Evaluation Report: Victorian DHS Short Course in Health Promotion

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Executive Summary

This report presents an evaluation of the Victorian Department of Human Services (DHS) funded Core Health Promotion Short Courses (Marshall et al 2003) which was delivered to over 800 participants during 2001-2 as an important component of the statewide workforce development strategy. Course participants came primarily from DHS funded agencies in the community, primary and women's health sectors, with participants from the acute health sector, alcohol and drug services, local government and sports assemblies also taking the course.

The objectives for the evaluation were developed by the DHS, and concepts of equity and effectiveness also guided the research. The research design utilised a triangulated study incorporating a survey distributed to all participants, and interviews/focus groups with over 80 stakeholders including participants, CEOs and program managers in agencies, program managers in the DHS, and DHS Regional Health Promotion Officers. The project was guided by a Project Advisory Group that provided a mechanism for wider consultation with stakeholder networks. A comprehensive literature review was also conducted around themes of health promotion workforce development, capacity building and organisational change.

The qualitative and quantitative data was overwhelmingly supportive of the value of the Short Course as a workforce development strategy. Participants positively evaluated the Short Course as an effective introduction to health promotion in both skills and knowledge. Practitioners and managers believed that the Short Course has had a positive effect on health promotion practice and on organisational capacity to conduct health promotion. Participants felt the content was appropriate and met their needs while challenging them to think critically about frameworks for planning and practice and in working with communities. It was common for participants to report on how they appreciated the folder of resources and how they had used the materials after the course.

Valuable data was gathered about future training needs to ensure continued momentum for further development of health promotion knowledge and skills. Many participants reported that since completing the course, they had become involved in Primary Care Partnership activities and/or joined a health promotion network. Participants found the course was really valuable for the opportunity it provided to meet other practitioners from a range of sectors and learn about the work going on in other agencies and sectors.

Barriers to participant uptake of the knowledge and skills learned in the course were primarily about the degree of opportunity to practice health promotion, available within their own organisation. There appears to be considerable opportunity for capacity building of more senior staff, to understand the concepts and orientation of health promotion towards the social model of health and community/health development.

The evaluation explored ideas with participants and stakeholders, about the sustainability of health promotion in the workplace and the sustainability of the Short Course more generally. Recommendations are centred on these two issues.
1.0 Background and context

This is the report of a state-wide evaluation of the Victorian Department of Human Services (DHS) Core Health Promotion Short Course that was delivered in 2001-2. The evaluation was conducted by a project team from the School of Health Sciences, Deakin University for the DHS, in 2003. The evaluation is based on an acknowledged need to both deliver targeted health promotion workforce development programs (DHS 2000a; DHS 2002a; Yeatman et al 1999) to the community, primary and women’s health sectors, and to evaluate their effectiveness. The establishment of the Core Health Promotion Short Course in Victoria is a determined initiative of the DHS to change knowledge, skills and behaviours of staff in these sectors, to reorient their practice and the policy orientation of their organisations, towards integrated health promotion approaches. The DHS defines integrated health promotion as “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 p 3).

Nevertheless, health promotion training courses are not a quick fix for capacity building in health promotion. Accordingly, the objectives for this evaluation research recognise the need for better understanding of: the motivation for participation of individuals attending and of organisations in sending staff; the impact of the Short Course on those practitioners who are beginners in health promotion; the impact on organisations; the reach and levels of satisfaction with the Short Course among stakeholders; the suitability of the program for the needs of the sector; the quality of the Short Course materials in terms of meeting needs; and issues in relation to future health promotion workforce development.

The Core Health Promotion Short Course was initially funded in 2001-2 through a larger workforce development grant from the Commonwealth Department of Health and Ageing. The Partnership Development Section of the DHS Public Health Division has been responsible for overseeing the implementation of the Short Course. Health promotion workforce development is also a key strategy of the Primary Care Partnerships (PCP) strategy. This strategy is located in the Primary and Community Health Branch of the DHS. The benefits of the Short Course therefore need to be considered and measured across Divisions of the DHS.

The DHS describe the Short Course as follows:

The Short Course is designed as a practical introduction to the principles and practices of health promotion. The course content applies the latest developments in health promotion to the current health policy environment, using current planning and funding frameworks as examples.

The aim is to help participants feel more confident about integrating health promotion into their work practices. The practical activities of the course examine real issues in the participant’s communities, encourage reflection on current health promotion practices, and provide time for staff from different agencies to network (DHS Short Course 2003, p1).

The Core Health Promotion Short Course was designed and developed by a consortium of Universities in late 2000, led by Deakin University Melbourne and La Trobe University Bendigo. The original course was piloted by academic trainers from
Deakin University Melbourne and La Trobe University Bendigo, in two sites: one metropolitan location with participants from the DHS Southern and Eastern Regions, and one rural location with participants from across the Loddon Mallee and Grampians Regions. The pilot course was intensely evaluated and considerable rewriting of the program was completed following the pilot. The final program that was delivered in 2001-2 was designed as 10 half day modules delivered over a 5-day period (see Appendix 1). It was recommended that the course be delivered over three weeks with at least the one 2-day block, to groups of approximately 25 people.

A tender process was used for delivery of the courses in each of the nine DHS Regions. A range of academic and practitioner health promotion (HP) specialists were selected to deliver two courses in each Region with a third course also funded in some Regions. Trainers were provided with a comprehensive training manual in conjunction with a one-day train-the-trainer workshop which was conducted by the lead writers of the course from Deakin University Melbourne and La Trobe University Bendigo. An additional course for the Regional Sports Assemblies was funded by VicHealth and provided by Deakin University Melbourne.

For the 2001-2 Short Courses, the trainers undertook some of the necessary administration for each Region’s courses with support from DHS Regional Health Promotion Officers (RHPOs). The evaluators note that some changes to course administration have been made subsequent to this round of courses. Over 800 people across the Victoria participated in the 2001-2 round of Short Courses. Initially recruitment was conducted through Primary Care Partnerships (PCPs), because of the brief for PCPs to take leadership for integrated health promotion planning. However, as the recruitment processes continued, other non-DHS organisations including local governments were also invited to participate. Participant criteria included that they had limited exposure to health promotion concepts and practices, and efforts were made to ensure that each Course included participants from a wide range of organisations. RHPOs worked with PCPs to select appropriate participants.

