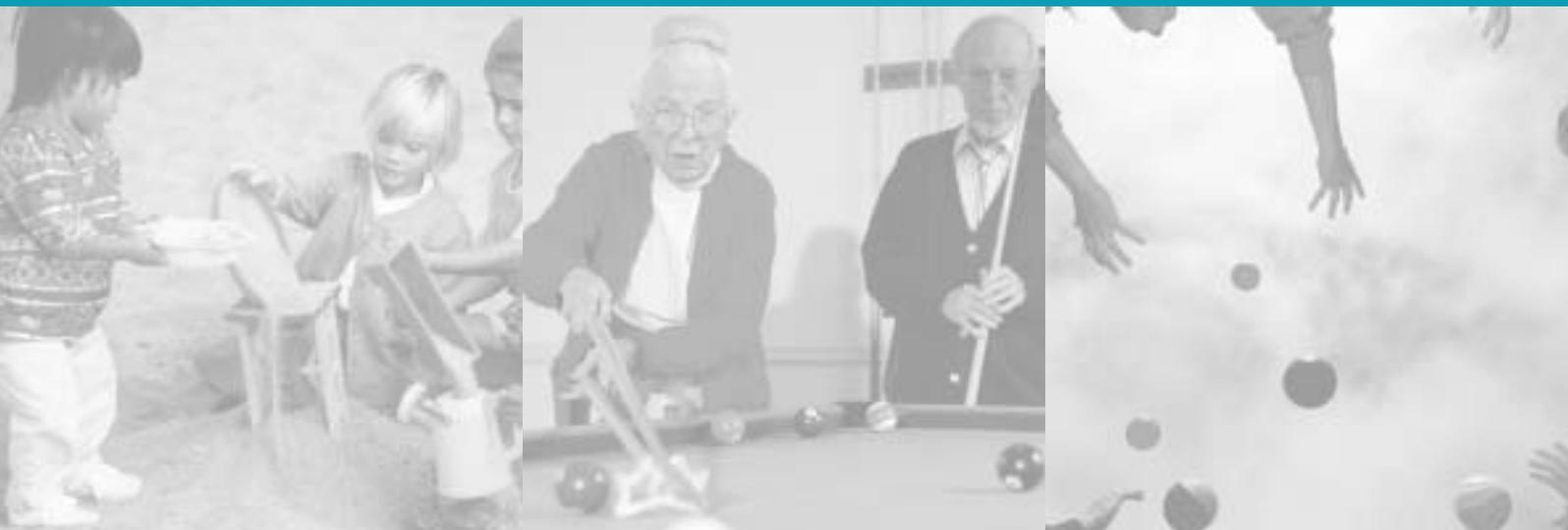


# Integrated health promotion

A practice guide for service providers



## 5. Health promotion interventions and capacity building strategies

### 5.1 Integrated health promotion in action

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

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

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

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

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

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

#### **Toolkit: enable, advocate, motivate**

**These three words describe the role of practitioners involved in integrated health promotion programs:<sup>76</sup>**

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

letters to the local paper calling on the council to improve facilities for physical activity for older people.

- **Mediate:** Many sectors of the community, such as government departments, industry, non-government organisations, volunteer organisations, local government and the media take action that has an impact on people’s health, sometimes acting to support one another, sometimes disagreeing about what should be done. Health workers play a role in mediating between these different groups in the pursuit of health outcomes for the community, or in mediating between the health requests of different sectors of the community.

## 5.2 Health promotion interventions

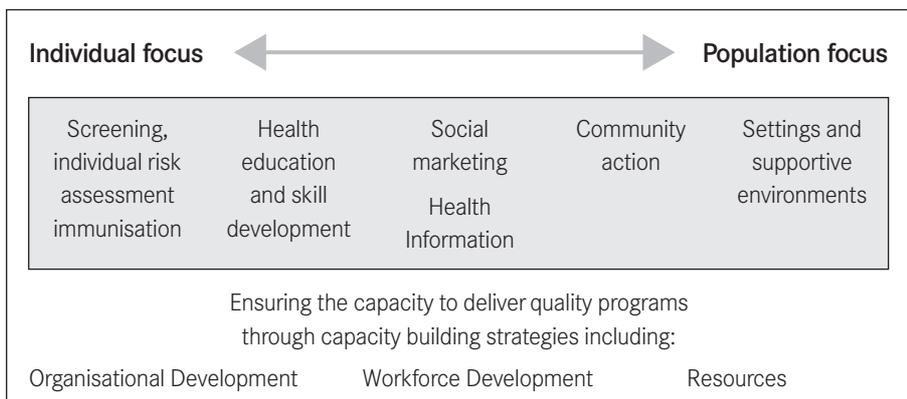
To guide planning for solution generation (Section 4.2.3), five categories of health promotion interventions have been developed including:

- screening, individual risk factor assessment and immunisation
- social marketing and health information
- health education and skill development
- community action (for social and environmental change)
- settings and supportive environments.

