

# **Health Promotion in Community Health**

## **The views of the health promotion workforce**

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## **EXECUTIVE SUMMARY**

Victorian community health services have been operating within the Integrated Health Promotion framework since 2000.

A recent report by the Victorian Auditor General found that community health services experience a range of challenges in integrating health promotion with their service delivery roles.

A written questionnaire was developed to explore the views of health promotion workers in Victorian community health services on:

- The strengths of health promotion in community health
- Areas for improvement in health promotion in community health
- The factors that support or work against effective health promotion in community health
- The changes that would make health promotion in community health more effective.

The survey was sent via email to health promotion workers in community health services across Victoria. 61 responses were received.

The survey responses revealed that health promotion workers in community health see the main strength of health promotion in community health as the close connection that community health has to its local community and the capacity this gives community health to empower communities and involve them meaningfully in decisions.

Building strong and effective partnerships is another area of strength.

The major challenge faced by health promotion in community health is lack of funding. Lack of funds were identified as a barrier to effective practice, a weakness of health promotion in community health and a threat to the future of health promotion in community health.

Other key areas of concern for health promotion workers include a lack of understanding, knowledge and skills in health promotion amongst their non-health promotion colleagues and amongst management.

A sense that health promotion is not given the same priority as direct service provision by staff, managers and by governments was also a concern that emerged through responses to various questions. Some respondents were optimistic that there was a growing recognition amongst governments of the role of health promotion, whilst others feared that the increasing focus on chronic disease management could sideline health promotion.

In terms of health promotion practice, evaluation is the area that causes health promotion the most concern. Advocacy is also seen as an area of weakness.

Training and organisational development were identified as the most effective capacity building strategies. Clear communication was also seen as central to building capacity.

Looking to the future, health promotion workers would like to see more funding for health promotion, clearer leadership and policy direction from the Department of Human Services and greater investment in training.

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# INTRODUCTION

## Context

Health promotion is a key role of community health services in Victoria. Approximately 100 community health services operate across Victoria, delivering a range of primary health care services to local communities from approximately 400 sites (DHS 2004a and 2008a). The Department of Human Services invests annually approximately \$30 million in health promotion in community health services through the Community Health Program. This funding amounts to 7.5% of the estimated combined annual budgets of community health services (DHS 2008a). Other funding for health promotion activities is provided through other DHS funding streams, from other state government departments such as the Department of Planning and Community Development, from the federal government, local governments, VicHealth and other bodies such as philanthropic trusts.

In Victoria community health services and other organisations funded by the Department of Human Services operate within the framework known as *Integrated Health Promotion* (IHP). IHP “refers to agencies 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, p.3). The key points of the IHP approach included partnership working across primary health care and other sectors, adopting a planned approach, delivering a balanced mix of individually focused and population-wide interventions, and working on capacity building strategies to strengthen the response to health issues.

The Integrated Health Promotion framework has been around since 2000 and in that time health promotion in community health is seen to have evolved and “matured” to the extent that DHS has expressed its “confidence in the sector’s ability to do this [the planning and delivery of IHP] well” (DHS 2008b, p.5).

Relevant DHS policy documents, including *Community Health Services – creating a healthier Victoria* (2004a) and the Primary Care Partnerships strategy (2004b) outline a strong commitment to the role of community health services in health promotion. More generally the Victorian Government and the new Australian Government have both outlined a strong policy interest in preventive approaches in health. The Victorian Government has called for a stronger emphasis on primary prevention, including the development of sub-regional “Healthy Living Partnerships” (Department of Premier and Cabinet 2008, p.26)

However, a recent investigation into health promotion directed towards promoting healthy eating and physical activity in Victoria found weaknesses in approaches to promotion at a number of levels (Victorian Auditor-General 2007). The Auditor-General found that community health services experience a range of challenges in integrating health promotion with their service delivery roles. These challenges included challenges associated with enabling a range of health professionals to incorporate health promotion into their work practices, allocating the health promotion budget across a diverse range of areas, and measuring the impact of health promotion on health outcomes.

More recently DHS has moved to address some of the concerns expressed by the Auditor General by tendering for the development of improved IHP performance measures for Primary Health funded agencies (DHS 2008b). The rationale given for this was both to improve accountability for health promotion funds and to strengthen the evidence base for IHP in order to strengthen practice.

### **Aims**

This study set out to explore the views of health promotion workers in Victorian community health services about the practice of health promotion in the organisations in which they work and across the community health sector in Victoria as a whole. The goal was to contribute to debate about the effectiveness of health promotion in community health by documenting the views of health promotion workers on the quality and effectiveness of the health promotion work undertaken and the factors impacting upon how health promotion work is delivered.

The objectives were to document the views of health promotion workers in Victorian community health services on:

- The strengths of health promotion in community health
- Areas for improvement in health promotion in community health
- The factors that support or work against effective health promotion in community health
- The changes that would make health promotion in community health more effective.

The rationale was that health promotion workers in community health would be able to offer worthwhile insights based on first-hand experience of how health promotion is performed in community health. Their experiences of trying to support or implement health promotion projects within the community health setting may offer insights into the strengths and weaknesses of health promotion in community health that have as yet been undocumented on a statewide level.

### **Methods**

This study sought to elicit the views of health promotion workers in Victorian community health services through an online questionnaire that was circulated through various email channels.

#### *The questionnaire<sup>1</sup>*

The first part of the questionnaire sought to collect key data on the respondents by asking questions on their role, the organisation they work for and their experience and training.

The second part of the questionnaire asked respondents to rank their organisations performance in various areas of health promotion practice. Collectively these questions were designed to provide an overview of the strengths and weaknesses of health promotion in community health services in terms of the objectives of health promotion, the organisational prerequisites for effective action, and the stages of the process of

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<sup>1</sup> See Appendix 1 for the questionnaire.

undertaking action in health promotion. Two key policy frameworks were used as the basis for these questions. The first was the Ottawa Charter for Health Promotion (WHO 1986). The three core roles and five action areas of health promotion, as outlined in the charter, remain a relevant framework for the role and aims of health promotion. The questionnaire asked respondents to rate their organisation's work in each of these roles and action areas and also to rank in order the amount of time their organisations directed towards each of the five action areas. The second framework used was the Integrated Health Promotion Resource Kit (DHS 2003). Respondents were asked to rate their organisations on the five domains of organisational capacity that the kit outlines as areas for capacity building in order to support effective health promotion and the ten stages of the program management cycle, which are described as the "key steps to ensuring quality practice" (DHS 2003, p.31).

A final set of closed-response questions asked respondents to indicate the extent to which they agreed or disagreed with a series of statements related to how they saw health promotion in the community health sector as a whole both currently and into the future.

The remainder of the questions were open-ended questions asking for respondents views on a number of topics related to the aims of the study. The questions asked respondents to identify:

- barriers to better health promotion practice in their organisation
- effective strategies in building the health promotion capacity of their organisation
- strengths of health promotion in community health
- weaknesses of health promotion in community health
- opportunities for the future development of health promotion in community health
- threats to the future effectiveness of health promotion in community health
- changes they would you like to see to strengthen health promotion across the community health sector.

During the design of the questionnaire feedback was requested and received from:

- Priscilla Robinson, Senior Lecturer in the School of Public Health, La Trobe University
- Vera Boston, Chief Executive Officer, North Yarra Community Health
- Members of the Northern Region Community Health Centres Health Promotion Network.

Once the content had been finalised the on-line survey was created using Survey Monkey. The questionnaire was pilot tested on members of the Northern Region Community Health Centres Health Promotion Network. The six pilot-test responses were not included in the survey results and colleagues who had completed the pilot version were encouraged to also complete the final version.