Process evaluation was undertaken through participant evaluation surveys completed at the end of each day. Results of the process evaluation are discussed in Chapter 4.

While implementation of the Core Health Promotion Short Course has continued throughout 2003, this evaluation relates specifically to the first round of courses. That is, those completed in 2001-2002.

1.1 Certification of the Core Health Promotion Short Course

The DHS has certified the Core Health Promotion Short Course, and provides participants with a Certificate of Attendance. Training providers complete the Certificates and ensure that it stipulates the days attended by participants. This Certificate is important professionally for participants in terms of their career development. Some Universities have also developed an articulation pathway with a prescribed assessment for participants who have completed all five days of the Short Course. For participants who enrol in relevant postgraduate courses, credit is provided for one academic subject/unit on successful completion of the assessment, potentially saving students’ fees and giving them recognition for the knowledge and skills acquired during the 5-day Short Course and applied to their personal and organisational practice.
1.2 **Aim**

The project brief identifies that the aim of the project was to undertake an impact evaluation research project of the delivery of Core Health Promotion Short Course in Victoria during 2001-2.

1.3 **Objectives**

The DHS project brief sets out the following process and outcome objectives:

**Objective 1: To determine if the Core Health Promotion Short Course was successful in achieving the stated aims and objectives, including:**
- Does the Core Health Promotion Short Course provide an introduction to health promotion for community and primary care workers in Victoria?
- To determine if the Core Health Promotion Short Course had a beneficial impact on health promotion practice and the health promoting work capacity of the target group across the different settings and Regions;
- To determine if the model of delivery of the Core Health Promotion Short Course met the needs of the target group;
- To evaluate the content of the Core Health Promotion Short Course;
- To evaluate the appropriateness and value of the resources and materials.

**Objective 2: To identify ongoing need for further training and development activities in the Victorian health promotion sector**

**Objective 3: To identify barriers and enabling factors for prospective Core Health Promotion Short Course participants**

**Objective 4: To determine if this model of program delivery is suitable for application to future health promotion training initiatives**

**Objective 5: To develop sustainability options for continuing the Core Health Promotion Short Course at the completion of the current (2003) funding cycle**

The tender for the Evaluation project was advertised by the DHS in January 2003. Deakin University was successful in obtaining the tender, and the project was carried out between March-July 2003. It should be noted that this evaluation was conducted while the 2002-3 course were being planned and delivered. As a result, some respondents made reference to the 2002-3 courses. Whilst these comments were noted, data provided in this report relates specifically to the initial 2001-2 courses.
2.0 Methodology

Evaluation in terms of this project involved the systematic collection of information about the impact of the DHS Core Health Promotion Short Course on participants, and to a degree, on organisations. The research was conducted in order to make some reasonable judgments about the effectiveness of the Short Course, and to inform decisions specifically about the future of the Short Course and more generally, about the health promotion workforce development in Victoria. As such, the evaluation methodology needed to be useful, practical and ethical with a high degree of validity.

The focus of the evaluation research was the first round of course delivery conducted over 2001-2 across the nine DHS Regions, as well as the two pilot courses conducted in Southern/Eastern and Loddon Mallee Regions. Our evaluation methodology incorporates mixed method research design that includes both quantitative and qualitative data. Thus, inductive and deductive analytical approaches were used and combined to develop reliable results.

2.1 Research design

Our evaluation research has a qualitative-quantitative design as this provides a sound foundation for reporting the findings of the evaluation. In particular, it provides rich data from which to develop patterns, themes, experiences and relationships between them. Quantitative methods provide statistical measures, while qualitative methods deepen understandings, tell the stories, and put ‘faces’ on the statistics. Our research used a mixed method, triangulated design, which has allowed the drawing of connections between themes and outcomes, in turn, linking them to the aim of the evaluation project. This design provides support for interpretations, and strengthens the nature and quality of the connections between themes and outcomes (Patton 2002). Triangulation was achieved by combining several observers, theories, methods and data sources to overcome the intrinsic bias that arises from single observer, single method and single theory studies.

The process for the evaluation was intended to be as inclusive and wide ranging as possible given the resources available, and to provide opportunities for as many stakeholders as possible to have an input. Evaluation data has been generated from a range of sources including a survey, focus groups, interviews and exemplars of organisational change.

2.2 Project Advisory Group

A Project Advisory Group (PAG) was formed early in the project, with wide representation. Membership of the PAG is listed at the beginning of this report. The PAG met face-to-face on three occasions with email contact between meetings. The PAG was given the opportunity to approve the survey questions, interview schedules, and nominate key people in each Region who might be invited to participate. The PAG was provided with transcripts for the purposes of auditing for themes and categories of analysis and was provided with draft reports on which to comment and provide feedback.

2.3 Survey

The final survey was the result of extensive consultation with the PAG, RHPOs and DHS Program Managers, and comprised of 34 questions. The DHS sanctioned the
provision of names from Short Course registration lists to the evaluation team for the purposes of the mail-out.

The survey was sent by mail with a reply paid envelope for anonymous return of the survey. A separate sheet inviting course participants to participate in focus groups or interviews was also included together with an additional reply paid envelope. This separation of personal information from the survey returns ensured that surveys were returned anonymously.

Survey data was entered into SPSS by a commercial data entry firm. Double entry of data was conducted to ensure accuracy. This process ensured a degree of separation for the purposes of independence, between the data results and the evaluation team. Raw data from the evaluation was made available to the PAG for verification, as were drafts of the analysis.

