Integrated Health Promotion Strategy

Developing a Hume Region Approach to Preventive Health 2012 – 2015
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Executive summary

The Department of Health in the Hume Region (and previously the Department of Human Services) has invested in Integrated Health Promotion for more than 10 years. During this time there has been a considerable change in the requirements of the Departments with regard to the planning, implementation and evaluation of health promotion programs. Organisational capacity within funded agencies has developed to meet many of these expectations; however there remain a number of challenges associated with the level of integrated approaches to prevention activity and the extent to which the sector is able to identify the health and wellbeing benefits from health promotion interventions. In particular, current practice includes the distribution of Integrated health promotion (IHP) funds across 19 different agencies, working on up to 3 different priority areas. In the 2006 – 2006 planning cycle 62 different priority plans were submitted to the Department.

In order to support a more integrated and focused approach, the Regional Office has developed an overarching strategy for Integrated Health Promotion under the auspice of the Hume Health Services Partnership and through consultation with the sector. The strategy has been developed to support funded agencies to deliver high quality health promotion programs that are informed by current best practice.

The Hume Region Integrated Health Promotion Strategy will: -

1) Limit the number of health promotion priorities addressed at the agency and sub-regional (currently Primary Care Partnership) level to allow consolidation of effort and sharing of resources and knowledge.
2) Support an integrated approach to planning and evaluation at Regional and Sub-Regional (currently PCP) level.
3) Concentrate IHP activity to focus mainly on the identified state-wide health promotion priorities.
4) Support an increased focus on evidence-based or evidence-informing practice.
5) Support an increased focus on vulnerable groups and individuals within the community.

The effects of this strategy are summarised in the diagram overleaf. An implementation plan is currently underway to ensure that the Integrated Health Promotion Program will be delivered consistent with this new approach by the next and subsequent planning and funding cycles.
Regional & Sub-Regional Integrated Health Promotion Planning Model

All Agencies Funded Under the Integrated Health Promotion Strategy

Facilitated Planning and Determination of a Common Health Promotion Priority for the Hume Region

Hume Region Health Promotion Priority

Central Hume PCP
Sub-regional HP Priority

Upper Hume PCP
Sub-regional HP Priority

Lower Hume PCP
Sub-regional HP Priority

Goulburn Valley PCP
Sub-regional HP Priority

Central Hume PCP Integrated Health Promotion Plan
3. Regional Priority
4. Sub Regional Priority

Upper Hume PCP Integrated Health Promotion Plan
3. Regional Priority
4. Sub Regional Priority

Lower Hume PCP Integrated Health Promotion Plan
3. Regional Priority
4. Sub Regional Priority

Goulburn Valley PCP Integrated Health Promotion Plan
3. Regional Priority
4. Sub Regional Priority

All Agencies funded under the IHP Program to contribute to the relevant PCP IHP Catchment Plan (implementation and evaluation) identifying goals, objectives, strategies and responsibilities of each agency for either one or both priorities.

Funded Agencies Integrated Health Promotion Activities in line with Regional and Sub Regional Priorities
Part 1: Background

1.1 Rationale

The Department of Human Services / Department of Health has provided strategic support for Health promotion activity in the Hume Region since 1998 with the establishment of the Regional health promotion officer position and the subsequent creation of Regional Public Health teams in 2002.

Integrated health promotion (including early intervention and prevention) has been a component of the Victorian State Government policy platform for several years and is reflected in the Government's signpost document *Growing Victoria Together* as an important component of the human services sector. The policy adopts a social model of health to guide work in the human services sector, clearly recognising the effect of broader social determinants of health on the wellbeing of the Victorian population.

A preventative health focus is also supported by other significant State Government policy frameworks including the *Victorian Health Priorities Framework 2012-2022*. In 2007 the Victorian Government endorsed the *Victorian Health Promotion Priorities 2007 – 2012*. The overarching aim of the health promotion priorities is to improve overall health and reduce health inequalities.

The seven priority issues 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. Creating safe environments to prevent unintentional injury
7. Promoting sexual and reproductive health

The Department of Health has a leadership role for supporting preventative health approaches through integrated health promotion, disease management and injury prevention strategies. The policy contexts discussed above are strengthened by initiatives such as the Primary Care Partnership (PCP) strategy, neighbourhood renewal and the development of health and wellbeing planning within local government.

In Victoria, the term ‘integrated health promotion’ refers to agencies and organisations from a wide range of sectors and communities in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues.

(DHS, 2003)
Underpinning integrated approaches to health promotion are the Victorian state guiding principles for health promotion or core values (see Appendix 1). These are built from the foundations of health promotion that focus on the broader determinants of health that reflect a social model of health (fundamental to integrated health promotion practice) and the link to social capital and community development.

In order to maximise the potential outcomes of integrated health promotion it is important to establish optimal conditions for success. The Department of Health has therefore focused on providing support for capacity building for integrated health promotion that enhances the potential of the system to prolong and multiply health effects and to address the underlying determinants of health.