*...a key requirement of quality integrated health promotion program delivery is the implementation of a mix of health promotion interventions (encompassing a balance of both individual and population-wide interventions) that contribute to achieving the goal and objectives stated for that integrated health promotion priority.*

As discussed in Section 4.2.3, a key requirement of quality integrated health promotion program delivery is the implementation of a **mix** of health promotion interventions (encompassing a **balance** of both individual and population-wide interventions) that contribute to achieving the goal and objectives stated for that integrated health promotion priority. These interventions are also supported by identified capacity building strategies. Figure 5 shows the relationships between the health promotion intervention categories (solution generation) and ensuring the capacity of the system for health improvement (capacity building). This figure also illustrates how these interventions relate (on a continuum) to an individual and to the whole population.

**Figure 5: Health promotion interventions and capacity building strategies**



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

### 5.2.1 Screening, individual risk factor assessment and immunisation

#### Definition

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

#### Examples

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

#### Further considerations

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

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

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

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

#### Examples of process indicators

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

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

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

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

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

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

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

## 5.2.2 Social marketing and Health information

### Description

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

### Examples

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

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

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

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### Examples of process indicators

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

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

#### ? Checklist: key questions to consider when reviewing health information resources<sup>78</sup>

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

### **Toolkit: Health Translations Online Directory**

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

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

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

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

- Knowledge alone does not lead to behaviour change.
- Social marketing is often directed at a 'typical' person. For example, are all 16 year-old females really so alike?
- The intervention alone ignores the social, economic and environmental determinants of health. Solutions suggested often reinforce the disadvantage of marginalised or poorer groups.
- Single-issue focus can discourage more holistic approaches to health and quality integrated health promotion practice.
- Some social marketing campaigns can lead to victim blaming (for example, anti-gay men sentiments were heightened as a result of the Grim Reaper campaign. See [http://www.thebody.com/cdc/news\\_updates\\_archive/oct3\\_02/aids\\_campaign.html](http://www.thebody.com/cdc/news_updates_archive/oct3_02/aids_campaign.html)).
- The interventions often encourage a focus entirely on individual choice rather than on a balance of this with structural conditions.

### 5.2.3 Health education and Skill development

#### Description

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

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#### Examples

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

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

#### Examples of process indicators

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

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

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

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

People learn best when:<sup>80</sup>

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

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

## 5.2.4 Community action (for social and environmental change)

### Description

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

### Examples

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

### Opportunities for development

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

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### Examples of process indicators

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

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## 5.2.5 Settings and supportive environments

### Description

It includes:

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

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### Examples

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

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

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

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#### **Opportunities for development**

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

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#### **Examples of process indicators**

Reach including the number of:

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

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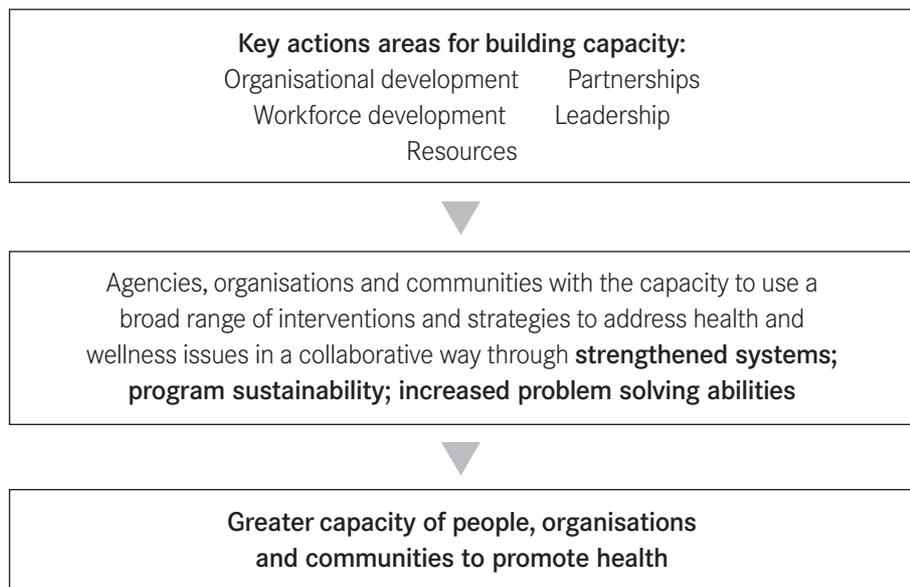
### **5.3 Capacity building – support and resources**

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

Capacity building involves the development of sustainable skills, organisational structures, resources and commitment to health improvement to prolong and multiply health gains many times over.<sup>82</sup> It can occur within a specific program and as part of broad agency and system development. Figure 6<sup>83</sup> highlights the pathways and the key action areas to build capacity to promote health and wellbeing.

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

Figure 6: Building capacity to promote health



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

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

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

**§ Toolkit:** For further information on specific indicators to help measure the success of these strategies see *Indicators to help with capacity building in health promotion (2000)* from NSW Health<sup>87</sup>, downloadable from <http://www.health.nsw.gov.au>

### 5.3.1 Organisational development

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

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

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

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

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

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

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

### 5.3.2 Workforce development

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

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

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

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

### 5.3.3 Resources

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

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

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

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

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

#### 5.3.4 Leadership

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

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

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

### Case study: learnings from the PCP strategy<sup>88</sup>

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

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

### 5.3.5 Partnerships

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

Partnerships and successful cooperative relationships involve:

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

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