2.4 **Focus groups and interviews**

Interviews were conducted in all DHS Regions in the respondent categories of participants, CEOs/Program Managers, DHS staff, and training providers. It was initially envisaged that focus groups would be conducted in each of the five regions. Limited response to focus group invitations meant that only three focus groups were conducted. Therefore additional interviews with participants were conducted to ensure their views were adequately encapsulated. Theme lists and question prompts were developed in conjunction with the PAG (see Appendix 3). Interviews were conducted primarily by telephone with some conducted face to face. Notes from focus groups and interviews were typed and returned to participants for confirmation where possible. Data was collected from across all categories until saturation was achieved.

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health</td>
<td></td>
</tr>
<tr>
<td>CEO/Manager</td>
<td>5</td>
</tr>
<tr>
<td>Allied health/nursing</td>
<td>6</td>
</tr>
<tr>
<td>HP</td>
<td>2</td>
</tr>
<tr>
<td>Acute</td>
<td>1</td>
</tr>
<tr>
<td>Local government</td>
<td>4</td>
</tr>
<tr>
<td>Smaller agencies</td>
<td>5</td>
</tr>
<tr>
<td>Primary Care Partnerships (Exec and project staff)</td>
<td>3</td>
</tr>
<tr>
<td>School nursing</td>
<td>3</td>
</tr>
<tr>
<td>DHS</td>
<td></td>
</tr>
<tr>
<td>RHPO</td>
<td>8</td>
</tr>
<tr>
<td>Central Office</td>
<td>5</td>
</tr>
<tr>
<td>Regional Office (excl school nursing)</td>
<td>4</td>
</tr>
<tr>
<td>Women’s health</td>
<td>3</td>
</tr>
<tr>
<td>Divisions of General Practice</td>
<td>2</td>
</tr>
<tr>
<td>Trainers</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
</tr>
</tbody>
</table>
2.5 Exemplars
Interviews and focus groups were used to identify potential exemplars. The evaluators were interested in identifying cases where they could learn the most, which is a technique described by Patton (2002) as illuminative cases. Therefore, exemplars whereby participants or organisations that have been able to change their health promotion practice, and those who have not had such success with implementing change were sought. To ensure that the exemplars were contextualised, we asked four organisations to provide us with their organisational health promotion planning tools and proformas, annual report and organisational strategic plan. Despite our best efforts, only two of these organisations followed through with this process.

2.6 Validity and objectivity
To ensure that data collection and analysis were valid and had produced non-biased results, the following steps were taken during data collection and analysis:
- The survey was developed through extensive consultation. Data from the survey was entered by an external, independent organisation. All records from this data entry were available to the PAG.
- Interview themes and schedules were approved by the PAG.
- No training provider collected data in a Region where that person provided Short Course training.
- Interviews and focus groups notes were analysed by a Research Fellow who was not involved in the course development or delivery together with the project team.
- The PAG were invited to select interview transcripts at random and to compare these with the interim report, to confirm themes.

2.7 Data analysis
Conceptual themes of effectiveness, appropriateness, acceptability, equity and efficiency guided the evaluation (Department of Finance 1994; Oakley 2001). These conceptual themes are thought to be key drivers for the development of an evaluation framework, were used to guide the evaluation framework for this project.

As the data collection proceeded, all interviews and focus groups were coded and thus de-linked from the data. Focus group and interview notes were loaded into NUDIST via category type. Cross-case and within case analysis was conducted to develop key themes.

2.8 Ethics
Approval for the research was granted by the Deakin University Human Research Ethics Committee (DUHREC). Privacy issues arose in relation to the use of participant registration lists for the survey mail-out. In accordance with DUHREC requirements, participants were informed through DHS channels that the evaluation was being conducted and that participation was entirely voluntary. No complaints about procedures or process of the evaluation were received from any person.
2.9  Limitations of the evaluation

Given the complexity of the organisations and diversity of staff who undertook the Short Course, the evaluation was constrained by the time schedule imposed by the contract, and by the resources available for the project.

For the 2001-2 round of courses, course providers were responsible for maintaining participant lists. These lists were incomplete in some regions. This therefore limited the evaluator’s ability to identify participants who should be invited to participate in the evaluation.

There appeared to be considerable turnover of staff in the community, primary and women’s sector between the time the Short Course was delivered in 2001-2 and the survey mail-out in 2003. This was evident by the number of surveys returned and marked, ‘not at this address’. It is quite possible that some Short Course participants did not know about the evaluation because they had moved organisations and were therefore not provided with an opportunity to respond to the survey or provide an interview. Every effort has been made to ensure that organisations were aware of the evaluation but our sample is limited by the extent to which organisations made known this information.
3.0 Literature Review

3.1 Public health workforce development

Workforce development in public health is defined as incorporating ‘a broad range of education and training activities...that are designed to develop the knowledge and skills of the workforce’ (O’Connor Fleming et al 2000: 141) for the purposes of infrastructure support for health advancement. An essential component of workforce development is ‘the application of contemporary knowledge and skills into workplace practice’ (O’Connor Fleming et al 2000: 141). Other components of workforce development may include ensuring quality practice, system and structural supports, sustainability, adequate resourcing, knowledge and skills development (O’Connor Fleming et al 2000).

Workforce development in public health has been recognized as an area requiring further investment (Department of Health 2001; NPHP 2002; U.S. Department of Health and Human Services 2000). In particular, assessment (beyond that of individuals), epidemiology, analytical thinking, effective communication, community development, policy development and politics, and organisational effectiveness have been identified as essential skills for public health practice that are often lacking among the workforce (Gebbie 1999).

The literature relating to health promotion workforce development is relatively sparse, particularly in Australia (NPHP 2002; Swerissen & Tilgner 2000). The push to deliver direct services in primary care has perhaps limited acknowledgment of workforce development needs beyond that of clinical competencies. However, workforce development as a tool for sustainability, quality and capacity building in public health and health promotion has been embraced more recently. Despite this shift, research suggests that there are key deficits in the workforce skill-base that may impact on its ability to use evidence-based approaches to public health (Australian Council on Healthcare Standards 1999).