Prior to November 2009, most recurrent funding for health promotion activity within the Hume region was provided via the Department of Human Services Primary Health Branch through the Community and Women’s Health and Primary Care Partnerships (PCPs) program areas. Responsibility for the Integrated Health Promotion (IHP) component of these funds was passed to the Prevention and Population Health Branch in late 2009.

The total annual investment in the Hume region through these programs is approximately $3.2 million with additional annual investments in health promotion via those agencies participating in the Small Rural Health Service Program. (Amounts based on 2009 – 2010 budget allocations). This investment is spread across 19 agencies and 4 PCPs.

The primary health and public health teams from the Hume regional office have provided support for the development of capacity within the funded sector to plan, implement and evaluate health promotion programs. Since 2000 there has been a considerable focus on encouraging an integrated approach among a range of stakeholders to address health promotion priority issues within defined catchments. This agenda was identified as a key deliverable of PCPs. Over this time regional support, in combination with a range of other factors, has contributed greatly to the development of common understandings of what is meant by health promotion and to an overall increase in the organisational capacity of many agencies to respond to the health and wellbeing needs of their communities.

In acknowledgement of this progress and in response to a range of developments including the establishment of the population health and service planning team (February 2009). The Hume regional office of the Department of Health sought to undertake a project that would build on existing health promotion activity and consider how the regional office could further support the strengthening of health promotion across the region. The overall intent of the project was to strengthen regional action on health promotion, through an increased focus on integration and consolidation of effort on evidence informed practice that aligns with State health promotion priorities.

The focus of this activity was considered to be consistent with the general broader directions at the Federal level as indicated in the National Preventive Health Strategy “Australia: the Healthiest Country by 2020” (National Preventative Health Taskforce, 2009) as well as supporting the National Partnership Agreement on Preventative Health (COAG, 2009).
The approach of the Hume regional office was also guided by the general recommendations of the report on *Promoting Better Health through Healthy Eating and Physical Activity* produced by the Victorian Auditor General (2007). The Auditor General’s report identified some gaps and weaknesses within current approaches and recommended the need to strengthen evidence based responses that guide investments, planning and coordination of programs across Government.

Of particular relevance to agencies funded for integrated health promotion was the need to strengthen the evidence base through:

- building a better understanding of the risks and outcomes through improved data gathering and monitoring.
- compiling and distilling the lessons on what works best from the existing evidence, and apply this knowledge when forming and updating plans
- consistently evaluate the effectiveness of programs in terms of their impact.

The region was also mindful of the need to ensure any regional approaches remained closely aligned with the overarching intentions of the *Victorian Public Health & Wellbeing Plan 2011 - 2015* (VPH&WP), expected to be released in 2011. A major aim of the VPH&WP is to strengthen a systemic approach to preventative health by providing effective and coordinated activity both at the whole of Government and community level.

The revised regional approach will be implemented at the commencement of the next three year planning and funding cycle of the Integrated Health Promotion Program (currently 2012 – 2015).

### 1.2 Methods

**Governance**

The development of the Regional Health Promotion Strategy (RHPS) project was conducted under the auspice of the Hume Health Services Partnership (HHSP) and sought to receive endorsement from this group ahead of implementation.

A steering committee comprising of representatives from a range of regional agencies and stakeholders was developed to guide the direction of the project. Efforts were made to ensure that all types of agencies funded for IHP (ie. stand-alone community health services, regional health services, small rural health services and the regional women’s health service) as well as local government were represented on the committee. Equitable representation across all four of the region’s PCP catchments was also a consideration. (see Appendix 2). An outline of the project Governance framework is provided overleaf.

Activities associated with the various components of the project were undertaken primarily by the Regional Health Promotion Advisor (RHPA) under the guidance of the steering committee and in consultation with the manager and selected members of the population health and service planning program.
Process

The following major activities were undertaken between May and November 2009.

1. Initial workshop with health promotion sector

- Approximately 34 health promotion practitioners representing regional agencies and PCPs that receive funding for health promotion from the primary health program participated in a half day workshop to commence the development of a health promotion strategy for the Hume region. The themes identified focused primarily on the inputs associated with implementation of a health promotion strategy not specifically on the outcomes.

2. Scope activity in a comparable Region

- The RHPA met with the Gippsland DHS regional public health team and key stakeholders including representatives from a community health service, PCP’s and the regional women’s health service. A summary of the main themes evolving from these discussions informed the facilitation process of the project.

3. Mapping existing regional health promotion activity

- A detailed analysis of agency IHP plans 2006 -2009 was undertaken.

