentional causes, with a number of differing risk factors contributing to these adverse outcomes.

2 As provided by the VicHealth Mental Health Promotion Framework. Adoption of this framework for this priority was seen as positive—to access the VicHealth Mental Health Promotion Framework go to: <http://www.vichealth.vic.gov.au/assets/contentFiles/vhp%20framework-print.pdf>

The consultation process highlighted the broad scope of this topic—safety and risk-taking behaviours, farm-related injury, workplace injury, family and intimate partner violence, childhood accidents, road safety, water safety, suicide and self-harm. In response, alternative titles were suggested: ‘improving self-esteem—preventing injury and harmful behaviour’; ‘healthy ageing and falls prevention’; ‘promoting community safety’ and ‘injury prevention and community safety’.

Some felt that the priority should be ‘preventing injury related directly to older people’ and ‘falls prevention’. After further discussion, it was agreed that this would narrow the priority and exclude the broader community. Environmental issues were identified as crucial in addressing this priority area.

Given the other priority issues of mental health and wellbeing, alcohol and physical activity, it was suggested that preventing suicide, self-harm, child abuse, road traffic accidents (strong link with alcohol usage) and sporting injuries be incorporated within these other priority areas.

Taking up the idea of narrowing this priority to ‘safe environments to prevent unintentional injury’, the decision-making criteria was reapplied. From this process, it was recommended that:

- the priority issue focus on *safe environments* (built, social and individual, economic and natural) to prevent unintentional injury, with emphasis on falls, poisoning, burns and scalds, hitting, striking and crushing injuries in the home that are amenable to prevention
- priority population groups are children and young people, older people, rural and remote populations
- the initial focus of activity will be on producing the overarching framework for the priority area (as with all other priority areas) and action relating to childhood injuries and falls in older people.

2.3 New priority—sexual and reproductive health

Feedback at the consultation forums was supported by numerous written submissions proposing sexual and reproductive health as a new health promotion priority for 2007–12. The evidence used to establish this priority is summarised below. For the other priority issues, evidence was outlined in the discussion paper available at:

www.health.vic.gov.au/healthpromotion

Impact, scale and significance

Sex and sexuality are fundamental to the sense of wellbeing experienced by people in their everyday lives. They are powerful drivers of many social behaviours and remain central to important aspects of contemporary life, including personal and social identity. All communities have particular cultural, structural and moral attitudes in relation to sex and sexuality, impacting on efforts to address the challenges of sexually transmissible infections. Factors influencing sexual and reproductive health include:

- individual self-esteem and its impact in sexual relationships
- changing societal values on sexual behaviour
- safe versus unsafe sexual practices
- access to a range of contraception
- a power imbalance between people in relationships (particularly between men and women)
- alcohol and drug use as a factor in unsafe sexual practices.

Sexually transmitted infections (STIs) are examples of preventable infectious diseases that if left untreated, generate secondary chronic health conditions. The following data supports this:

- Chlamydia notifications have increased from 3,656 in 1999 to 7,878 in 2005. This is a 115 per cent increase over the seven years (16.5 per cent each year). In 2004, 58 per cent of chlamydia notifications in Victoria were diagnosed among women, with 66 per cent of notifications among young women aged 16–24 years.
- Between 10–40 per cent of chlamydial infections in women can lead to pelvic inflammatory disease (PID) if left untreated. This is responsible for 50 per cent of ectopic pregnancies, with up to 20 per cent becoming infertile. Infertility places a significant future burden on the health system, through increasing demand for costly *in vitro* fertilisation services. Chronic pain is sometimes experienced with PID; this can be severely debilitating and lead to hospitalisation.