Due to the diversity of the public health workforce, there are a number of difficulties in providing an accurate description and definition of its components (NPHP 2002). However, it can be said that the public health workforce includes a range of health professionals including medical practitioners, nurses, epidemiologists and biostatisticians, researchers, environmental health practitioners and various practitioners involved in health promotion, health education (Rotem et al 1995 cited in O’Connor Fleming et al 2000) and community building, and who work in wide range of organisations including government, academia and the community health sector.

3.1.1 History of public health workforce development in Australia

Public health workforce development in Australia has a long but not particularly strong, history. The University of Sydney Faculty of Medicine had occasionally awarded a Diploma in Public Health from 1910. This course was strengthened by the Faculty’s connections to the Australian Institute of Tropical Medicine, established at Townsville in 1909. By 1930, the Faculty had moved to set up the School of Public Health and Tropical Medicine, teaching preventive, social and tropical medicine through subjects such as bacteriology, medical entomology, parasitology, tropical health and occupational medicine and hygiene (Young et al 1984: 401). During this time the University also awarded a Diploma in Tropical Medicine and Hygiene. This training program, supported by the then Commonwealth Department of Health, was
only for medical graduates. The University of Melbourne first conferred the award of Diploma of Public Health, in 1908 but the course was not strong. Few if any further candidates presented and regulations for the diploma were eventually suspended due to a lack of resources (Keleher 2000). Indeed, medicine and nursing in Australia historically, have had little regard for public health as a core paradigm (Keleher 2000).

Public health training was given more significant support with the introduction of the Commonwealth Public Health Education and Research Program (PHERP) in the late 1980s. The core of the program was funding to selected universities to provide a Master of Public Health (MPH). For the first triennium, entry was restricted to medical graduates. From 1993, entry was opened to graduates from other courses including nursing and allied health. The Commonwealth has continued to fund PHERP and the MPH remains the flagship qualification for the public health workforce.

The National Public Health Partnership published a discussion paper in 2002 outlining a proposed model for public health workforce planning (NPHP 2002). In order to address public health workforce development, the paper suggests that agencies should identify their workforce needs in terms of essential competencies for the achievement of organisational objectives, in four steps:

1. identify/measure (future) goals and activities,
2. determine what information, priority or program changes generate demand for public health services,
3. describe the organisational competencies required to achieve the goals and implement action and
4. describe the competency set required by the workforce of the future. (NPHP 2002)

The model puts social needs rather than provider/staff needs, at the centre of workforce planning. It is envisaged that this model will be trialled at either organisational level or through occupational groups at local or state levels. Further developments regarding this process are not yet available.

Subgroups of practitioners are conceptualized in various ways. In Australia, three groups have been identified: leaders/champions; the direct workforce (specialists); and the indirect workforce (Cook, Gadiel, Ridoutt and Wise 2001 as cited in NPHP 2002). The UK Department of Health (2001) defines the public health workforce slightly differently as including consultants/specialists (including senior/strategic management level), a small number of professionals who spend a major part of their time in public health practice, and most people (which includes those who have a role in public health practice). Further, the public health workforce is now thought to comprise subgroups including health promotion, around which there is a growing body of literature.

3.1.2 The health promotion workforce
Health promotion is a strategy of the wider public health endeavour. Thus, workforce development for health promotion practitioners should be situated within a public health framework to ensure a comprehensiveness of theory and practice. Both the public health and health promotion workforces are difficult to define (O’Connor Fleming et al 2000) and work at various levels (Keleher & Marshall 2002). Health professionals may be designated to undertake health promotion, they may engage in
health promotion as part of their clinical or direct service role or may do so to a lesser extent in relation to injury or illness prevention roles (O’Connor Fleming et al 2000).

3.1.3 Health promotion workforce development

The diversity of the health promotion workforce in Australia is thought to be both its strength and its weakness (Commonwealth of Australia 1993). While this diversity brings with it a range of health promotion skills and expertise, competencies for a range of core functions in health promotion may not always be adequately spread through the workforce. Certainly, workforce development in health promotion seems to have emerged in an unstructured manner. There is therefore a strong argument for the development of a coordinated effort towards the strengthening of workforce development in a range of areas but this review has found that attempts to evaluate workforce development strategies in Australia have been limited.

The Better Health Report commissioned by the Commonwealth in the early 1990s developed a set of preconditions for effective health promotion workforce development (Commonwealth of Australia 1993). A range of core attributes of health promotion professionals, which focused on knowledge, skills and need, were compiled. This report also recognized that structural and organisational barriers to effective practice required investigation. However, there appears to have been limited development of this work on a national scale.

A key challenge of implementing effective health promotion is to provide appropriate education and training for the workforce involved (O’Connor Fleming et al 2000). Organisational preconditions for health promotion include access to education and training for both management and staff to increase competencies in health promotion (Fawkes 1997). These are strategies to assist in enabling organisational change through the acceptance and recognition of health promotion as a legitimate activity (White and Ashton 1999).

Issues about the HP workforce re-emerged with the development of a joint initiative between the National Public Health Partnership and the Australian Health Promotion Association in 2000-2001. The aim of the collaboration was to develop recommendations on a national strategic plan for health promotion workforce development. To date the report of the Working Group has not been released by the National Public Health Partnership.

An analysis of health promotion practice and training needs for Victorian health promotion professionals was undertaken in the late 1990s (Swerissen & Tilgner 2000). This research defined health promotion professionals as health promotion practitioners, health professionals with an ongoing role in health promotion and decision-makers who influence the uptake of health promotion education and training. This study did not evaluate existing training programs but it found, not surprisingly, that health promotion professionals spent the greatest amount of time on health promotion activities when compared to other health professions. When asked to indicate their preferences for health promotion training and education, the majority of respondents preferred a modular format with face-to-face group work delivery (Swerissen & Tilgner 2000). Interestingly, whilst health promotion professionals and ‘other’ health professionals preferred training to be conducted by health promotion experts, general practitioners (GPs) preferred an experienced peer or colleague from the medical profession (Swerissen & Tilgner 2000).
On a broader scale, another study mapped health promotion workforce developments throughout Australia, finding that opportunities for training and education to be limited in terms of access and of varying quality (O’Connor Fleming et al 2000). Given the diversity of the health promotion workforce, courses often did not meet the needs of the range of health professionals attending. The commitment and capacity of organisations to support health promotion workforce development was found to be limited. One of the conclusions of this study was that health promotion education is in need of increased legitimacy (O’Connor Fleming et al 2000). While this study made some broad statements about the adequacy of health promotion training, individual programs were not evaluated.