#### *Dissemination of the questionnaire*

The questionnaire was disseminated via emails through 3 routes – DHS Regional Health Promotion Officers (twice), community health service Chief Executive Officers or senior managers, and Primary Care Partnership Integrated Health Promotion Officers.

The multiple routes used to disseminate the survey were designed to ensure that the survey reached health promotion workers in at least 90% of community health services across Victoria. However, it is not known who received the survey and who did not and so it is not possible to estimate the follow-up rate on the survey nor to be totally sure that it did reach all of the intended recipients.

### *Analysis*

Survey Monkey provides responses both in summary form and in full. The quantitative data are presented in the results section in summary form as collated automatically by Survey Monkey. The responses to the open-questions were analysed manually for common themes and issues. The responses for each of the open-ended questions were coded and then grouped into key themes for each question, as presented in the results section. Due to time constraints no attempts have been made to analyse the data in a stratified way, for example by looking at whether there are differences in responses between rural and metropolitan community health services, or between independent community health services and integrated or multipurpose health services. Such analysis, particularly of those variables mentioned, could be a valuable future use of these data.

### *Literature review*

A review of relevant literature was conducted with the aim of providing context and additional insight to the data collected through the survey. A search for relevant literature was conducted on four health sciences databases: CINAHL, OVID Medline 1950-present, Embase and Informit. The searches conducted were as follows:

**CINAHL:** Community health AND Australia AND health promotion

**Embase:** Community health AND Australia AND health promotion

**Informit:** Community health AND health promotion AND Victoria

**OVID Medline (1950 – 2008)**

- 1 health promotion/ and community health services/ (1086)
- 2 australia/ or victoria/ (55113)
- 3 1 and 2 (32)

In addition to academic literature, policy documents were also highly relevant to this study. A range of policy documents were accessed through the Department of Human Services website and other sources.

### **Limitation of this study**

The original project plan for this study outlined two stages of research. The questionnaire was to be followed by a series of semi-structured interviews with key informants to further explore issues and themes that arose from the written survey. However, due to the designing of the questionnaire taking longer than expected the timelines for the project had to be altered with the result that the planned interview stage was abandoned. Whilst the interviews would have provided a rich source of data that would have complemented the data derived from the survey, I believe that the survey responses provided enough data to allow me to address the objectives of the project using this single method approach.

## RESULTS

61 responses to the survey were received. Several factors mean that it is hard to assess what this response rate means for the strength of the results of this study. The dissemination methods used mean it is not possible to ascertain a response rate for the survey. Furthermore I do not have access to information that would indicate how many people working in community health in Victoria would fall into the target group of "workers for whom health promotion constitutes the primary focus of their position". Finally, to ensure confidentiality no information was gained to indicate which health services respondents came from so it is not possible to know how many of the 108 community health services were represented in the responses.

Summary tables of responses are included in Appendix 2.

### Part One – Characteristics of respondents

#### *Type of health service worked for*

Responses were received from 29 people who work for Independent or Stand-alone Community Health Services<sup>2</sup>, 21 people who work for Integrated Community Health Services and 11 people who work for Multipurpose health services.

Figures from DHS indicate that Community Health Program funding is received by 40 Independent or Stand-alone Community Health Services, 62 Integrated Community Health Services (operating as constituent parts of 54 separate organisations) and 6 Multipurpose Health Services. This indicates that the response rate amongst Integrated Community Health Services was much lower than amongst Independent Community Health Services and Multipurpose Health Services. Further, it can be said that Multipurpose Health Services were significantly over-represented in the responses.

#### *Service location*

Responses were received from 24 people who work for services in a DHS rural region and 37 who work for services in a DHS metropolitan region.

DHS figures indicate that there 74 Community Health Program funded agencies situated in DHS rural regions, constituting 68.5% of agencies, and 34 Community Health Program funded agencies in DHS metropolitan regions. The responses clearly indicate a bias towards metropolitan services.

#### *Worker role*

6 respondents identified their role as Health Promotion Manager, 7 as Manager with responsibility for health promotion, 12 as Health Promotion Coordinator and 28 as Health Promotion Officer. 8 people who responded as "other" and were asked to specify their roles. The responses received were:

- Health Promotion Officer - Mental Health Worker
- Community Development Project Officer

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<sup>2</sup> Both terms are used to describe Community Health Services that have an independent Board of Management and are not aligned to any other type of health service.

- youth worker with health promotion (sic) component in role
- Youth Community Development Worker
- Health Promotion Team Leader - 6 staff in team
- CEO
- community health worker
- Community Health Nurse Health Promotion Coordinator

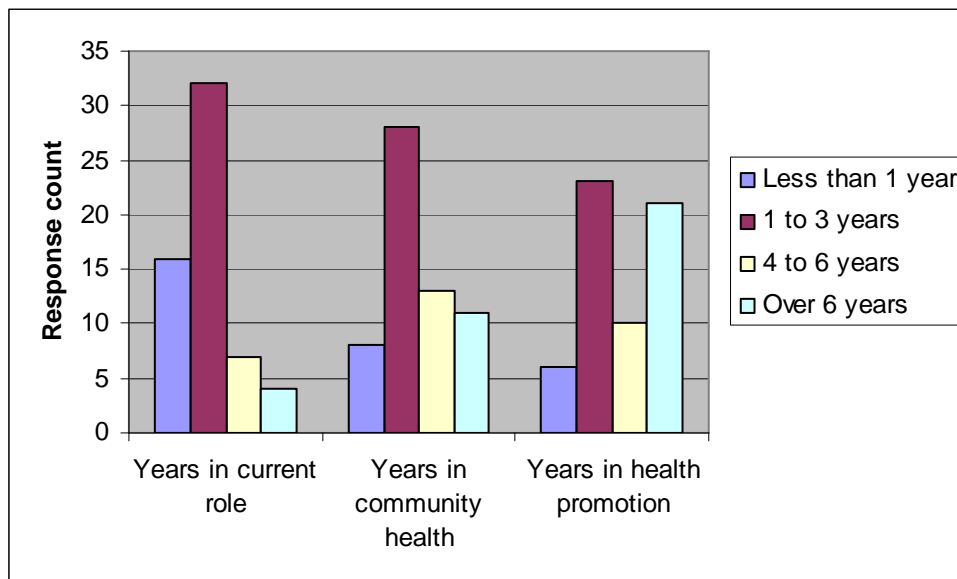
I have decided not to exclude any of these people’s responses from the analysis despite the fact that they may not strictly qualify under the category “workers for whom health promotion constitutes the primary focus of their position”. I have chosen to presume that all those who completed the survey self-identified as people whose role was primarily focused on health promotion including the CEO.

Health Promotion does not have a clearly defined career structure nor any clear definition of what different roles may entail. However it can be assumed that a Health Promotion Manager, Coordinator or Team Leader is someone who has a level of organizational responsibility and some sort of leadership role for health promotion within an organization. A Health Promotion Officer is more likely to have a role that focuses on particular projects or priority areas. If we make some assumptions on the nature of people’s roles based on this division we can say the survey elicited a fairly even split of responses between people with a leadership role of some kind and people with a project role.

*Experience*

To get a feel for the experience of the people responding to the survey 3 questions were asked about the amount of experience they had of health promotion and community health.

**Figure 1: Experience of respondents**



As figure 1 illustrates the profile of experience shows more respondents have over 3 years experience in health promotion than have more than 3 years experience in

community health, suggesting that community health is attracting health promotion workers from other sectors.

### *Education and training*

The question “What is your highest level of training or education in health promotion?” was asked in part because it is often said that there are too few people with health promotion qualifications working in community health. This was an assertion that was made in the open-ended responses to the questionnaire (see below). The responses to this question show that 67% of respondents did have a formal qualification in health promotion.