- In up to 80 per cent of cases, chlamydia infection produces no symptoms. Past screening initiatives have led to a significant increase in notifications. The Australian Bureau of Statistics estimates there to be 525,300 young people aged between 15 and 29 within Victoria, as at 30 June 2005. Applying the chlamydia prevalence rate of 5.8 per cent to this population indicates a potential infection level of 30,468 individuals.
- Estimates show that, where the prevalence of infection is 5 per cent, the lifetime costs associated with no intervention for chlamydia are more than \$50 million for a one-year cohort.
- Aboriginal and Torres Strait Islander people have an eight-fold higher rate of diagnosis of chlamydia than non-Aboriginal people.
- The rate of other STIs notifications (syphilis, gonorrhoea and HIV) is unacceptably high and continues to grow. The number of notifications for the three major STI conditions combined has increased by more than 240 per cent over the past six years. Syphilis, which was all but eradicated in Victoria, has increased from two to 80 cases over this period, an alarming 4000 per cent increase, while HIV notifications have increased from 140 in 1999 to 217 in 2004.
- Untreated syphilis in pregnant women is associated with perinatal death in up to 40 per cent of cases. If syphilis is acquired during the four years preceding pregnancy, there is more than a 70 per cent chance of transmission to the foetus, leading to foetal damage.
- Human papilloma virus is the most prevalent viral STI; types 16 and 18 of this virus cause about 70 per cent of cervical cancers.

Other data related to sexual and reproductive health:

- Among women aged 50–59, just over 22 per cent first became pregnant as teenagers, compared to approximately 17 per cent of women aged 20–29³.
- One in five women and one in 20 men reported experiencing sexual coercion, with 50 per cent of those people being under the age of 16 years³.

3 Australian Study of Health and Relationships: Sex in Australia, *Australia and New Zealand Journal of Public Health*. 2003. Vol 27. No.2 as quoted in the Family Planning Victoria paper, *A submission paper in response to the discussion paper Health Promotion Priorities for Victoria 2007–12*.

- Among Aboriginal and Torres Strait Islander women in Victoria, 22 per cent of births occur in teenagers.
- Approximately 12 per cent of all abortions in Victoria are performed on teenagers.

Degrees of health inequality

Evidence suggests that the impact of poor sexual and reproductive health is borne largely by adolescents (particularly young women, Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse backgrounds), men having sex with men, and sex workers. Growth in sexually transmissible infections (notifiable STIs include chlamydia, gonorrhoea, syphilis and HIV) is occurring at alarming rates in Victoria. Infection rates are highest in young people and disadvantaged groups (rural and indigenous).

Adolescence is characterised by risky social and sexual behaviours—often, these behaviours occur together. Repeated risk-taking behaviours are evidenced by the 73 per cent of young women with chlamydial infections who present with reinfections within seven months. The burden of sexual ill health is not equitably distributed, being particularly high in young people who develop unsafe patterns of behaviour, with poor health consequences and reduced educational attainment in those who have unplanned teenage pregnancies.⁴

Action areas amenable to change through health promotion and prevention action

The identified protective factors for this priority issue include⁵:

1. family connectedness and good parent-child communication
2. sex education, including:
 - whole-of-school approach to sexuality education in schools (supported by relevant policies, including professional development for teachers)

4 The Sexual and Reproductive Health of Young Victorians, a collaborative project from Family Planning Victoria, Centre for Adolescent Health and Royal Women's Hospital. Family Planning Victoria. November 2005.

5 Department of Human Services, (2006) Victorian Sexually Transmissible Infections Strategy 2006–09, Victorian State Government, Melbourne.

- strategies to increase availability and effective condom use by young people and within Aboriginal and Torres Strait Islander communities
 - STI/blood-borne virus (BBV) education programs for people in prisons, sex workers, people from CALD communities, people living with HIV/AIDS (and in particular men who have sex with men), to inform them of the consequences of co-infection with STIs and to promote sexual health monitoring and treatment.
3. screening the following groups for chlamydia:
 - sexually active people under the age of 25 years
 - Aboriginal and Torres Strait Islander people who are at increased risk, when attending for other health care issues
 - men who have sex with men
 - people over the age of 25 who are at increased risk, as indicated by their sexual history.
 4. encouraging agencies that work with young people to provide sexual health education, where appropriate
 5. supporting broad primary health initiatives that reduce barriers to Aboriginal and Torres Strait Islander people accessing health services.

Strategic opportunities for key players

A focus on sexual and reproductive health in Victoria is consistent with the Australian Government's view expressed in the National STI Strategy, which calls for an urgent coordinated approach to address the rising incidence of STIs. The consequences of poor sexual health and reproductive health carry potentially drastic social costs—ectopic pregnancies, pelvic inflammatory disease, infertility, neonatal blindness, morbidity and death related to HIV/AIDS.