- (Refer to the next section for a discussion of the results.).
Hume Health Services Partnership (HHSP) Authorising Body

Regional Health Promotion Strategy (RHPS) Steering Committee

Consultation and Planning Processes

Goulburn Valley PCP (GVPCP)
Lower Hume PCP (LHPCP)
Central Hume PCP (CHPCP)
Upper Hume PCP (UHPCP)

RECOMMENDATIONS

Planning

Implementation

RHPS Implementation Steering Committee

Priority setting Working Party
Quality Working Party
Workforce Working Party
4. Discussion paper

- A discussion paper was developed by the steering committee (SC) that incorporated key elements of a proposed model. The paper included summary of current activity, main issues, potential strategic response and some possible options for inclusion in a regional strategy that had been generated by the steering committee.

5. Facilitation of regional workshops

- Consultation workshops on the discussion paper were conducted within four regional PCP catchment areas. The consultations were conducted by a small sub group of the steering committee. The total number of participants at the workshops was 47. 14 out of a possible 19 agencies receiving recurrent funding for health promotion funded were represented at the workshops.

6. Summary Document

- A summary of common issues from the workshops was developed describing emerging themes and alternative options for discussion with the steering committee.

- There was general consensus amongst participants that there was a need to develop a more efficient and effective framework for the delivery of preventative health action in the Hume region.

7. Structural Options Paper.

- A document outlining various structural options developed on the basis of previous discussions and incorporating feedback from the consultation process was developed and circulated to the steering committee. In considering the various options the steering committee identified a number of principles that would support the development of a more strategic approach to delivery of health promotion services across Hume region. In addition, the views of agencies with respect to priority selection, number; and the sub regional catchment size were taken into account in determining a final set of recommendations.

8. Presentation & Recommendations to HHSP.

- A presentation was made to the Hume health services partnership in November 2009. The presentation included a final list of 5 recommendations. All recommendations were accepted by the HHSP.
Part 2: Analysis

2.1 What is the story?

The efficacy of the Integrated Health Promotion program on health and wellbeing outcomes within the Hume region is difficult to determine. This is the same situation across the state as reflected in the Victorian Auditor General Report (2007) which identified the need to reinforce evidence based health promotion practice and to support evaluation of the impacts of current activities.

Within the Hume region there were a number of factors which may have been contributing to challenges associated with planning, implementing and evaluating evidence informed health promotion practice.

IHP funding within the Hume region is distributed across 19 different agencies, of which 17 were required to provide IHP plans and subsequent reports to the Department of Health. An analysis of all funded agency health promotion plans 2006 -2009 was conducted in July 2009. It was acknowledged that the plans were generated from the previous funding cycle and in the absence of the seven state-wide health promotion priorities and that many plans had evolved over the three year period. It was also acknowledged that agency budgets and allocations were only estimates and at best indicative of agency resource allocations.

Audit findings:

- A total of 13 priorities were identified for HP action across the region.
- 41 per cent of funding was used for activities in areas that were not identified State priorities.
- 62 different plans were written and submitted to the Department.
- Individual agencies were working on up to 5 different priority areas.
- Individual PCPs were working on up to 7 different priority areas.
- There was little to no integrated planning across agencies or PCPs.
- There was limited evaluation of projects beyond simple process indicators.
- There was little evidence of targeting of activities to those population groups who are most disadvantaged.
- There was limited use of an evidence-based approach.

See Appendix 3 for further details.
The audit indicated that not only were there a very high number of priorities being addressed but a significant amount of the funding was being allocated to activities that were not easily identified as being consistent with the Victorian Health Promotion Priorities. In addition there were a large number of individual plans and approaches, with some agencies spreading resources across many priorities. It would appear that such a dilution of activity creates an environment in which there is much activity occurring but limited focus on appropriate evaluation processes and to some extent inadequate consideration of evidence informed practice. With so many separate plans it appeared that the extent of integrated practice across various agencies and opportunities for joint planning and evaluation was limited.

Whilst it was acknowledged that there had been some improvement in these areas over the more recent planning period (2009 – 2012), it was still generally accepted by most stakeholders that there was potential for much greater strategic responses to health promotion activity across the region and that reform of the current situation could assist with the overall level of integrated and evidence informed practice.

2.2 What needs to be addressed?

The steering committee identified a number of key issues that should inform the development of any new strategic approach to the delivery of health promotion activity across Hume region.

These included:

- Limiting the number of priorities that would be addressed at agency and PCP level to allow consolidation of effort and sharing of resources and knowledge.
- Supporting an integrated approach to planning and evaluation at PCP level.
- Limiting activity to focus mainly on the identified state-wide priorities.
- Supporting an increased focus on evidence-based or evidence-informing practice.
- Supporting an increased focus on vulnerable groups and individuals within the community.

2.3 What are the options?

Following consultation with the health promotion sector and a review of the options by the steering committee a set of recommendations were developed.

The final recommendations (as described below), were endorsed by the Hume Health Services Partnership in November 2009:

1. Each agency will work in partnership with its PCP to plan to address one Regional HP Priority and one Sub-regional HP priority developed and applicable at the PCP catchment level. Where there is a strong rationale, more than one Sub-regional priority can be identified within a PCP (minimum catchment size of 1 LGA).
2. The regional health promotion priority will be identified through a consultative process to be commenced no later than 18 months prior to the end of the current funding cycle.