## **Part Two – Strengths and weaknesses in health promotion practice**

### *The Ottawa Charter*

The Ottawa Charter was the foundation document for modern health promotion and remains a key document in health promotion theory and the health promotion policy landscape. The questionnaire sought to establish how respondents thought their organisations were performing in each of the three roles and five action areas of the Ottawa Charter.

### *Core roles of health promotion*

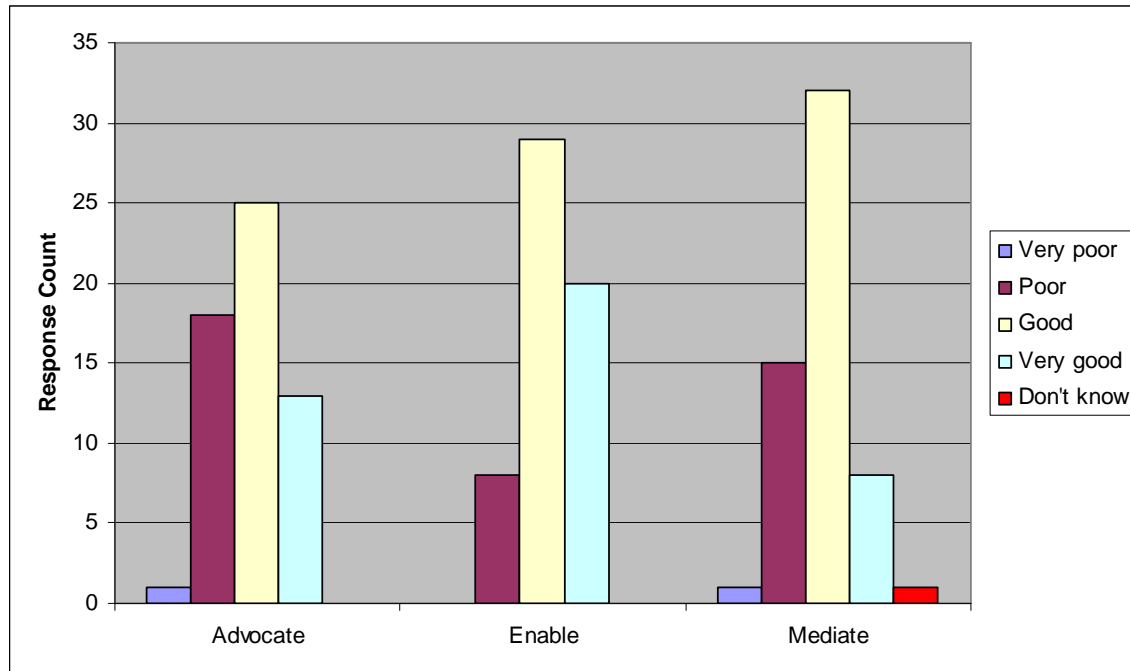
The Ottawa Charter outlines 3 core roles for health promotion:

- To **advocate** for political, economic, social, cultural, environmental, behavioural and biological conditions favourable for health
- To **enable** people to achieve their fullest health potential by taking control of the things that determine their health
- To **mediate** between differing interests in society for the pursuit of health.

Overall respondents displayed a high level of confidence in their organisations’ performance in the area of enabling people to achieve their health potential by taking control of the things that determine their health, with nearly 86% of respondents rating their organisation as “good” or “very good” in this area. Whilst a significant majority also reported positively with regard to the advocacy and mediation roles, more people put their organisation’s performance in the “poor” category for these areas.

This is in alignment with some of the responses to the open-ended questions, in which advocacy was mentioned by several people as an area that could be improved. The phrase “to mediate” was not mentioned in the open-ended responses but partnerships, which can be seen as a closely related concept, was mentioned frequently. On the whole partnerships were mentioned in a positive sense of being one of the strengths of community health although they were also mentioned by a few people as an area of weakness.

**Figure 2: How would you rate the work of your organization in each of the 3 core roles of health promotion as defined by the Ottawa Charter?**



#### *Ottawa Charter Action Areas*

The Ottawa Charter outlines five action areas for health promotion, which remain the basis for health promotion activity within the Integrated Health Promotion framework adopted in Victoria. The five action areas are:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

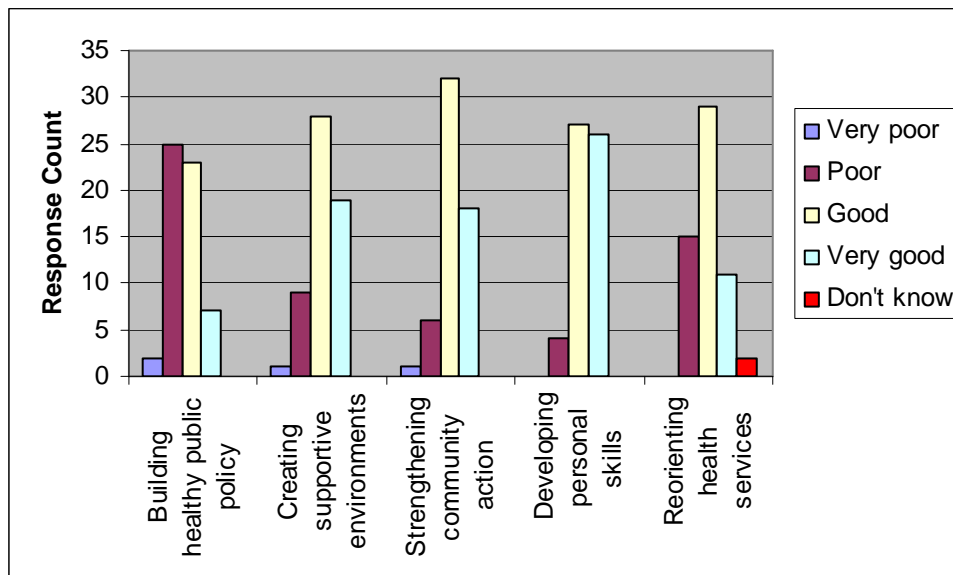
For every area a majority of respondents rated the work as “good” or “very good”. The most strongly rated area was developing personal skills which 47.4% rated as “good” and 45.6% as very good. Strengthening community action and creating supportive environments both scored very strongly as well, with each of them scoring over 80% as “good” or “very good”. Reorienting health services was also strongly rated, although 26.3% of respondents rated the organisation as “poor” in this area. By far the most poorly rated action area was building healthy public policy which 47.4% of respondents rated as “poor” or “very poor”.

If a prediction of which area would score most highly had been made based on the literature, developing personal skills would have been the safest bet. Keleher and Marshall (2002) have suggested that many workers within community health are more comfortable with the medically based primary prevention approach, of which developing personal skills is a core strategy, than other forms of health promotion.

It is no surprise to note that the answers to the next question on the amount of work that organisations direct towards each action area of the Ottawa Charter correlated in broad terms with the ratings given for performance in those areas.

When Parkinson (1997) interviewed managers and staff members at 5 community health services in the 1990s she found that policy reforms had led to health promotion that focused more on developing personal skills than other action areas of the Ottawa Charter. It is tempting to say that not much has changed. However, the picture is quite mixed. Whilst developing personal skills was ranked 1 by the most respondents it was also ranked at number 5 by more people than both creating supportive environments and strengthening community action. If each area is given a rating average by adding up the rankings awarded by each person and dividing it by the number of people who ranked the area, creating supportive environments actually comes out on top as the area with the lowest overall ranking. By this method there is almost nothing to distinguish between creating supportive environments, strengthening community action and developing personal skills. Reorienting health services scores notably higher and building healthy public policy higher again.

**Figure 3: How would you rate the work of your organisation in each of the 5 action areas of the Ottawa Charter?**



*Organisational capacity for health promotion*

The Integrated Health Promotion Resource Kit (DHS 2003) outlines five key action areas for building capacity to promote health: organisational development, workforce development, resources, leadership, and partnerships. These areas are seen as the domains of organisational capacity that need to be strong in order for effective and sustainable health promotion to be undertaken within organisations.