Despite some overlap between risk factors for this priority issue—the mental health and wellbeing priority and alcohol—there are key aspects remaining uncovered. In particular, this priority issue will focus on:

- a comprehensive, multi-sector approach to responding to STIs in the Victorian community
- implementing strategies to support young people's self-esteem (recognising the impact this has on sexual relationships), knowledge and understanding of unsafe sexual practices and access to a range of contraception types
- working to build an environment where cultural and moral attitudes to sex and sexuality support positive health outcomes.

2.4 Other priority issues for consideration

Where organisations wished to raise additional priorities for consideration, they were asked to submit a written submission. The suggested format involved addressing the consultation questions and decision-making criteria outlined in the discussion paper. Working through each of these proposals, the decision-making criteria (Appendix 1) were used to finalise the health promotion priorities. Brief comments are given below, addressing each of the additional priorities proposed.

1. **Reducing health inequalities** is clearly the underpinning motivation for establishing health promotion priorities. To ensure that this is embedded in all health promotion action, it is a criterion in selecting priority issues and a key principle for health promotion policy and action (see section 3 for the underpinning principles). **Building inclusive communities, capacity building, taking a gendered approach to practice and integrated planning** are also identified as key health promotion principles.
2. A determinants framework for each priority issue will be developed in stages, giving more information on priority population groups. It is anticipated that **people experiencing homelessness** would be a key at-risk population group, across *all* priority issues.
3. **Equality and social justice; freedom from discrimination and violence; access to resources and participation; preventing child abuse; preventing family violence, including intimate partner violence** are key determinants of the mental health and wellbeing priority issue, as identified in the VicHealth Mental Health Promotion Framework.

4. As identified in the submission on **eye health and eye care**, this topic relates to all priority issues. Improvements in eye health will be an important intermediate outcome from more coordinated action, across the seven priority issues.
5. The **Neighbourhood Renewal** strategy and sites were raised as an effective model for health promotion practice in disadvantaged areas. These sites will remain as a priority setting for health promotion practice, from 2007–12.
6. **Oral health and disease** is a major indicator of inequality and is amongst the most costly diet-related diseases in Australia. Promoting oral health will be an important intermediate outcome across numerous priority issues. Examples include physical activity (protecting face/lips from sun and sporting injuries); tobacco and gum disease; alcohol and oral cancer; illicit drug use and severe caries; ensuring nutrition information is available and supporting environments for good access to nutritious food. In 2004–05, funding was allocated over the next four years to extend water fluoridation to communities in rural and regional Victoria.
7. **Skin cancer** remains a significant public health problem in Victoria and work implemented by the Cancer Council of Victoria and VicHealth is acknowledged as a model of excellence. When applying the four selection criteria, limited evidence was provided to establish the degree of health inequalities involved. There is some overlap between sun-related sporting injuries and the physical activity priority issue.

2.5 Comments on health promoting systems

This section summarises responses to part two of the consultation process—about the system and support mechanisms for health promotion in Victoria. This part of the consultation was structured around two primary questions:

1. What are good examples of systems and support mechanisms (for example, information, workforce development, policy environment) that work well in helping you to deliver quality health promotion programs?
2. What is your organisation's systems and support vision for the next five years? What is missing from your first answer that is important?

Participants worked in groups to answer the above questions, in terms of:

- their organisation
- the region or partnerships they work within
- support required from central and statewide systems. When thinking about this support, participants were asked to think beyond the department and VicHealth.

Tables 1 and 2 summarise participant responses. This will inform the future implementation planning for health priorities (particularly the central and statewide systems data).

Table 1: Summary of responses to question 1

1. What are good examples of systems and support mechanisms (for example, information, workforce development, policy environment) that work well in helping you to deliver quality health promotion programs?