3. Each PCP catchment will develop and submit one integrated health promotion plan outlining all agencies’ contributions to the regional HP priority and to the identified PCP HP priority (or each of the sub-regional priorities where negotiated).

4. Each agency will allocate its health promotion funding to reflect an approximate split of 40 per cent for activity on the regional HP priority, 50 per cent for activity on the sub-regional priority and 10 per cent for flexible use.

5. A sub-committee of the HHSP will be established to guide the implementation and monitoring of the regional health promotion strategy. (This committee to be established in Feb / March of 2010).

6. If a funded agency is allocated less than $100,000 they will not be required to have a sub-regional priority and will only report to the selected regional health promotion priority (as recommended by the implementation steering committee meeting on 15 August 2011).

2.4 What are the priorities for action?

In February 2010 an implementation steering committee was established in accordance with recommendation 5. This implementation group has slightly different membership than the original steering committee (see Appendix 2) and different terms of reference. The primary role of this group is to inform the implementation of the strategy in such a way as to ensure that all intended outcomes are achieved.

The steering committee has decided that in order to achieve the desired outcomes of the strategy the PCP catchment will be the default sub-regional planning area with one catchment IHP Plan being developed that incorporates the relevant activity of all agencies funded for IHP in the first instance. In future it is envisioned that the preventative health plans of other relevant stakeholders could also be incorporated into the IHP catchment plan. Figure 1 provides a diagrammatic representation of the structure of IHP planning under the RHPS.

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### Hume Region Health Promotion Priority

<table>
<thead>
<tr>
<th>Central Hume PCP Sub-regional HP Priority</th>
<th>Upper Hume PCP Sub-regional HP Priority</th>
<th>Lower Hume PCP Sub-regional HP Priority</th>
<th>Goulburn Valley PCP Sub-regional HP Priority</th>
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<tr>
<td>Central Hume PCP Integrated Health Promotion Plan</td>
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<td>Goulburn Valley PCP Integrated Health Promotion Plan</td>
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<tr>
<td>1. Regional Priority</td>
<td>1. Regional Priority</td>
<td>1. Regional Priority</td>
<td>1. Regional Priority</td>
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<td>2. Sub Regional Priority</td>
<td>2. Sub Regional Priority</td>
<td>2. Sub Regional Priority</td>
<td>2. Sub Regional Priority</td>
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</table>

All Agencies funded under the IHP Program to contribute to the relevant PCP IHP Catchment Plan (implementation and evaluation) identifying goals, objectives, strategies and responsibilities of each agency for either one or both priorities.

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**Figure 2:** Sub-Regional Integrated Health Promotion Planning under the Regional Health Promotion Strategy

**One Catchment – One Plan**

Funded Agencies Integrated Health Promotion Activities in line with Regional and Sub Regional Priorities
Part 3: Implementation

The RHPS implementation steering committee considered a number of strategic approaches to ensure the overarching recommendations and desired outcomes could be achieved.

**Figure 3: Implementation**

**Recommendations**

1) Limit the number of health promotion priorities addressed at the agency and sub-regional (currently PCP) level to allow consolidation of effort and sharing of resources and knowledge.
2) Support an integrated approach to planning and evaluation at Regional and Sub-Regional (currently PCP) level.
3) Concentrate IHP activity to focus mainly on the identified state-wide health promotion priorities.
4) Support an increased focus on evidence-based or evidence-informing practice.
5) Support an increased focus on vulnerable groups and individuals within the community.

**Implementation Plan**

- a) Develop guidelines and processes to support the implementation and uptake of the regional strategy.
- b) Deliver excellence and innovation in integrated health promotion practice.
- c) Develop and support a skilled workforce to deliver the regional IHP strategy.
- d) Establish health promotion as an integral part of the health system.
As part of the implementation plan three working parties have been established by the implementation steering committee to deliver on the first three outcomes. (The fourth will be addressed by the steering committee in total).