In general people rated their organisations higher on the domains of organisational capacity than they did on the Ottawa Charter action areas. The lowest scoring domain of capacity was organisational systems and supports which 13 out of 57 (22.8%) of respondents rated as "poor" or "very poor". Partnerships was the domain with the best

scores, with 53 out of 57 (93.0%) of respondents rating it as "good" or "very good". Workforce capacity, allocation of resources and leadership all scored fairly similarly, with the percentage of people ranking these as "good" or "very good" ranging from 78.6% and 84.2%.

A number of these areas were picked up in the responses to the open-ended questions. For example, in the responses to the question "what three strategies have you found to be most effective in building the health promotion capacity of your organisation?" each of these areas was touched on as areas where successful work had been undertaken.

#### *The Program Management Cycle*

In the program management cycle, stages related to evaluation and dissemination were by a long-way the stages which people ranked most poorly. 41 out of 57 respondents (71.9%) ranked outcome evaluation as "poor" or "very poor". 31 out of 57 (54.4%) ranked impact evaluation as "poor" or "very poor". Dissemination and planning for evaluation and dissemination also scored quite poorly. These findings align with the responses to the open-ended questions where evaluation was frequently mentioned as an area of weakness.

Vision setting was the stage which scored best: 29.8% of respondents ranking it as very good and 63% as good.

### **Part Three – Views on the future of health promotion**

Respondents were asked to indicate the extent to which they agreed or disagreed with a series of statements relating to the future of health promotion in community health. There was consensus that community health sector should play significant role in health promotion in the future, with all respondents agreeing that it should and 89.4% (42 out of 47) "strongly agreeing".

As to where health promotion in community health is going in the future, 68.1% expressed confidence that health promotion in the sector will improve in the future, including 42.5% who "strongly agreed" that they were confident of this. However 44.7% of respondents agreed or strongly agreed that they were "concerned about the future of health promotion in the community health sector". 51.1% disagreed or strongly disagreed with that statement. The answers indicate mixed views about the future of health promotion in community health.

### **Part Four – Open-ended questions**

#### **Barriers**

Identifying barriers to effective health promotion practice in community health was one of the key objectives of this research project. The Auditor General's report on health promotion in Victoria had identified some weaknesses in the way health promotion is done in Victoria, by community health and other organisations at a local, regional and state-wide level. Areas such as evaluation, the use of evidence in planning and the coordination of programs across different areas of government were all identified as

areas of weakness. The Auditor-General's report also referred to a number of specific challenges faced by community health services in attempting to integrate health promotion into what was described as their core business of service delivery. The challenges identified included establishing what incorporating a health promotion role means on a day-to-day basis for health professionals, ensuring that health professionals understand their health promotion role, ensuring staff have the knowledge and skills to do health promotion work, and delivering and evaluating initiatives. The Auditor General suggested that many Community Health Services found it hard to overcome these challenges, when faced with limitations on resources and team size (Auditor General 2007).

The question "What do you see as the three most significant barriers to better health promotion practice in your organisation?" sought to get an insight from health promotion workers on what they see as the factors that prevent their from delivering the best possible level of health promotion work. 53 respondents answered this question.

Two themes emerged particularly strongly in the responses to this question. The first was a theme of resources, which was referred to in a couple of different ways, most commonly as an issue of lack of financial resources or lack of time. The second major theme was around understanding of health promotion.

#### *Funding and resources*

The words "funding" and "resources" recurred with striking frequency in the responses to the question on barriers. Frequently these words were included in phrases such "lack of funding", "lack of resources" or "limited resources". Where responses were more specific they expanded on the issues of lack of resources in a number of ways. The most common way to frame the issue was around funding – funds or financial resources were the most commonly mentioned resources that were lacking in the system. Some respondents related this to the level or structure of funding from DHS: phrases included "funding remains unchanged from DHS", "DHS continues to fund according to demand management initiatives" and "limitations ... within DHS block funding". For others the barrier was one that could more appropriately be related to internal decisions around the allocation of funds – these included issues such as "lack of a dedicated HP budget" and "all HP funds go to human resources, so nothing left for projects".

After funds, the most commonly mentioned resource that was lacking were "staff" and "time". "Lack of funding allocated to health promotion EFT", "not enough staff" and "lack of staff to deliver HP activities" give a flavour of some of the responses that clearly identified a lack of human resource for health promotion. Several people listed "time" as a barrier. Some people expanded on this, with explanations of why the time they had was insufficient such as "lack of time to deal with competing priorities"

The issue of health promotion workers feeling over-stretched and lacking the time to do their jobs properly was a strong theme. People expressed frustration that their time was "spent mostly on writing plans and evaluations" or that there was "so much time spent coordinating and teaching other staff that nothing gets done". Several people commented that there was not time to do capacity building. Some other responses

explicitly linked lack of resources to areas of work that suffered as a result, with planning and evaluation each mentioned a couple of times.

Clearly sufficient resources are a prerequisite for effective work. The Integrated Health Promotion Resource Kit (DHS 2003) acknowledges this by including resources as one of the key areas of organisational capacity that need to be developed in order to support health promotion. The Auditor General's report acknowledged that lack of resources was a barrier to effective health promotion for some community health agencies although others had made strong progress (Auditor General 2007). Lack of resources is not just a question of funds: in research into the factors that stop people who have received health promotion training from implementing their learning in their workplace lack of time was identified as key barrier (Keleher et al 2005).

It is interesting to note that "allocation of resources" scored fairly strongly as a domain of organisational capacity in the responses to the question outlined above, with 28 rating it "good" and 16 "very good" out of a total of 56 responses. This suggests that in general lack of resources is seen not as an issue of internal resource allocation decisions but rather the impact of lack of investment in health promotion from funders. A lack of investment in health promotion and primary prevention has been acknowledged by the Victorian government. In the Premier's proposal for *Next Steps in Australian Health Reform* it was acknowledged that investment in keeping people healthy had been stuck at 1.7% since 1999, a level of investment that was described as "not enough" (DPC 2008, p. 20).

The theme of lack of resources also recurred through the responses to other questions discussed below.

#### *Understanding, knowledge and skills*

The second major theme that emerged in the barriers was around understanding of health promotion. Lack of understanding in relation to health promotion was described amongst staff, managers and organisations. Staff were described as not understanding health promotion or not understanding the "role of health promotion". Some respondents described misconceptions that staff had about the role of health promotion, such as that "health promotion is about marketing, handing out leaflets and promoting their programs" or that "we put the posters up". Other respondents referred to a lack of knowledge or lack of skills amongst colleagues, both in general terms and with reference to specific areas of health promotion practice, particularly evaluation. Managers were also seen to lack knowledge and understanding.

These observations fit with those of Keleher et al (2005) who suggested that competencies for health promotion are not adequately spread through workforce. They argue that an emphasis on direct service delivery in primary care has contributed to limited acknowledgement of workforce development needs beyond clinical competencies.

#### *Commitment and support for HP*

A number of responses tied a lack of understanding of the role of health promotion to a lack of "recognition" of its value. Also common were responses to the effect that staff

were not committed to health promotion or did not value it. Some of the phrases included "culture of indifference to HP", "relative unwillingness of direct service staff to incorporate HP into their job" and "personal attitudes of staff towards HP work". Other responses framed barriers around "competing priorities" rather than personal attitudes: for example "workers commitment to health promotion v's demand of direct service".

Lack of commitment or support from management was another common theme. One respondent wrote that management was not "pushing ... to ensure that time is not taken up with clinic work only". Another wrote of "disproportionate decision making power vested in people committed to the medical model", whilst another wrote of "prioritising of direct care" at senior levels. Several respondents wrote of "lack of leadership".