In your organisation	In your region/partnerships	Statewide
<ul style="list-style-type: none"> • Management is committed to health promotion. • Access to workforce development resources. • Organisational commitment to health promotion is demonstrated by its inclusion in strategic plans, position descriptions and performance management systems. • Programs such as Quality Improvement Program Planning System (QIPPS) recognised as providing practical support. • There is a dedicated health promotion staff member, or health promotion outcomes have been built into all positions. • Established community engagement processes were identified as essential to practice. 	<ul style="list-style-type: none"> • Existing platforms for partnership include PCPs, health promotion networks, working groups and peer support groups. • Common planning processes such as the Integrated Health Promotion Planning (IHP) framework and Environments for Health (E4H) are used to initiate discussion about common objectives and to develop partnerships. • Partnership platforms and integrated planning processes have resulted in the development of partnerships outside of health and the sharing of resources within catchment areas. • The five-day health promotion short course—and other workforce development opportunities—are regarded as essential. • The department's regional office staff are seen as effectively supporting practice. 	<ul style="list-style-type: none"> • Universal support at a statewide level includes the five-day health promotion short course and other targeted workforce development opportunities. • Department of Human Services produces supports and frameworks—Integrated Health Promotion, Environments for Health. • The Leading the Way program (VicHealth) for key leaders in local government increases understanding of health promotion. It is also identified as a highly effective model for work in other settings. • Department of Human Services health promotion website and evidence-based resources are available. • Ongoing contact with staff from the department and VicHealth. • Evidence generation and evidence informed practice identified as essential for quality practice.

Table 2: Summary of responses to question 2

What is your organisation's systems and support vision for the next five years? What is missing from your first answer that is important?

In your organisation	In your region/partnerships	Statewide
<ul style="list-style-type: none"> Resources for health promotion are increased and made recurrent, enabling longer term strategic planning. Health promotion is recognised and actively supported as core work by management and colleagues. Workforce development opportunities to support health promotion in organisations are readily available to key decision makers. This would include participation from decision makers across sectors. Organisational structures are in place to support practice— budget allocation, including health promotion within strategic plans, position descriptions and performance monitoring mechanisms. Systems are developed to enable ready access to, and continuous opportunity to contribute to, the evidence base. Skills are developed to access and interpret evidence for both problem definition and solution generation. Priority setting frameworks are developed and used within and amongst agencies. Community engagement processes will be central to the problem definition process. 	<ul style="list-style-type: none"> Funding for health promotion is recurrent, enabling long-term strategic planning. Workforce development opportunities, such as the five-day short course, are available. Collaborative partnerships like PCPs operate within and across sectors. Local government will be key players in these. Common planning and reporting processes are established. IHP is entrenched in organisational practice. 	<ul style="list-style-type: none"> Leadership in health promotion in Victoria is obvious. Commitment is demonstrated to cross-government/intersectoral partnerships. A set of underpinning principles guides health promotion and prevention policy and practice. Resource allocation for health promotion has increased. Schematic frameworks like the <i>VicHealth Mental Health and Wellbeing</i> framework are available for each of the other priority issues. Systems are developed to enable ready access to, and continuous opportunity to contribute to, the evidence base for both problem definition and solution generation. There is a central point for ensuring this information is current and accessible. This readily available data will reflect the social determinants of health. There is no short term, tagged, targeted funding—rather, there is recurrent funding to support health promotion action directed at the agreed priorities. Workforce development supporting health promotion priorities and action is available. Health promotion training is included in undergraduate programs, for professions playing a role in social determinants of health. Planning frameworks and evaluation mechanisms are consistent among organisations that fund health promotion.

3. Health promotion priorities and next steps

Following the consultation process and analysis of results, the Minister for Health has established seven health promotion priorities for 2007–2012.

The seven priority issues are:

- physical activity and active communities
- accessible and nutritious food
- promoting mental health and wellbeing
- reducing tobacco-related harm
- reducing and minimising harm from alcohol and other drugs
- safe environments to prevent unintentional injury
- sexual and reproductive health.

The overarching aim of the priorities is to improve overall health and reduce health inequalities. Neighbourhood Renewal sites will remain as one of the priority settings for health promotion practice from 2007–12.

While RRHACS Division and VicHealth developed the health promotion priorities, other program areas from across the department—including Neighbourhood Renewal, Office for Children and Disability Services—have also been involved.