A significant health promotion workforce development program was developed by the NSW Western Sydney Area Health Service in the mid-1990s, called the Core Skills in Health Promotion Course. This has been the principal vehicle for skill development in health promotion among the NSW community health sector. Evaluation of the Core Skills in Health Promotion Course has been conducted (Yeatman et al 1999). The evaluation identified that almost one third of community health staff were more likely to be involved in health promotion if they had taken the course. Further the extent of support required for workers to undertake health promotion was established (Yeatman et al 1999). Analysis of the project was conducted within a framework of organisational change.

There has also been a movement towards the development of health promotion competencies in the last 10 years (Howat et al 2000). Competencies can be defined as ‘a combination of attributes which enable an individual to perform a set of tasks to an appropriate standard’ (Shilton et al 2001: 118). Therefore, competencies provide a framework for achieving workforce development as they recognize the skills and attributes required of the workforce (Shilton et al 2001). Competencies for health promotion are complicated by the varying definitions of health promotion practice and the diversity of professionals involved in health promotion practice. Research undertaken to identify a broad consensus around health promotion competencies revealed eight key domains:

- needs assessment,
- planning,
- implementation
- communication
- knowledge
- organisation and management,
- evaluation and research,
- use of technology. (Howat et al 2000; Shilton et al 2001)

3. 2. **DHS policy context for workforce development**

Reorientation towards health promotion in the primary care and community support sector has increased the importance of workforce development in health promotion, and is consistent with recommendations of the Ottawa Charter for Health Promotion (WHO 1986). The Victorian policy context for this includes DHS policy for partnerships and integrated service delivery through the Primary Care Partnerships strategy, the Municipal Public Health Planning (MPHP) strategy, and the Primary and Community Health sector. Within this sector, the health promotion policy context including funding and strategy for health advancement through integrated health promotion at the local level, and organisational policy within which health promotion sits in agencies.
The DHS policy platform states the priority given by the DHS to health promotion and confirms commitment to the social model of health as a guiding framework for the work of the human services sector (DHS 2000a). Recognizing differences in organisational capacity for health promotion, and the need for stronger cross agency activities, the DHS has developed what is known as the Primary Care Partnership strategy to strengthen this capacity (DHS 2000a).

3.2.1 Primary Care Partnerships

A total of 32 Primary Care Partnerships (PCPs), were established across Victoria in 2000. The aim of the PCP strategy has been to:

- improve the experience and outcomes for people who use primary care services
- reduce the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people’s need for support. (DHS 2000b)

The early PCP policy documents identified three key elements of PCPs activity:

- service planning – to identify population health needs of the community and propose strategies to address these needs, such as health promotion and integrated disease management strategies;
- service coordination – how local systems and infrastructure, such as information management, needs identification and referral, will enable services to be better coordinated so that outcomes are improved for people using the primary care system; and
- service partnerships – how providers and the community will work together to implement the plan (DHS 2000b).

Since 2000 all PCPs have been required to submit annual Community Health Plans representing the catchment identified health priority issues. Following this, the PCP strategy directed its attention to service planning and service partnerships. In doing so, it was intended that agencies would also focus more closely on integrated health promotion. DHS planning guidelines for integrated health promotion activity expect that PCP member agencies and other key stakeholders will be involved in planning, implementing and evaluating this action (DHS 2000a).

3.2.2 Health promotion in local government

The policy environment in local government is in a period of reform with a new focus on health promotion within a public health/health development framework. Health promotion is incorporated in local government strategy through the Municipal Public Health Plan document, Environments for Health (DHS 2002c). This strategy aims to reform approaches to health taken by local government by enlarging its focus from traditional environmental health activities to a wider scope that includes population health strategies, health development, community capacity building and community wellbeing (DHS 2002c). This document clearly locates responsibilities for health promotion and some aspects of community health with local government, and sets expectations that local government will actively pursue partnerships with the health (and other) sectors to develop health promotion activities.
The MPHP strategy represents an increased investment and support of health promotion activities but it also requires a change in the way local government service providers conduct their practice, and the DHS has given recognition to the need for workforce development to support and sustain the reforms. With the support of the DHS, the local government sector has established its Good Practice Program, which aims to ‘stimulate new developments and creative approaches to municipal public health planning’ (DHS 2002c: np) and does so via projects that serve as models of good practice. In 2002, Good Practice Projects were funded in relation to health planning, health issues, health status profiles, health promotion capacity building, population health and wellbeing, mental health and community development. Further, VicHealth has developed the Leading the Way initiative which aims to address the social determinants of health through a multi-sectoral local government approach (Dubly & Jolley 2003).

3.2.3 Health promotion in primary and community health sector

The DHS Workforce Development Program is intended for agencies funded through the Community Health Program and PCP organisations. However, it should be noted that some aspects of DHS health promotion workforce development programs have been available to staff from the wider primary health and community support sector such as local government, hospitals and the non-government sector.

3.2.4 Community health

The policy environment for community health has been dominated by a focus on outputs and competition. In regular cycles, the primary and community health sector has been subject to quite intensive periods of reform (Brown 2000). From the late 1980s through to the late 1990s, market based models had a strong influence on funding and service delivery through a focus on outputs. More recently, there has been a move away from market-based models of health care delivery to refocus on outcomes. Since 1999, the DHS has a stated mission about the health of populations, with a focus on improving the health of vulnerable groups. This environment has reinvigorated interest in health promotion as a legitimate activity.