**Table 1** Summary of the regional integrated health promotion strategy implementation plan

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Responsibility</th>
<th>Objective</th>
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</table>
| A. Develop guidelines and processes to support the implementation and uptake of the regional strategy | Working Party 1: Priority setting | A1 Establish & communicate DH requirements for IHP program (P&PHB) 2010 – 2012, 2012 & beyond  
A2 Establish & communicate DH Hume regional requirements for IHP Program 2010 – 2012, 2012 & beyond as indicated in the RHPS  
A3 Determine the processes required to establish regional IHP Priority(s) for IHP Program 2012 & beyond  
A4 Determine the processes required to establish sub-regional priority(s) for IHP Program 2012 & beyond  
A5 Determine opportunities for alignment b/w Regional IHP Program and the priorities of other DH programs / agencies / sectors for 2012 & beyond |
| B. Deliver excellence and innovation in integrated health promotion practice | Working Party 2: Quality Practice | B1 Embed an understanding of quality IHP practice across all levels of targeted organisations to ensure that the RIHPS can be delivered.  
B2 All IHP interventions outlined in organisational plans 2012 and beyond to be informed by evidence based or evidence informing practice.  
B3 Formal recognition and promotion of current best practice activity on Statewide priorities will be established in regional agencies.  
B4 Embed a focus on vulnerable communities / individuals into IHP interventions |
| C. Develop and support a skilled workforce to deliver the regional IHP strategy | Working Party 3: Workforce | C1 The skill level of the current HP workforce will be enhanced by the introduction of the RIHPS.  
C2 The skills of the current HP workforce will be shared more evenly across the region / sub-region  
C3 Levels of recruitment of skilled HP personnel to the Hume Region will be increased. |
<table>
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<tr>
<th></th>
<th>C4 Establish relationships / alignment with tertiary institutions</th>
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<tr>
<td>D.</td>
<td>Establish health promotion as an integral part of the health system.</td>
</tr>
<tr>
<td></td>
<td>RHIPS Implementation Steering Committee</td>
</tr>
<tr>
<td>D1</td>
<td>An appropriate brand for health promotion activity in the Hume Region will be developed.</td>
</tr>
<tr>
<td>D2</td>
<td>Explore options to market Health Promotion and the regional brand within the health and non-health sectors across the region</td>
</tr>
<tr>
<td>D3</td>
<td>The RIHPS will be acknowledged as an appropriate approach to support improved population health and wellbeing outcomes.</td>
</tr>
</tbody>
</table>
Timeline for implementation

At present the timeline for implementation of the RHPS is based on the commencement of the next planning and funding cycle for agencies funded under the Integrated Health Promotion Program. Currently this is scheduled for July 2012.

**Figure 4** The time line below identifies the major implementation activity key milestones ahead of the commencement of the new cycle.

For additional information on the Hume Regional Health Promotion Strategy contact Mr Sandy Geddis (Regional Health Promotion Advisor) Phone: 03 57220631 Email: sandy.geddis@health.vic.gov.au
References

  

  

  

  

  

  

  

  
Appendix 1

Health Promotion Principles

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

1. **Addressing the broader determinants of health**, recognising that health is influenced by more than genetics, individual lifestyles and provision of health care, and that political, social, economical and environmental factors are critical.

2. **Basing activities on the best available data and evidence**, both with respect to why there is a need for action in a particular area and what is most likely to effective sustainable change.

3. **Act to reduce social inequities and injustice**, helping to ensure every individual, family and community group may benefit from living, learning and working in a health promoting environment.

4. **Emphasise active consumer and community participation** in processes that enable and encourage people to have a say about what influences their health and wellbeing and what would make a difference.

5. **Empower individuals and communities**, through information, skill development, support, advocacy and structural change strategies, to have an understanding of what promotes health, wellbeing and illness and to be able to mobilise resources necessary to take control of their own lives.

6. **Explicitly consider differences in gender and culture**, recognising that gender and culture lie at the heart of the way in which health beliefs and behaviours are developed and transmitted.

7. **Work in collaboration**, understanding that while programs may be initiated by the health sector, partnerships must be actively sought across a broad range of sectors, including those organisations that may not have an explicit health focus. This focus aims to build on the capacity of a wide range of sectors to deliver quality integrated health promotion programs; and to reduce the duplication and fragmentation of health promotion effort.
## Appendix 2

### Governance Groups

2a) RHPS Reference Group (May 2009 – Dec 2009)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>Ms Doreen Power</td>
<td>CEO Seymour Health</td>
</tr>
<tr>
<td>Ms Anne Wearne</td>
<td>CEO Ovens &amp; King Community Health Service (O&amp;KCHS)</td>
</tr>
<tr>
<td>Ms Jenny Donnelly</td>
<td>Indigo North Health (INH)</td>
</tr>
<tr>
<td>Ms Rebecca Lorains</td>
<td>Goulburn Valley Community Health Service (GVCHS)</td>
</tr>
<tr>
<td>Ms Janine Holland</td>
<td>Northeast Health Wangaratta (NHW)</td>
</tr>
<tr>
<td>Ms Liz Hillenaar</td>
<td>Benalla Rural City</td>
</tr>
<tr>
<td>Ms Kylie Stephens</td>
<td>Women’s Health Goulburn North East (WHGNE)</td>
</tr>
<tr>
<td>Ms Alana Chambers</td>
<td>Upper Hume PCP</td>
</tr>
<tr>
<td>Ms Janet Chapman</td>
<td>Department of Health- Hume Region (DH)</td>
</tr>
<tr>
<td>Mr Harvey Ballantyne</td>
<td>Department of Health - Hume Region (DH)</td>
</tr>
<tr>
<td>Ms Judith Moore</td>
<td>Department of Health - Hume Region (DH)</td>
</tr>
<tr>
<td>Mr Sandy Geddis</td>
<td>Department of Health - Hume Region (DH)</td>
</tr>
<tr>
<td>Ms Vicky Mason (Ex-Officio)</td>
<td>Assistant Director Health Development, Public Health Branch</td>
</tr>
<tr>
<td>Ms Anne Shaw</td>
<td>Community Representative</td>
</tr>
</tbody>
</table>
2b)  RHPS Implementation Steering Committee (Feb 2010 – Present)