A management group has been established, comprising representatives from VicHealth and program areas across the department. The group's focus is on implementation planning for each priority issue and ensuring integration across all the priorities. The purpose is to strengthen Victoria's health promotion system, based on the feedback from part 2 of the consultation forums (see section 2.5 and tables).

Specific management group actions are outlined below. Communication mechanisms will be established to allow for ongoing input from key stakeholders. Later in 2007, more information related to implementation planning for a health promoting system will be published.

The management group developed a set of eight underpinning principles in response to the consultation feedback. These principles should be used to guide health promotion and prevention policy and practice:

1. addressing the broader determinants of health
2. basing action on the best available data and evidence
3. acting to reduce inequalities and injustice
4. emphasising active consumer and community participation
5. empowering individuals, communities and organisations through capacity building action
6. ensuring that diversity (including gender, culture, ethnicity, age, disability and sexual orientation) is explicitly considered
7. working in collaboration across sectors, to ensure an integrated approach to action
8. ensuring access for all to health promoting activities.

The VicHealth Mental Health and Wellbeing Framework was seen as a useful visual and practical tool to ensure program planning was underpinned by a determinants approach. The management group will consider incremental development of schematic frameworks for each of the other priority issues.

This priority setting agenda will enable agencies and organisations throughout Victoria to align their local health promotion program and planning activity to contribute to, and benefit from, statewide direction. Based on these seven health promotion priority issues, statewide health promotion action will move to a more strategic focus over the next five years.

Appendix 1: Consultation forums

The **objectives** of the consultation forums conducted between February and May 2006 were to:

- provide opportunities for the diverse range of stakeholders⁶ to participate in setting the health promotion agenda for Victoria
- gather information to assist in defining health promotion priorities 2007–12 for the RRHACS Division of the Department of the Human Services, VicHealth and other key stakeholders, and to inform systematic strategic planning for health promotion
- contribute to and support key initiatives such as VicHealth's Strategic Priorities 2006–09, *Go for your life* strategy, Primary Care Partnership strategy, Community Health policy, Neighbourhood Renewal strategy, *Care in your community* framework, Aboriginal Health Promotion and Chronic Care (AHPACC) partnership, *Environments for health* and Municipal Public Health Planning, the *Well for Life* initiative and the Victorian Oral Health Promotion strategy 2005–10.

Ten consultation forums were conducted across Victoria, to discuss issues arising from the discussion paper and to seek feedback from organisations. A total of 575 people participated. Project staff also attended the Department of Human Services Consumer, Carer and Community Advisory Committee, to canvas feedback and comments on this process. Table A1 provides a summary of the locations, dates and number of participants at each forum.

Table A1 Consultation forums

Region	Location	Date	Number of participants
Gippsland	Traralgon	February 21	34
Loddon Mallee	Bendigo	March 6	39
Southern	Noble Park	March 9	63
Grampians	Ballarat	March 30	57
North and West	Preston	March 31	98
Barwon-South West	Port Fairy	April 3	44
Eastern	Blackburn North	April 6	93
Hume	Benalla	April 12	56
Loddon Mallee	Mildura	April 13	25
Other			
Statewide HP organisations	Carlton	March 10	58
Consumer, Carer and Community Advisory Committee	Melbourne	June 5	8
Total			575

⁶ It was expected that those participating in the consultation forums or forwarding submissions would express the views of the organisations or communities they represent and/or the communities they work with.

The consultation forums were divided into two parts.

Part one: Health promotion priorities

- Of the priorities listed in the discussion paper, which are current priorities for your organisation? What other priorities are you addressing?
- The discussion paper proposes a list of priorities for the period 2007–12. What do you think the priorities should be? Please provide justification for your selections.
- Priorities review: opportunities for discussion, debate, and questions from the floor.

Part two: Health promoting systems

- What are good examples of systems and support mechanisms (for example, information, workforce development, policy environment) that work well in helping you to deliver quality health promotion programs? Group your ideas:
 - (i) within your organisation
 - (ii) within your partnerships
 - (iii) statewide/other.
- What is your organisation's systems and support vision for the next five years? What is missing from your first answer? Group your ideas:
 - (i) within your organisation
 - (ii) within your partnerships
 - (iii) statewide/other.
- Any other comments? Anything we have missed or should have asked?