Since 2002, Community Health Services have been expected to allocate 15% to 35% of their primary health budgets to health promotion (DHS 2002a). All agencies in receipt of this health promotion funding are required annually to develop, submit and implement an organizational health promotion plan. Biannual evaluation reporting is also required (DHS 2002a; DHS 2002b).

The community health sector in Victoria comprises 100 Community Health Services on 250 sites, with over 200,000 registered clients each year. They employ a workforce of around 8,000 staff (DHS 2003a).

Nonetheless, the degree of sophistication of health promotion activities in community health varies considerably. Health promotion in community health has been more focused on information/social marketing and group education than on health development and socio-environmental approaches (Round 1999; Keleher & Murphy 2001). The DHS Health Promotion Guidelines (DHS 2003) are clear in their intention to move health promotion activity to the more population based, upstream approaches than individual prevention and health education approaches.

In any change process, reform is likely to challenge the existing skills of health professionals. Constant up-skilling in a changing environment is therefore crucial.
(Gebbie 1999). The DHS has recognized the importance of workforce development for health promotion and is providing financial support for these activities (DHS 2002a). The health promotion reporting template allows agencies to develop workforce development strategies. These may include:

- Individual staff learning and training
- Leadership and management development
- Organisational development activities
- Sector-wide activities (DHS 2002a)

### 3.3 Elements of effective workforce development

#### 3.3.1 Organisational change

Organisational change is commonly studied in management and business literature with frequent application in the education context but less so in the context of community based health organisations. Generally, organisational development is regarded as a series of interventions or strategies for planned change that seek to improve the effectiveness of organisations and to improve employee wellbeing (Robbins et al 1994). Organisational change in the community based health organisation context is related to increased capacity to effect health outcomes. This might involve planning, delivery and evaluation of effective health promotion programs. Identification of the most effective strategies to achieve organisational development is the challenge of any workforce development strategy.

The evaluation of the NSW Core Skills in Health Promotion identified five principles of organisational change:

1. Principle 1: It is important to involve staff at all levels of the change process
2. Principle 2: Sustainability of change requires involvement of management
3. Principle 3: Capacity building for health promotion
4. Principle 4: External stimulus and support for change
5. Principle 5: Organisational change takes time

(Yeatman et al 1999)

As identified earlier, health promotion, especially in the community and women’s health sector, has depended on program champions to be the drivers of change. Program champions are often appointed in designated Health Promotion positions, although not all these positions are necessarily funded on a full-time basis. The titles of these positions vary considerably, from Health Promotion Officer or Coordinator to Health Development Manager. The position of Health Promotion Coordinator (however styled) is a central position in the infrastructure of most Community Health Services (Keleher & Marshall 2002). The Health Promotion Coordinator role has the capacity to concentrate on internal and external health promotion relationships, to develop partnerships, to influence health promotion planning, guide program development and steer implementation and evaluation activities. No other position within the Community Health Service has the capacity to fully engage in this range of health promotion activities. So while health promotion activities are part of the job description for many other staff, their responsibility for health promotion activity is much more confined than that of the Health Promotion Coordinator. For clinical staff, health promotion practice, especially primary health driven health promotion, requires considerable reorientation, training and development. Leadership within Services is necessary for this kind of health development to occur and is more likely to reside in
the position of Health Promotion Coordinator, than any other position (Keleher & Marshall 2002).

As program champions are instrumental in ensuring program institutionalization or sustainability, this has often been a valuable strategy for services (Shediac-Rizkallah and Bone 1998). However, the shift towards integrated health promotion and the belief that health promotion is every health practitioner’s business, limits the degree to which organisations should depend on individual program champions. While workforce development strategies do not reduce the need for program champions, they are likely to enable and empower the wider workforce to achieve sustainability of health promotion programs with more limited direction/guidance from a Coordinator. Thus a wider workforce development strategy is indicated.

Integrated health promotion is a response to traditional patterns of delivering single services or programs without collaboration or partnerships or an overall vision for medium and longer term goals and outcomes, particularly in relation to equity (Eager, Garrett & Lin 2001). Across the hospital-community interface, there is a focus of integration through improved communication, collaboration and coordination of care for high-risk diseases. In health promotion, integration requires a considerable shift, perhaps systemic, to achieve greater planning and program coordination across sectors, across health promotion approaches (medical/preventive-behavioural-socio-environmental) and across interventions (i.e. screening, health education, social marketing, community action) across sectors and at different levels of the health system (DHS 2000b). Thus, integrated health promotion is a coordinated effort of action an can occur within organisations across departments or across organisations (DHS 2000a). It aims to reduce duplication and build capacity (DHS 2000a).

### 3.4 Organisational capacity building

An increased focus on efficient and effective service delivery highlights the importance of investment in capacity building. It is the workforce that strengthens the capacity of the organisation to deliver efficient and effective services (Lin 2000). In strengthening workplace or organisational capacity, workforce development capacity is also increased (O’Connor Fleming et al 2000). This therefore provides an argument for the development of learning organisations that allow both cultural and organisational shifts (Lin 2000).

Capacity building provides a framework for system change of this magnitude (Bowen et al 2001). It has been defined as:

> ‘the development of sustainable skills, structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over’ (Hawe et al 2000: 3).

There are three dimensions of capacity building:

- infrastructure development,
- program sustainability and
- enhanced problem solving

(Hawe et al 2000)
Workforce development is a key strategy for building capacity. It can be argued that singular (single arm) workforce development strategies are unlikely to have a sustainable impact on workforce capacity (NSW Health 2001). Certainly, the DHS acknowledges the varying capacity of primary health agencies to undertake health promotion activities (DHS 2000a).

Organisational capacity for workforce development can be viewed as the extent to which education and training are promoted and supported (O’Connor Fleming et al 2000). While workforce development may be an important strategy for capacity building, the importance of organisational development should not be underestimated. It is organisational development that allows the facilitation of change. Organisations that are responsive to the changing environment can be described as learning organisations (NSW Health 2001).