Management understanding, support and leadership have been identified as key pre-requisites for effective health promotion in previous studies. Keleher et al's (2005) study of the barriers to implementing learning from the DHS health promotion short course identified lack of understanding by managers and lack of managerial support as key barriers. In analyses of partnership working for health promotion, lack of management support has also been identified as a barrier (Keleher and Marshall 2002).

#### *Organisation of health promotion*

A number of responses identified issues related to how health promotion is organised within community health services. A couple of respondents made reference to the difficulties of "integration" across different program areas. Divergent views were expressed amongst respondents over who should be doing health promotion. Several respondents suggested that a barrier was that too many non-specialist staff were engaged in health promotion – with the result that staff had too little time or too few skills to make a difference. The more commonly expressed view, however, was that there were too few people doing health promotion.

#### *Other areas*

Some respondents listed as barriers areas of health promotion practice that were not done well. Evaluation was the most commonly mentioned area of practice, with planning also mentioned by several people. These are consistent with the issues document by the Auditor General and also with the responses to the question on weaknesses.

### **Weaknesses**

There was considerable overlap between the responses to the question on the barriers and responses to the question: "What do you see as the three most significant weaknesses of health promotion in community health?".

#### *Lack of funds*

Issues relating to funding were again prominent in responses on weaknesses. "Lack of funding", "under-funding" "lack of resources", "limited resources" and other similar comments were frequently raised. The focus was mainly on financial resources although lack of time and lack of staffing capacity were also mentioned several times. Once again a number of respondents described the impact of lack of funding on health promotion

work, suggesting that lack of funds limits the ability of Community Health sector to do “thorough”, “comprehensive” or “high quality” work, particularly in regards to planning and evaluation.

A number of other issues were raised in relation to funding, beyond just the lack of it. The issues of sustainability was raised by a couple of people, with “short-term” or “one-off” funding seen as working against sustainable outcomes. Other respondents raised the issue of having to always be looking for additional funds.

#### *Losing out to direct care*

Several respondents made the point that they lose out in funding terms to direct service provision. These responses fit into another strong theme in the responses to this question which was that health promotion is often competing with, and losing out to, direct service provision. Health promotion was described as being “taken over by direct care” or being seen as “not ... as important” or “the poor relation”. A number of respondents described the challenges that community health staff face in balancing dual roles in direct care and health promotion, with health promotion seen as often losing out. Others suggested that the framework in which community health operates is “dominated” by the medical model.

#### *Understanding and support*

As in the responses to barriers, lack of understanding of health promotion – what it means, its principles and theory – was raised by a number of respondents. Both staff and management were identified as lacking this understanding. Other responses spoke of a lack of skills or knowledge amongst staff as a weakness, and several suggested that there was an unjustified “assumption that anyone can just ‘do’ health promotion” without appropriate training. Issues of “commitment”, “support” and engagement from staff within community health services were also raised as weaknesses.

#### *Areas of practice*

In terms of areas of practice that were identified as weaknesses, the most commonly identified area was evaluation. As mentioned above this was often linked to a lack of time to put into evaluation, although lack of expertise and skills were also mentioned. Dissemination and planning were other stages of the program management cycle that were also mentioned as weaknesses. In terms of areas of HP activity, advocacy was mentioned several times as an area of weakness.

The responses to the quantitative questions told a similar story to this, with impact and outcome evaluation clearly emerging as the areas of the program management cycle that people rated their organisation’s performance the lowest in and advocacy scoring lowest of the Ottawa Charter roles. As has been mentioned poor evaluation was highlighted as an issue by the Auditor-General. The Department of Human Services (2007a) has highlighted evaluation as an area that they would like to see improvement in, although experts have in the past recognised that the evaluation of health promotion interventions is highly complex and challenging (Nutbeam 1998).

### *Health Promotion workforce issues*

In relation to the specialist health promotion workforce, a few issues were raised. The most common issue raised was around retention, with poor retention of health promotion workers being attributed to there being “no career path” and also the nature of these roles with their focus on capacity building. These are issues that were picked up more strongly in the responses on the threats to health promotion in community health.

### *Wrong focus*

A fairly disparate theme that emerged from the responses were a series of responses that suggested that health promotion in community health could at times be focusing its attention in the wrong areas. A couple of people suggested that the focus may be “too local”. A few people suggested that CH was not focusing on those most in need, with the suggestion that services were engaging the “worried well” rather than “the most isolated”.

### *Other issues*

Several people made the point that there was a tendency for health promotion in community health to be over-stretched. One person put this as “trying to do too much with too little” whilst another described the weakness as “trying to be all things to all people”.

One policy issue that was raised by several people was the issue of the planning and reporting requirements of DHS. Several people made observations to the effect that the planning and reporting requirements were too time consuming.

Some of the other weaknesses that were identified included that other sectors do not understand or recognise health promotion and neither does the community. A couple of people commented that the language of health promotion is inaccessible or “jargonistic” which is perhaps part of the explanation for why those outside the sector don’t understand.

## **Strengths**

### *Connections with the community*

The strongest theme to emerge in response to the question “What do you see as the three most significant strengths of health promotion in community health?” was a theme around the connection that community health services have to their local communities. A significant number of respondents listed community involvement in decision making, “community ownership”, the scope that community health has to work with communities “in partnership” or the ability to communicate directly with local communities as strengths. Another sub-theme was the idea that community health is strong on “community capacity building”, “empowerment” and “community development”. Being community focused and having strong local knowledge were also strong themes.

A lot of responses stressed the local focus of community health as a strength. Being “on the ground” or at the “grass roots level” were phrases that recurred. The ability to engage with local communities and to work on community development initiatives were clearly the main advantages from this local community connectedness. Other

advantages that also emerged included the understanding it gives community health of community needs and local issues, the ability to respond to emerging issues, the ability to reach disadvantaged and “hard to reach” groups and the ability to build strong local partnerships.

These strengths of health promotion are consistent with the strengths of community health in general identified by others. Community involvement has long been an area that community health has prided itself on (Baum 2005). More recently DHS (2004a) identified the strengths of community health as its connections to local communities, its focus on populations with poor health status and its local focus in responding to needs.

### *Partnerships*

Partnerships were perhaps the next strongest theme that emerged in response to the question on strengths. A large number of people listed partnerships as a strength, with phrases such as “great partnerships” and “partnership building”. Particular mention was given to local partnerships and inter-sectoral partnerships. Several respondents talked about the leadership role that Community Health agencies play in partnerships. The identification of partnerships as a strength suggests that a number of organisations have managed to overcome the institutional barriers to effective partnership working that were identified by Walker (2002).

### *Philosophy*

Another broad theme that emerged was around the philosophy of community health. Clearly the community focus described above is part of that philosophical approach. Further to that a focus on prevention was mentioned several times. Equity and a holistic approach were other elements of the philosophical approach of community health that were mentioned by more than one respondent. Baum (1996) has observed that the strength of community health has been that it has a clearly articulated set of values and principles on which to base its work.

### *Workforce*

A number of respondents mentioned the community health workforce as a strength. The diverse skill base which community health can draw on was seen as a strength as was the commitment of community health staff. Having dedicated Health Promotion workers was mentioned by several respondents as was having dedicated resources, including hours and funding.

### *Other strengths*

Organisational commitment to health promotion was mentioned by several respondents as a strength. Respondents wrote of being “accepted as part of the organisation” and “being recognised as a significant component”. Integration and coordination were also mentioned as strengths. A number of respondents referred to the outcomes that health promotion can achieve, with “health outcomes” mentioned several times. “Sustainability” was mentioned by a couple of respondents, with this linked to capacity building and an evidence-based approach.

## Threats

Responses to the question “What do you see as the three most significant threats to the future effectiveness of health promotion in community health?” also shared some similar themes with the responses to the questions on barriers and weaknesses.