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Doreen Power</td>
<td>Seymour Health</td>
</tr>
<tr>
<td>Ms Anne Wearne</td>
<td>Ovens &amp; King Community Health Service</td>
</tr>
<tr>
<td>Ms Rachael Rheese</td>
<td>Central Hume PCP and Delatite Community health service</td>
</tr>
<tr>
<td>Ms Sam Campi (Till March 2011)</td>
<td>Goulburn Valley PCP</td>
</tr>
<tr>
<td>Ms Leigh Rhode</td>
<td>Goulburn Valley Health</td>
</tr>
<tr>
<td>Ms Alana Chambers</td>
<td>Gateway Community Health Service</td>
</tr>
<tr>
<td>Mr David Kidd</td>
<td>Beechworth Health Service</td>
</tr>
<tr>
<td>Ms Suzanne Miller</td>
<td>Mitchell Community Health Service</td>
</tr>
<tr>
<td>Ms Jenny Donnelly (Till July 2010)</td>
<td>Indigo North Health Service</td>
</tr>
<tr>
<td>Ms Kylie Stephens (Till July 2010)</td>
<td>Women’s Health Goulburn North East</td>
</tr>
<tr>
<td>Ms Janet Chapman</td>
<td>Department of Health Hume</td>
</tr>
<tr>
<td>Mr Harvey Ballantyne</td>
<td>Department of Health Hume</td>
</tr>
<tr>
<td>Ms Judith Moore</td>
<td>Department of Health Hume</td>
</tr>
<tr>
<td>Mr Sandy Geddis</td>
<td>Department of Health Hume</td>
</tr>
<tr>
<td>Ms Kaaren Smethurst (Till Oct 2010)</td>
<td>Mansfield Shire Council</td>
</tr>
<tr>
<td>Ms Deb Randich</td>
<td>Benalla Rural City</td>
</tr>
</tbody>
</table>
Appendix 3

Health Promotion Activity Hume Region 2008 - 2009: Summary of Allocations (as per Agency Plans)

The following information represents a partial analysis of health promotion resource allocations to varying health promotion priority issues as identified by agencies funded through the DHS Community and Women's Health program area. The summaries are primarily based on information provided to the regional office via the organisational (three year) and operational (twelve month) health promotion plans of agencies.

Where actual figures for agency allocations 2008 – 2009 were not available the general proportional allocations as identified in the three year Organisational Health Promotion Plans 2006 – 2009 were used to develop estimates for current expenditure per priority.

In most cases the actual monetary figures and subsequent percentage allocations are indicative only and should not be considered as being a truly accurate representation of the exact allocations of any individual agency.

Summary Points:

According to agency organisational health promotion plans…

- 17 funded agencies identified a total 62 different priority issue health promotion plans spanning 13 different health promotion priorities.

- The number of priorities identified in agency plans at the PCP level ranged from 5 to 7 priorities.

- Approximately 52 per cent of agency Community & Women’s health (C&WH) HP funds were allocated to 3 of the 7 State-wide health promotion priorities.

- Approximately 41 per cent of agency C&WH HP funds were allocated to areas not specifically identified as State-wide health promotion priorities.

3a) Health Promotion Priorities Addressed (Table 1)

- Based on IHP Plans 2006 -2009, 17 regional agencies have identified 13 different areas in which health promotion resources have been allocated. The areas include 6 of the 7 statewide (SW) health promotion priorities.

- The 17 agencies does not include those regional agencies receiving HP funding that were not required to submit plans 2008-2009.

- Priority plans are defined as the documented goals, objectives, interventions and evaluation strategies identified for each of the priority issues indicated by agencies (excluding flexible / opportunistic activity).

- The total number of priority plans for health promotion activity identified by the agencies is 62.
- Significantly, “Reducing the Harm from Alcohol and Illicit Drugs” has not been specifically identified by any agency as an organisational priority. Only one agency, WHGNE, has chosen “Sexual & Reproductive Health” as an area of focus for their work across the region.

- For the period 2006 – 2009 funded agencies were given the flexibility to utilise 15 per cent of HP funding to address emerging, opportunistic or unspecified priority issues.

- For the 2006 – 2009 planning period agencies were also given the opportunity to identify organisational capacity building as separate and specific issue for organisational HP activity.