3.5 Barriers and facilitators to health promotion training

While there has been increased investment in health promotion workforce development, barriers to and facilitators of training have been identified.

Barriers are primarily related to cost and lack of time (O’Connor Fleming et al 2000; Swerissen & Tilgner 2000). Organisational capacity issues include:

- backfill of staff;
- management of waiting lists while staff are undertaking training;
- funding of travel and time of rural participants to attend training.

Swerissen & Tilgner (2000) found that cost was raised as a barrier and therefore facilitators included financial support both at a government level and within organisations. Managers and practitioners need to appreciate the value of training in health promotion. Availability of practical courses and professional credits were other incentives for practitioners to undertake health promotion training (Swerissen & Tilgner 2000).

Given the financial and time issues associated with training, it has been acknowledged that an organized approach to workforce development for HP is required (Swerissen & Tilgner 2000). More generally, in 2000 there was no State or Territory with a systematic approach to the provision of health promotion training that was up to date ‘with the challenge of the growing magnitude of today’s public health problems’ (O’Connor Fleming et al 2000, p 147).

3.6 Summary

Workforce development is now recognized as a crucial aspect for the macro aspects of capacity building for public health as well as for more micro issues of effective health promotion planning and implementation. Much of the research to date has focused on mapping the health promotion workforce, identifying shortfalls in workforce development or developing competencies to guide the health promotion workforce. Limited investment in evaluating existing workforce development programs has been undertaken. This project aims to address this issue and build on the limited knowledge around the factors that create successful and sustainable health promotion training programs and document factors that contribute to less than optimal training programs in health promotion. Into this environment the DHS developed the Victorian Short Course in Health Promotion.
4.0 Survey data

This chapter reports on the state-wide survey designed as a central measure of impact evaluation of the Short Course. The survey was developed specifically for this evaluation.

4.1 Process evaluation

Process evaluation has not been the focus of the research conducted for this report, because this level of evaluation was conducted in conjunction with the delivery of the course in the 2001 funding round. A brief overview of the findings of the process evaluation is provided in this section.

A process evaluation survey tool for the 2001-2 courses was developed by the DHS and included with course materials for providers to distribute to participants and collect, at the end of each day of the 5 day course. Providers were able to read participant feedback and were then asked to send them to the DHS. The surveys that were returned were analysed internally by the DHS. Providers were invited to attend a meeting to discuss the results of the process evaluation. The meeting was well attended and provided an opportunity for general discussion about content and delivery issues related to the Short Course. The following account is a summary of the notes of that meeting taken by the DHS.

Reach

The process evaluation showed that the first round of courses primarily reached staff in Community Health, Local Government and the Acute sectors (see Table 4.1).

Other participants came from a variety of smaller sectors including bush nursing, alcohol and drug, dental health, district nursing, housing, indigenous health, neighbourhood houses and PCP staff.
### Table 4.1: Participants by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health</td>
<td>220</td>
</tr>
<tr>
<td>LG</td>
<td>64</td>
</tr>
<tr>
<td>Acute</td>
<td>56</td>
</tr>
<tr>
<td>Service Agency</td>
<td>37</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>32</td>
</tr>
<tr>
<td>State Government</td>
<td>28</td>
</tr>
<tr>
<td>Sport and Recreation</td>
<td>26</td>
</tr>
<tr>
<td>Secondary School Nurse</td>
<td>22</td>
</tr>
<tr>
<td>Division of General Practice</td>
<td>20</td>
</tr>
<tr>
<td>Non-government Organisation</td>
<td>15</td>
</tr>
<tr>
<td>Koori Health</td>
<td>12</td>
</tr>
<tr>
<td>Mental Health</td>
<td>12</td>
</tr>
<tr>
<td>Tertiary/Edu</td>
<td>9</td>
</tr>
<tr>
<td>Multi-Purpose Service</td>
<td>8</td>
</tr>
<tr>
<td>Primary School Nurse</td>
<td>8</td>
</tr>
<tr>
<td>Neighbourhood House</td>
<td>6</td>
</tr>
<tr>
<td>Primary Care Partnership</td>
<td>5</td>
</tr>
<tr>
<td>District Nursing</td>
<td>4</td>
</tr>
<tr>
<td>General Practice Clinic</td>
<td>4</td>
</tr>
<tr>
<td>Alcohol &amp; Drug</td>
<td>3</td>
</tr>
<tr>
<td>Hospital</td>
<td>3</td>
</tr>
<tr>
<td>LG - Sports and Rec</td>
<td>3</td>
</tr>
<tr>
<td>Bush Nursing</td>
<td>2</td>
</tr>
<tr>
<td>Commonwealth Government</td>
<td>2</td>
</tr>
<tr>
<td>Housing</td>
<td>2</td>
</tr>
<tr>
<td>Community</td>
<td>1</td>
</tr>
<tr>
<td>Dental Health</td>
<td>1</td>
</tr>
<tr>
<td>GP Practice</td>
<td>1</td>
</tr>
<tr>
<td>Regional Sports Assembly</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>632</td>
</tr>
</tbody>
</table>

**Course delivery**

The delivery of the course was rated highly by participants. Analysis of responses for particular modules were not conducted but the vast majority of participants found the providers and the course material inspiring. Some participants commented on the jargon included in the course and others commented on delivery styles that were didactic.

The process evaluation provided insights into the structure and function of the Short Course. Participants generally preferred some days to others. Where a provider ran five consecutive days, participants commented that modules should be separated by a number of days or even weeks. Analysis revealed that networking was an important aspect of the course for participants.

During the meeting, providers made some general comments about the delivery format, recommending that the course be conducted over 3-4 weeks to allow participants time to reflect on the content and consider its application to their work. Course administration processes differed between regions. DHS Regional Health Promotion Officers usually conducted advertising and recruitment aspects of course
administration, and this was felt to be beneficial in terms of ensuring a mix of participants attended, with recruiting primarily being targeted at Primary Care Partnership members. However, course administration was felt to be very time-consuming for RHPOs.