### *Funding*

Once again issues of funding and resources were major themes. “Lack of funding” or “lack of resources” were both mentioned on numerous occasions, whilst references to possible changes in funding models were also raised several times. Other issues related to funding that were mentioned included short-term funding, siloed funding streams or multiple funders which were raised as threats to effective work.

### *Chronic disease management*

A major theme that emerged in responses to the question on threats was a feeling that an increased emphasis on chronic disease threatened health promotion. Chronic disease management was seen as bringing with it a focus on “downstream approaches” or “secondary prevention” as distinct from health promotion directed at the “determinants” of health. Linked to this was a suggestion by a number of people that health promotion was under threat from the “medical model”. Others suggested that increased demand on health services could lead to health promotion funding being cut. In responses to the question on opportunities the counter-argument was also made, that increased demand creates an opportunity for health promotion to be a demand management solution.

### *Policy issues*

The role of governments was raised by a number of respondents in responses to this question. Health promotion not being a priority on the policy agenda was raised as a threat by several people. Others made observations about “lack of leadership” or “lack of direction” at the government level. Several others raised the issue of reporting requirements, which were seen as over-burdensome.

### *Workforce issues*

A wide range of workforce issues were raised, with no single theme emerging particularly strongly. Perhaps the strongest in this area was around recruitment and retention. Retention or turnover were mentioned on several occasions, whilst “burn-out” was also raised by a couple of respondents. Some of the issues that were mentioned that may be impacting on these recruitment and retention issues included lack of career prospects and a poor award structure.

### *Evaluation*

Once again evaluation was the main area of practice that emerged quite strongly in the discussion on threats, the threat being that evaluation will continue to be an area of weakness. Several people mentioned not being able to demonstrate outcomes as a threat.

### *Organisational issues*

Lack of organisational support was another significant theme to emerge from the responses to this question. As with responses to the questions on barriers and

weaknesses, the issues raised were around health promotion not being seen as a priority by organisations or organisations not having “commitment” to health promotion. Other organisational issues raised included increasing “managerialism” in community health and a fear that if community health services and health services are amalgamated “community health work and influence is lost”.

#### *Other issues*

Some other issues that were raised by a few respondents included lack of partnerships or ineffective partnership working, poor planning and issues around managing community expectations.

### **Opportunities**

The question “What do you see as the three most significant opportunities for the future development of health promotion in community health?” elicited a broad range of responses, a number of which covered themes which were also picked up in responses to other questions on the survey. Respondents seemed to interpret the question in a couple of different ways, with some focusing on opportunities that they could currently see whilst others focused on opportunities or developments that they would like to see.

#### *Government support and policy issues*

One of the major themes was support for health promotion at a government policy level. Several respondents were of the belief that a shift is occurring at a policy level around health promotion. Responses along this line included “political environment feels more favourable”, “government and the health sector is becoming acutely aware of the importance and necessity of prevention based strategies in health” and “the current strong interest from government (state and federal) in developing the primary care sector to address future population health needs”. A couple of people mentioned the Victorian governments *Care in Your Community* policy specifically as an opportunity, one person describing it as “a strategic driver for HP into the future”.

Lin and Fawkes (2007) would agree that there has been an increased interest in prevention since the late 1990s from government decision makers in areas such as treasury as result of increasing concern over the cost of medical care and labour productivity. They argue that this creates a new policy space for health promotion. Recent government rhetoric has certainly been sufficient to give health promotion workers hope of more support in the future. The Victorian Government has also outlined imperatives for health reform such as an ageing population, rising health care costs, an increasing prevalence of chronic diseases, and an overstretched health workforce, which they have said requires a renewed focus on prevention (DPC 2008).

#### *Planning and reporting requirements*

Several people mentioned the changes to the DHS planning and reporting requirements as an opportunity. “Reduced”, “improved” and “easier and clearer” were all used to describe the direction people hoped the reporting requirements were moving towards. Other people referred to the move to develop impact measures for reporting as a positive.

### *Funding*

Funding was again raised by a significant number of people. "Increased resourcing", "more funding", "greater funding for preventative work", are some examples of the comments that were made. These responses seemed to fall more into the category of a development people would like to see rather than something that they believed was imminent.

### *Ways of working*

Several ways of working were identified as opportunities. "More partnerships" or "improved partnerships" were raised by several people. More focus on advocacy was also raised by several people. Several others suggested more of an "upstream" focus on influencing policy.

### *Areas to focus on*

Several people listed as opportunities areas of work for health promotion to focus on. The list was fairly disparate with none of these emerging as strong themes: "indigenous health", "rural remote focus", "mental health promotion", "environment", "chronic disease", "alcohol abuse", "ageing population", "access to economic resources" and "climate" were all mentioned.

### *Ways to improve health promotion*

A number of people outlined as opportunities strategies for improving health promotion in community health. Education and training were mentioned by several people. Getting a wider range of staff involved in HP was suggested by several others. Some of the other suggestions included developing the evidence base through pilot models, focusing on capacity building, and getting the media involved.

Evaluation and dissemination once again were both mentioned as areas to strengthen. Suggestions around evaluation included improved frameworks and the development of links with universities.

## **Capacity Building**

The question on strategies employed to build the capacity of Community Health Services to deliver effective health promotion produced a diverse range of answers, with several themes emerging.

### *Training*

Training and workforce development was the strongest theme. Most of these responses were quite general, referring broadly to training, workforce development or professional development in various ways. Amongst the more specific responses the Department of Human Services five day Health Promotion Short Course was mentioned by several respondents. In addition to training, several people mentioned induction or orientation processes to introduce new staff to health promotion.

### *Organisational development*

A few respondents mentioned organisational development as a key strategy, whilst a number of others gave examples of various different kinds of organisational

development strategies or structural changes within the organisation. Creating a dedicated health promotion team was one of the more common examples, although several people also referred to getting more people involved in health promotion from across organisations. Developing policies and procedures to support health promotion was a frequently mentioned strategy. Including health promotion in position descriptions was another strategy that was mentioned a couple of times.

#### *Communication*

Communication was a strong theme in this section. A number of people wrote of the importance of direct communication with people about the role of health promotion, whilst several people mentioned communication strategies. Some examples of specific areas of communication that were mentioned included disseminating knowledge about health promotion impacts and sharing information about the impacts of projects. Several respondents talked about raising the profile of health promotion in the organisation.

#### *Management support*

Gaining management support was another strong theme on capacity building. Some of the strategies that were referred to in relation to this included training for managers, having a Health Promotion Manager on the senior management team, and working to establish relationships with senior management and boards.

#### *Leadership*

Leadership also emerged as a strong theme. Where people expanded on the concept it was in terms of a Health Promotion Coordinator or Team Leader putting HP on the organisation's agenda or providing strong support to staff.

#### *Partnerships*

Partnerships were also a theme. Respondents talked about building and sustaining partnerships. One respondent talked about forming partnerships and then "dragging my organisation along". Primary Care Partnerships were mentioned specifically by several people.

#### *Planning*

Strengthening planning was another theme that emerged. Strategies mentioned included increasing involvement from staff in planning and the use of planning tools such as the Quality Improvement Program Planning System.

#### *Other strategies*

A range of other strategies were also mentioned, including resourcing health promotion, the formation of health promotion committees of various kinds including steering groups or working groups and having health promotion team meetings.