**Table 1**  Distribution of Funded Agency Activity per Priority Area  
(17 Organisational Health Promotion Plans 2006 –2009)

<table>
<thead>
<tr>
<th>Statewide Priority</th>
<th>No. of Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity, Active Communities</td>
<td>8</td>
</tr>
<tr>
<td>Accessible &amp; Nutritious food (Incl. 4 Healthy Weight / Obesity)</td>
<td>11</td>
</tr>
<tr>
<td>Promoting Mental Health &amp; Wellbeing</td>
<td>11</td>
</tr>
<tr>
<td>Reducing Tobacco Related Harm</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol &amp; Other Drugs</td>
<td>0</td>
</tr>
<tr>
<td>Preventing Unintentional Injury</td>
<td>1</td>
</tr>
<tr>
<td>Sexual &amp; Reproductive Health (WHGNE)</td>
<td>1</td>
</tr>
<tr>
<td>Non SW HP Priority Issues</td>
<td>5</td>
</tr>
<tr>
<td>- Family Safety (Family Violence) x 2</td>
<td></td>
</tr>
<tr>
<td>- Oral Health</td>
<td></td>
</tr>
<tr>
<td>- Healthy Start</td>
<td></td>
</tr>
<tr>
<td>- Healthy Ageing</td>
<td></td>
</tr>
<tr>
<td>Organisational Capacity Building</td>
<td>11</td>
</tr>
<tr>
<td>Other Opportunistic</td>
<td>11</td>
</tr>
</tbody>
</table>

**Total Number of Individual Priority Plans identified by agencies (including WHGNE)**  62
### Funding Allocations by Priority for Funded Agencies (Table 2 & Fig 1)

- Approximate funding allocations for each priority are based on Operational Plans 2008-2009 where available or Organisational Plans 2006 – 2009. Whilst the amounts per priority should be considered as indicative only, the information could be seen as representing general themes in current allocations for health promotion activity.

- Figures do not include PCP IHP funding or funded agencies that were not required to submit HP plans.

#### Table 2: Distribution of Funded Agency Activity per Priority Area and Funding Allocations (17 Organisational Health Promotion Plans 06 – 09)

<table>
<thead>
<tr>
<th>Statewide Priority</th>
<th>No. of Agencies (n = 17)</th>
<th>Funding Allocations</th>
<th>% of Regional Allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity, Active Communities</td>
<td>8</td>
<td>278,559</td>
<td>10.7%</td>
</tr>
<tr>
<td>Accessible &amp; Nutritious food (Incl. 4 Healthy Weight / Obesity)</td>
<td>11</td>
<td>407,133</td>
<td>15.7%</td>
</tr>
<tr>
<td>Promoting Mental Health &amp; Wellbeing</td>
<td>11</td>
<td>660,277</td>
<td>25.4%</td>
</tr>
<tr>
<td>Reducing Tobacco Related Harm</td>
<td>3</td>
<td>80,845</td>
<td>3.1%</td>
</tr>
<tr>
<td>Alcohol &amp; Other Drugs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Preventing Unintentional Injury</td>
<td>1</td>
<td>22,000</td>
<td>0.8%</td>
</tr>
<tr>
<td>Sexual &amp; Reproductive Health (WHGNE)</td>
<td>1</td>
<td>83,785</td>
<td>3.2</td>
</tr>
<tr>
<td>Non SW HP Priority Issues</td>
<td>5</td>
<td>356,120</td>
<td>13.8%</td>
</tr>
<tr>
<td>- Family Safety (Family Violence) x 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Oral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Healthy Start</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Healthy Ageing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational Capacity Building</td>
<td>11</td>
<td>513,822</td>
<td>19.8%</td>
</tr>
<tr>
<td>Other Opportunistic</td>
<td>11</td>
<td>194,617</td>
<td>7.5%</td>
</tr>
<tr>
<td><strong>Total number of individual priorities identified by agencies (including WHGNE)</strong></td>
<td><strong>62</strong></td>
<td><strong>$2,597,158</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
• Three of the SW health promotion priorities (Physical Activity, Food and Nutrition and Promoting Mental Health) attract approximately 52 per cent of the total health promotion funding.

• No funding is specifically allocated to the SW health promotion priority “Reducing Harm from Alcohol and Illicit Drugs”. Only one agency WHGNE (Regional Women’s Health Service) has identified “Sexual and Reproductive Health” as an area of primary focus.

• Approximately 41 per cent of regional funding is allocated to areas not specifically identified as SW health promotion priorities.

• 27 per cent of the regional funding is allocated towards organisational capacity building or emerging issues or opportunistic health promotion.