End-of-day evaluations from the forums indicated that:

- 96 per cent of participants agreed that the discussion paper provided sufficient pre-workshop reading material to allow full participation in the day
- 91 per cent of participants agreed that there was sufficient discussion during the day about possible health promotion priorities for 2007–12
- 88 per cent of participants agreed that there was sufficient discussion during the day about issues concerning systems and support mechanisms for quality health promotion
- 92 per cent of participants agreed that there was sufficient opportunity to put their views forward during the day.

Appendix 2: Regional snapshots

Gippsland—Traralgon

No. of participants	34
Sectors/organisations represented	Community health, PCP staff, Divisions of General Practice, local government, sport, academia, Aboriginal cooperative, private health care providers
Notes from joint discussion	Generally supportive of proposed priorities Others to consider: social connectedness, family violence, equality, personal development Support for focus on midstream to upstream determinants of health Need for a common language to engage other sectors Need for common planning and evaluation frameworks
Other comments	Gippsland was the first forum, after which the structure of the workshops changed to better suit the needs of the consultation process

Loddon Mallee—Bendigo

No. of participants	39
Sectors/organisations represented	Community health, PCP staff, local government, sport, academia, Victoria Police, youth services, drug and alcohol services, statewide health agency
Issues raised in joint discussion	Need to draw links between priorities to ensure an integrated approach Consider life stage and population group approach Need for common planning and evaluation frameworks Support a 'social determinants of health' approach

Southern—Noble Park

No. of participants	63
Sectors/organisations represented	Community health, PCP staff, local government, academia, youth, mental health, statewide health agency, welfare, dental health, school nursing
Issues raised in joint discussion	Complex relationships between priorities Need upstream approach to all priorities Priorities of physical activity, accessible and nutritious food and mental health and wellbeing all need further articulation and discussion about language Priorities for consideration—social connectedness, young people's sexual and reproductive health Gender, culture, ethnicity and same sex attraction need to be considered Cross-government action required Need for policy to support upstream action

Grampians—Ballarat

No. of participants	57
Sectors/organisations represented	Community health, PCP staff, local government, academia, Divisions of General Practice, youth, mental health, school focused youth service, welfare, self-help group
Issues raised in joint discussion	<p>General support for preliminary priorities</p> <p>Support midstream focus but need to consider broader determinants</p> <p>Consider gender focus</p> <p>Other priorities to consider—capacity building, oral health and disease, life stage approach, family violence, transport, social connectedness, sexual health</p>

North and West—Preston

No. of participants	98
Sectors/organisations represented	Community health, PCP staff, local government, academia, Divisions of General Practice, youth, mental health, Aboriginal services, aged care, welfare, culturally specific agencies, metro fire brigade, disability, professional association, neighbourhood house, statewide health organisations, statewide networks
Issues raised in joint discussion	<p>General support for preliminary priorities, with some language changes</p> <p>Include a human rights framework</p> <p>Consider population approach as well as place-based approach – this would include gender, culture and geographical focus</p> <p>Greater emphasis on health inequality</p> <p>New priorities suggested—sexual and reproductive health, equity and social justice, community building with vulnerable groups, community, active and public transport, poverty</p> <p>Need for better access to data reflecting an upstream approach</p> <p>Need for common planning and reporting mechanisms</p>

Barwon-South West—Port Fairy

No. of participants	44
Sectors/organisations represented	Community health, PCP staff, local government, sport, academia, Divisions of General Practice, youth, mental health, welfare, disability, Department of Veterans Affairs
Issues raised in joint discussion	<p>General support for all priorities, apart from injury prevention as currently presented</p> <p>Oral health to be included as a stand alone priority, or have a strong presence within nutrition priority</p> <p>Need to consider the inequalities that exist between rural and metro areas</p> <p>Need to have better access to data on impact indicators</p> <p>Need to strike balance with priorities (neither too broad nor too prescriptive) and provide a few entry points</p> <p>Problems with recruitment and retention of staff in rural areas</p>