#### *Discussion*

In general the capacity building strategies outlined by respondents were in alignment with the literature on capacity building for health promotion in community health. The Regional Infrastructure for Improving Health Promotion (RIIHP) model developed by the Southern Metro Region of the Department of Human Services following interviews with 45 health promotion practitioners, managers, academics and DHS program advisers

outlined a range of strategies for capacity building. Many of those came out in the responses including: developing planning processes and policies, communication strategies, continuing workforce development, management support, and building alliances (Bensberg 2000). More recently in 2003 DHS mapped and analysed capacity building strategies implemented in one region of Victoria. The key driving and resisting forces for successful capacity building that were found included communication with all levels of the system, active commitment and involvement of managers, clear and consistent vision and adequate resourcing for change (Heward et al 2007). Finally, in 2006 as part of a consultation on health promotion priorities DHS asked consultation participants, which included community health staff as well as representatives of other agencies, what effective capacity building strategies they had implemented in their organisations. Responses included: management commitment to health promotion, access to workforce development resources, organisational commitment to health promotion, the Quality Improvement Program Planning System, dedicated health promotion staff or health promotion outcomes built into all positions (DHS 2007).

## **Changes**

The final question of the survey asked respondents to outline the three changes they would like to see to significantly strengthen health promotion across the community health sector.

### *Funding*

Funding was again the most prominent theme. In most cases the call was for more funding. The other strong call was for funding to be directed more towards long-term projects. Other suggestions in this general area included for more funding for other areas of community health work, more accountability for funding, increased congruency between funding programs, and funding for other sectors to undertake health promotion.

### *Policy issues*

In addition for calling to more funding, a number of respondents also made other calls on governments. The Victorian Department of Human Services was mentioned specifically by a number of respondents, with calls on DHS to do various things. This included increasing support for health promotion in a general sense, providing more support in particular areas of health promotion practice: "planning/evaluation templates", "planning processes" and "training" were all mentioned. Increased coordination from government was mentioned by several people. Several people also suggested that the reporting requirements associated with health promotion funding should either be lessened or should be maintained consistently without change.

### *Workforce*

A number of people outlined changes that relate to the workforce. Training was the most commonly mentioned of these. A number of the workforce recommendations related to changes that would improve the attractiveness of health promotion as a career: an improved career structure and a improved award system were both mentioned several times.

### *Partnerships*

A number of people talked about more partnership working or better collaboration.

### *Program management*

A number of people made reference to stages of the program management cycle that they would like to see strengthened. Again evaluation was the most common area that was mentioned. Some of the suggestions put forward included more resources to be put into evaluation, training, better use of evaluation tools, health promotion workers gaining and using additional research qualifications, and links between community health and the academic sector. Another area of practice that was mentioned more than once was strengthening the use of evidence in practice, both in reference to the use of local needs data and the use of evidence on the effectiveness of interventions.

### *Health promotion structures within organisations*

Several respondents made reference to the structure of health promotion within organisations, including calls for a review of structures to produce recommendations on how health promotion should be structured.

## Conclusion

Across the range of questions that this survey asked a number of issues reoccurred as strong themes across several different questions.

Funding clearly emerged as a highly contentious issue. In responses to the questions on barriers, weaknesses, threats and changes the need for more funding and resources was repeatedly stated. Lack of funding and lack of other types of resources were stated as significant barriers to effective health promotion practice. Increased funding for health promotion is the change that most workers would like to see.

Health promotion being given a higher priority is also something that health promotion workers want to see. Health promotion was seen as too often losing out to direct care in terms of the focus of other community health staff, of managers and of governments. Some respondents were optimistic that there was a growing recognition amongst governments of the role of health promotion, whilst others feared that the increasing focus on chronic disease management could sideline health promotion. From the management perspective, some respondents felt that they had been successful in getting the support of managers for health promotion whilst others lamented a continued lack of support. Some people tied these two issues together – looking for government to play a leadership role in ensuring that health promotion becomes a priority for community health.

Workforce capacity was a key issue. Whilst a number of respondents commented on the commitment of community health staff and the value of having input into health promotion from a range of health professionals, the dominant theme was that too many community health staff don't understand health promotion and don't have the skills to do it effectively.

The area of health promotion practice that was most frequently mentioned as a weakness was evaluation. The major reasons proposed for this were lack of time and lack of skill. Training in evaluation and in other areas of health promotion was identified as a key way forward.

The great strength of community health was seen to be its connection to the community. A local focus and strong commitment to community involvement shone through as key strengths that enable community health workers to engage and empower communities to improve their health. Strong partnerships are also a strength.

There are some areas where differences of opinion are strong. A number of respondents expressed the view that dedicated health promotion teams achieve more effective results, whilst others suggested that more people need to get involved in health promotion from across community health organisations.

Despite these differences the overall vision for the future was pretty clear: health promotion workers want to see more funding for health promotion and more commitment to health promotion from government and from their organisational leaders.

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## Appendix 1 – The survey

### 1. Introduction

This questionnaire has been designed to capture the views of people in health promotion roles in Victorian Community Health Services about health promotion in community health. This includes staff in Stand-alone or Independent Community Health Services, Integrated Community Health Services and Multipurpose Health Services. It should be completed only by workers for whom health promotion constitutes the primary focus of their position.

The questionnaire has been designed by David Godden, Health Promotion Team Leader at North Yarra Community Health, as part of a research project I am undertaking in pursuance of a Master of Public Health at La Trobe University. If you have any questions with regard to the questionnaire you can contact me on 9349 7312 or david.godden@nych.org.au.

The objectives of this project are to document and analyse the views of health promotion workers in Victorian Community Health Services about:

- Areas of strength and weakness in current health promotion practice in community health
- The factors that support or work against effective health promotion in community health
- The future of health promotion in community health.

The aim is to provide insights into the views of health promotion workers in community health which may be able to contribute to improving health promotion policy and practice in Victoria.

Data collected during the project will be used to fulfil the requirements of the Action Learning Unit of the Master of Public Health at La Trobe University. Data collected may be included in a thesis, presented at conferences and published in journals.

All data collected in response to this questionnaire will be anonymous. No personal identifying information is requested at any point. As all responses are anonymous, once survey responses have been submitted it will not be possible to withdraw data from the project.

### 2. About you and your organisation

#### 1. What type of health service do you work in?

- Independent or Stand-alone Community Health Service
- Integrated Community Health Service
- Multipurpose health service

#### 2. Where is the service located?

- DHB rural region
- DHB metropolitan region

#### 3. What is your role?

- Health Promotion Manager
- Manager with responsibility for health promotion
- Health Promotion Coordinator
- Health Promotion Officer
- Other (please specify)  
\_\_\_\_\_

**4. How long have you been in your current role?**

- Less than 1 year
- 1 to 3 years
- 4 to 6 years
- Over 6 years

**5. How long have you worked in health promotion in community health?**

- Less than 1 year
- 1 to 3 years
- 4 to 6 years
- Over 6 years

**6. How long have you worked in health promotion?**

- Less than 1 year
- 1 to 3 years
- 4 to 6 years
- Over 6 years

**7. What is your highest level of training or education in health promotion?**

- Postgraduate degree
- Other postgraduate qualification
- Undergraduate degree
- DHS 3-day health promotion short-course or equivalent
- Other training

**3. Your views on health promotion in your organisation**

The following questions ask for your views on the strength of your organisation in various areas of health promotion practice and capacity.