Figure 1  Distribution of Regional Health Promotion Funding by HP Priority Area

<table>
<thead>
<tr>
<th>Health Promotion Priority</th>
<th>Allocations All Agencies (Excluding WHGNE)</th>
<th>Hume Region Health Promotion Funding (C&amp;WH) by HP Priority 08 - 09 (Including WHGNE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity</td>
<td>$278,559</td>
<td>$407,133</td>
</tr>
<tr>
<td>Food &amp; Nutrition</td>
<td>$22,000</td>
<td>$22,000</td>
</tr>
<tr>
<td>Mental Wellbeing &amp; Community Connectedness</td>
<td>$80,845</td>
<td>$356,120</td>
</tr>
<tr>
<td>Tobacco Related Harm</td>
<td>$200,000</td>
<td>$513,822</td>
</tr>
<tr>
<td>Unintentional Injury - Falls Prevention</td>
<td>$0</td>
<td>$194,617</td>
</tr>
<tr>
<td>Alcohol &amp; Illicit Drug Harm</td>
<td>$83,785</td>
<td></td>
</tr>
<tr>
<td>Sexual &amp; Reproductive Health</td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td>Non SW HP Priorities</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Capacity Building</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>Other - Opportunistic</td>
<td>$100,000</td>
<td></td>
</tr>
</tbody>
</table>

*NB. Capacity Building includes Sectoral Capacity Building undertaken by WHGNE.
3c) Priorities Addressed Primary Care Partnerships (PCP)

As identified by agency plans within each of the four regional PCPs the total number of different priority issues addressed by funded agencies is:

<table>
<thead>
<tr>
<th>PCP</th>
<th>Agencies</th>
<th>Priorities</th>
<th>Priority Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goulburn Valley PCP</td>
<td>5</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4 PCP IHP Priorities)</td>
<td>(4 Plans)</td>
</tr>
<tr>
<td>Lower Hume PCP</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2 PCP IHP Priorities)</td>
<td>(2 Plans)</td>
</tr>
<tr>
<td>Central Hume PCP</td>
<td>3</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2 PCP IHP Priorities)</td>
<td>(3 Plans)</td>
</tr>
<tr>
<td>Upper Hume PCP</td>
<td>5</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3 PCP IHP Priorities)</td>
<td>(5 Plans)</td>
</tr>
</tbody>
</table>

- The above list excludes the whole of region activities of Women’s Health Goulburn North East.
- Includes Organisational Capacity Building & Identified allocations for Flexible / Opportunistic Activity.
- Priority Plans are defined as the documented goals, objectives, interventions and evaluation strategies identified for each of the priority issues indicated by agencies (excluding Flexible / Opportunistic Activity).
- 2 of the agencies in the Lower Hume PCP and 2 agencies within the Goulburn Valley PCP submitted joint plans within the 2006 – 2009 planning period.
- An expectation of Integrated Health Promotion Planning would be the development of agency plans to address common PCP / Catchment priorities. The extent to which agency plans are integrated with other agency plans addressing the same priorities within the same catchment is not evident within the individual plans.

3d) Funding Allocations by Priority for PCP Catchments

The graphs (Figure 2, pg 30) represent the amount of funding allocated by funded agencies for each priority area within each of the Regions 4 PCPs.
3e) Target Groups

The following information indicates the principle priority (population) target groups for agency health promotion priority plans (as identified by 16 organisational HP plans 06 – 09).

A total of 14 different categories of population target group were identified within agency plans. The categories were based on general assumptions regarding age, gender, location and setting of the target as described in agency plans and placed accordingly. Some identified target groups were recorded in more than one category.

In most cases a separate category was established if the target group was identified more than once (exception Secondary Schools). Target groups mentioned only once were placed in the “other” category. The “other” category also includes target groups that were difficult to define. This category includes groups such as education and health professionals, populations at risk of chronic disease, patients, representatives of local government etc.

Apart from identification of activity within a Neighbourhood Renewal site there were 20 separate additional indications of the need to work with vulnerable groups. Vulnerability included specific reference to people or groups at risk due to geographic or social isolation, cultural background, linguistic background, low income, low socioeconomic status, educational attainment and vulnerability to the impacts of drought.

Primary Schools (children / parents / communities) were identified as a target group (setting / population) on 11 occasions. Secondary schools were only identified once.

Women were identified more than men and older persons) was the age cohort most often mentioned. Reference to families included pre school age children and their parents / family groups. Mixed populations were identified on 7 occasions. Internal organisation included reference to agency personnel, staff, boards etc.
Figure 3: HP Priority Target Groups as identified by 16 Agency Plans

At the PCP level between 17 and 23 priority target groups were identified (Figure 4).

The number of different target groups at the PCP level was as follows…

- LH PCP 11
- GV PCP 10
- UH PCP 8
- CH PCP 8
Figure 4  Number of Priority Groups at PCP level.

Identified Priority Groups / PCP

Primary Care Partnership

Number of Specific Identifications

LHPCP  GVPCP  CH PCP  UH PCP

0 5 10 15 20 25

LHPCP  GVPCP  CH PCP  UH PCP
Figure 2  Distribution of Health Promotion Funding within PCP Catchments by HP Priority Area.