Eastern—Blackburn North

No. of participants	93
Sectors/organisations represented	Community health, PCP staff, local government, Victoria Police, Divisions of General Practice, youth, mental health, aged care, welfare, culturally specific agencies, disability, statewide health organisations, statewide network, consumer groups
Issues raised in joint discussion	<p>In principle agreement on priorities, but need to focus on language. Inequality and social determinants need to be a higher order priority. Need to have subpopulation groups for each action, for example, CALD and most disadvantaged.</p> <p>Language/framework in priorities needs to be inclusive, otherwise this will stop intersectoral action—such as arts and cultural sectors.</p> <p>Other priorities: sexual health (BBV-STI); family violence; addressing poverty; oral health (discussion: it is separate from or part of nutrition?); promoting inclusive communities; gambling; indigenous health; public transport; disability and impairments</p>

Hume—Benalla

No. of participants	56
Sectors/organisations represented	Community health, PCP staff, local government, housing, women's health, school focused youth services, sport and recreation, youth, mental health, aged care, welfare, disability
Issues raised in joint discussion	<p>Communities need to have flexibility to identify priorities</p> <p>Inequality needs a stronger positioning</p> <p>Need to be working upstream</p> <p>Need to more clearly define target groups</p> <p>Proposed new priorities—domestic violence, oral health and disease, youth health, community safety, sexual and reproductive health, education, transport, social connectedness, road trauma, capacity building</p>

Loddon Mallee—Mildura

No. of participants	25
Sectors/organisations represented	Community health, PCP staff, local government, sport and recreation, youth, mental health, aged care, welfare, disability, statewide health organisation
Issues raised in joint discussion	<p>General support for the priorities proposed</p> <p>Proposed new priorities—asthma, breastfeeding, oral health and disease, poverty, environment, access to services, sexual and reproductive health, rurality, transport, violence, social connectedness</p>

Appendix 3: Written submissions to the consultation process

Submissions were received from the following organisations:

1. Advocates for Survivors of Child Abuse
2. Anex—Association for Prevention and Harm Reduction Programs Australia
3. Australian Dental Association Victorian Branch Inc
4. Brotherhood of St Laurence
5. Centre for Developmental Disability Health Victoria
6. City of Casey
7. City of Melbourne
8. Department for Victorian Communities—Sport and Recreation Division
9. Department for Victorian Communities
10. Djerriwarrh Health Services
11. Dr Beverley Wood, Consultant in Food, Nutrition and Dietetics
12. Equal Opportunity Commission Victoria
13. Family Planning Victoria
14. Family Resource Centre—Family Services, Royal Children’s Hospital
15. Human Rights and Bioethics: Department of Epidemiology and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University
16. Inner South Community Health Service
17. Inner South East Area Health Council
18. Ministerial Advisory Committee on Gay and Lesbian Health
19. National Heart Foundation—Victorian Division
20. North Central Metro Primary Care Partnership Integrated Health Promotion Steering Group
21. Northeast Health Wangaratta
22. Quit Victoria
23. The Cancer Council Victoria—SunSmart
24. Optometrists Association Australia
25. The Salvation Army Crisis Services and Royal District Nursing Service Homeless Persons Program
26. Australian Health Promotion Association Victorian Branch
27. Victorian Council of Social Services—VCOSS
28. Victorian Safe Communities Network Inc
29. Vision 2020
30. Western Region Health Centre
31. Women’s Health Association of Victoria
32. Women’s Health Goulburn North East
33. Women’s Health Victoria
34. Women’s Health West

Appendix 4: Priority setting—management group representation

- DHS, Aged Care, RRHACS Division
- DHS, Disability Services
- DHS, Drugs Policy & Services Branch, RRHACS Division
- DHS, Neighbourhood Renewal (Office of Housing)
- DHS, Office for Children
- DHS, Planning and Resources Branch, RRHACS Division
- DHS, Premier's Drug Prevention Council, RRHACS Division
- DHS, Primary Health Branch, RRHACS Division
- DHS, Public Health Branch, RRHACS Division
- DHS Regional office representation
- DHS, Rural & Regional Health Services Branch, RRHACS Division.
- VicHealth