**1. How would you rate the work of your organization in each of the 3 core roles of health promotion as defined by the Ottawa Charter?**

	Very poor	Poor	Good	Very good	Don't know
Advocate for political, economic, social, cultural, environmental, behavioural and biological conditions favourable for health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enable people to achieve their fullest health potential by taking control of the things that determine their health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mediate between differing interests in society for the pursuit of health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**2. How would you rate the work of your organisation in each of the 5 action areas of the Ottawa Charter?**

	Very poor	Poor	Good	Very good	Don't know
Building healthy public policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creating supportive environments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strengthening community action	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developing personal skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reorienting health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**3. Please rank the 5 action areas of the Ottawa Charter in order of the amount of health promotion work that your organisation directs towards each of them, where 1 is the area to which you direct the most work and 5 is the area to which you direct the least work.**

	1	2	3	4	5
Building healthy public policy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Creating supportive environments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Strengthening community action	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developing personal skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reorienting health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**4. How would you rate your organisation in each of the following components of organisational capacity as they relate to health promotion?**

	Very poor	Poor	Good	Very good	Don't know
Organisational systems and supports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Workforce capacity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allocation of resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leadership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partnerships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5. How would you rate your organisation in each stage of the program management cycle for integrated health promotion?**

	Very poor	Poor	Good	Very good	Don't know
Vision setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Priority setting and problem definition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Solution generation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Capacity building	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Planning for evaluation and dissemination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implementation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Process evaluation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Impact evaluation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outcome evaluation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dissemination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**6. What do you see as the three most significant barriers to better health promotion practice in your organisation?**

**7. Does your organisation currently have capacity building as a health promotion priority?**

- Yes
- No
- Don't know

**8. What three strategies have you found to be most effective in building the health promotion capacity of your organisation?**

#### **4. Your views on Health Promotion in the Community Health sector**

The following questions ask for your opinions on health promotion in the community health sector as a whole.

**1. What do you see as the three most significant strengths of health promotion in community health?**

**2. What do you see as the three most significant weaknesses of health promotion in community health?**

3. Please indicate the extent to which you agree or disagree with each of the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
The community health sector is currently well placed to make a significant contribution to improving health and reducing health inequalities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The community health sector should play a significant role in health promotion in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am confident that health promotion in the community health sector will improve in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am concerned about the future of health promotion in the community health sector.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. What do you see as the three most significant opportunities for the future development of health promotion in community health?

5. What do you see as the three most significant threats to the future effectiveness of health promotion in community health?

6. What three changes would you like to see to significantly strengthen health promotion across the community health sector?

### 5. Thank you

Thanks for completing this survey. If you wish to be kept informed about the progress of this project please email me: [david.golden@rych.org.au](mailto:david.golden@rych.org.au).

## Appendix 2 – Responses

**Table A1: What type of health service do you work for?**

	Response Count	Response Percent	Number of health services of this type	Response rate per number of services
Independent or Stand-alone Community Health Service	29	47.5%	40	0.73
Integrated Community Health Service	21	34.4%	62	0.34
Multipurpose health service	11	18.0%	6	1.8
<b>TOTAL RESPONSES</b>	<b>61</b>	<b>100%</b>		

**Table A2: Where is the service located?**

	Response Count	Response Percent	Number of health services in each location	Responses per services in each location
DHS rural region	24	39.3%	74	0.32
DHS metropolitan region	37	60.7%	34	1.09
<b>TOTAL RESPONSES</b>	<b>61</b>	<b>100%</b>		

**Table A3: What is your role?**

	Response Count	Response Percent
Health Promotion Manager	6	9.8%
Manager with responsibility for health promotion	7	11.5%
Health Promotion Coordinator	12	19.7%
Health Promotion Officer	28	45.9%
Other (please specify)	8	13.1%
<b>TOTAL RESPONSES</b>	<b>61</b>	<b>100%</b>

**Table A4: How long have you been in your current role?**

	Response Count	Response Percent
Less than 1 year	16	27.1%
1 to 3 years	32	54.2%
4 to 6 years	7	11.9%
Over 6 years	4	6.8%
<b>TOTAL RESPONSES</b>	<b>59</b>	<b>100%</b>

**Table A5: How long have you worked in health promotion in community health?**

	Response Count	Response Percent
Less than 1 year	8	13.3%
1 to 3 years	28	46.7%
4 to 6 years	13	21.7%
Over 6 years	11	18.3%

<b>TOTAL RESPONSES</b>	<b>60</b>	<b>100%</b>
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**Table A6: How long have you worked in health promotion?**

	Response Count	Response Percent
Less than 1 year	6	10.0%
1 to 3 years	23	38.3%
4 to 6 years	10	16.7%
Over 6 years	21	35.0%
<b>TOTAL RESPONSES</b>	<b>60</b>	<b>100%</b>

**Table A7: What is your highest level of training or education in health promotion?**

Postgraduate degree	14	23.0%
Other postgraduate qualification	7	11.5%
Undergraduate degree	20	32.8%
DHS 5 day health promotion short-course or equivalent	13	21.3%
Other training	7	11.5%
<b>TOTAL RESPONSES</b>	<b>61</b>	<b>100%</b>

**Table A8: How would you rate the work of your organization in each of the 3 core roles of health promotion as defined by the Ottawa Charter?**

	Very poor	Poor	Good	Very good	Don't know	Total
Advocate for political, economic, social, cultural, environmental, behavioural and biological conditions favourable for health	1	18	25	13	0	<b>57</b>
Enable people to achieve their fullest health potential by taking control of the things that determine their health	0	8	29	20	0	<b>57</b>
Mediate between differing interests in society for the pursuit of health	1	15	32	8	1	<b>57</b>

**Table A9: How would you rate the work of your organisation in each of the 5 action areas of the Ottawa Charter?**

	Very poor	Poor	Good	Very good	Don't know	Total
Building healthy public policy	2	25	23	7	0	<b>57</b>
Creating supportive environments	1	9	28	19	0	<b>57</b>
Strengthening community action	1	6	32	18	0	<b>57</b>
Developing personal skills	0	4	27	26	0	<b>57</b>
Reorienting health services	0	15	29	11	2	<b>57</b>

**Table A10: Please rank the 5 action areas of the Ottawa Charter in order of the amount of health promotion work that your organisation directs towards each of them, where 1 is the area to which you direct the most work and 5 is the area to which you direct the least work**

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>Total</b>	<b>Rating average</b>
Building healthy public policy	8	8	2	14	24	56	3.679
Creating supportive environments	12	13	12	10	4	51	2.627
Strengthening community action	9	15	14	12	3	53	2.717
Developing personal skills	19	6	11	9	8	53	2.642
Reorienting health services	5	13	16	10	12	56	3.196

**Table A11: How would you rate your organisation in each of the following components of organisational capacity as they relate to health promotion?**

	<b>Very poor</b>	<b>Poor</b>	<b>Good</b>	<b>Very good</b>	<b>Don't know</b>	<b>Total</b>
Organisational systems and supports	2	11	28	15	1	57
Workforce capacity	0	9	36	12	0	57
Allocation of resources	1	11	28	16	0	56
Leadership	2	8	23	24	0	57
Partnerships	0	4	22	31	0	57

**Table A12: How would you rate your organisation in each stage of the program management cycle for integrated health promotion?**

	<b>Very poor</b>	<b>Poor</b>	<b>Good</b>	<b>Very good</b>	<b>Don't know</b>	<b>Total</b>
Vision setting	2	2	<b>36</b>	<b>17</b>	0	57
Priority setting and problem definition	2	6	32	17	0	57
Solution generation	1	8	36	12	0	57
Capacity building	0	8	28	21	0	57
Planning for evaluation and dissemination	0	22	26	9	0	57
Implementation	0	2	<b>34</b>	<b>21</b>	0	57
Process evaluation	0	11	31	15	0	57
Impact evaluation	<b>1</b>	<b>30</b>	21	5	0	57
Outcome evaluation	<b>10</b>	<b>31</b>	11	4	1	57
Dissemination	<b>2</b>	<b>24</b>	26	4	1	57

**Table A13: Please indicate the extent to which you agree or disagree with each of the following statements.**

	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly agree</b>	<b>Don't know</b>	<b>Total</b>
The community health sector is currently well placed to make a significant contribution to improving health and reducing health inequalities.	0	4	23	20	0	47
The community health sector should play a significant role in health promotion in the future.	0	0	5	42	0	47
I am confident that health	0	8	12	20	7	47

promotion in the community health sector will improve in the future.						
I am concerned about the future of health promotion in the community health sector.	4	20	15	6	2	47