The process evaluation form itself had inherent difficulties so providers recommended that changes should be made to the forms for the next round of course delivery. Providers also felt that differing evaluation methods such as follow up focus groups could be utilised for process evaluation. Providers suggested that follow-up of course participants might be useful when further training needs could also be discussed with participants.

Other comments related specifically to the course content. Further, providers explained that some adjustment to the course material had been necessary due to the amount of material to be included. Providers also commented that participant’s knowledge of PCPs could not be assumed.

The process evaluation indicated that there were a number of issues to be addressed prior to the commencement of the next round of courses. Accordingly, before implementation of the 2003 courses, the DHS commissioned a process for revision of course content and for the development of revised process evaluation surveys. The 2003 Short Course structure can be found at Appendix 1.

4.2 Impact evaluation survey

A survey instrument was a central form of data collection for the impact evaluation. The Deakin University project team in conjunction with the Project Advisory Group developed the survey. The PAG received a draft for comment, which was discussed in detail at a PAG meeting, then modified before final approval by the PAG. All RHPOs and DHS Public Health Managers also had an opportunity to comment on the survey through the RHPO representative on the PAG. The final survey comprised 34 questions. It was mailed to all course participants according to the attendance registers provided by trainers to the DHS. The survey is presented as Appendix 2.

4.2.1 Survey distribution

In total, 618 surveys were mailed to participants whose contact details were held by the DHS. From records kept, we estimate 800-900 participants for the first round of courses, but the 618 is reflective of the actual participant records kept in the Regions and the transient nature of the health promotion workforce. In total, 155 surveys were completed and returned and a further 75 were returned as undeliverable. Table 4.2 gives information on the number of surveys mailed to each region, the number undelivered and ‘returned to sender’, and the number completed and returned. The most common statements written on surveys that were returned as undeliverable were ‘no longer at this address’ and ‘not known at this address’ signifying significant movement in employment in the period between the short course delivery and the evaluation.

<table>
<thead>
<tr>
<th>Region</th>
<th>No of surveys distributed</th>
<th>No. of surveys not delivered</th>
<th>No. of surveys completed and returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barwon South</td>
<td>72</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Western</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.2: Distribution and return of surveys
Overall the response rate was 25%. However, if removing the surveys that were returned as ‘undeliverable’ from the sample, the response rate amongst those receiving the survey rises to a figure of 29%. The response rate was relatively low. There appears to be high mobility in this sector. It is also an over-researched sector with high demands made on staff to participate in research, project evaluations, and workforce studies. It is likely that many in the sector have survey fatigue.

### 4.2.2 Survey results

**Demographics of course participants**

The majority of respondents were female (86.5%) and aged between 40 and 49 years (55%), with more than 10 years working in the health sector (49%). People with less than two years work represented 13% of the cohort, and those with 2-5 years experience, 20%.

Survey respondents were most likely to work in community health (see Table 4.3). Those in the ‘other’ sectors included Divisions of General Practice, neighbourhood houses and small community agencies. The vast majority of participants (84%) worked in agencies that were members of Primary Care Partnerships.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health</td>
<td>68</td>
<td>43.9</td>
</tr>
<tr>
<td>Acute health service</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Alcohol and drug services</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Local government</td>
<td>17</td>
<td>11.0</td>
</tr>
<tr>
<td>State government</td>
<td>11</td>
<td>7.1</td>
</tr>
<tr>
<td>Rural health service</td>
<td>7</td>
<td>4.5</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>21.3</td>
</tr>
<tr>
<td>Multiple response</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Missing response</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>155</td>
<td>100</td>
</tr>
</tbody>
</table>

Respondents to the survey were more likely to be from rural areas (n=90) than metropolitan areas (n=60). Five respondents did not state a region or indicated that they worked across regions or statewide. The most responses were received from Barwon South West, Eastern Metropolitan and Loddon Mallee Regions (see Figure 4.1).
The survey also asked participants to be more specific in terms of location of their organisation. Thirty percent of respondents came from metropolitan Melbourne, 30% from rural cities, 21% from rural towns, 12% outer-fringe Melbourne and 7% from provincial cities.

**Course participation**
While all days of the course had strong rates of participation, day one (*Health Promotion Concepts and Approaches*) and day two (*Needs Assessment and Program Planning*) had the highest rates, at 95% and 93% respectively. Day 4 (*Skills and Strategies in Health Promotion*) had the lowest attendance rate, with 87% of respondents completing this day.

The majority of participants (85%) had heard about the course through their workplace, with a further 6% indicating that they had been approached and recommend undertaking the course. Participation in the course had been voluntary for most participants (84%) with approximately half of these people indicating that although their attendance was voluntary, it had been recommended that they attend. Only 8.4% of respondents indicated that their attendance had been compulsory.

**Prior to course**
Participants were asked to rate their knowledge of health promotion (question 11), their experience in health promotion (question 12) and their perception of the need for health promotion in their organisation (question 13) prior to attending the course. Results are shown in Table 4.4.
Table 4.4: Knowledge of, experience in, and perception of the need for health promotion prior to the course

<table>
<thead>
<tr>
<th>Knowledge of HP</th>
<th>Experience in HP</th>
<th>Perception of need for HP</th>
</tr>
</thead>
<tbody>
<tr>
<td>No knowledge</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>Some knowledge</td>
<td>65%</td>
<td>64%</td>
</tr>
<tr>
<td>Good level of knowledge</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Very high level of knowledge</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

After attending the course

The course was deemed to be ‘very relevant’ (44%) or ‘quite relevant’ (39%) by most participants, although 16% had seen it as only ‘somewhat relevant’ and one participant had considered it to be of no relevance.

Perceptions of knowledge of health promotion and change in practice

Participants were asked to rate their knowledge of health promotion after the course (question 16), the effectiveness of the course in providing them with the knowledge and skills to incorporate health promotion into their work (question 17) and the extent to which they had actually been able to incorporate it into their work (question 18). The results (Table 4.5) show a considerable perception of change in knowledge and practice, when compared to the results in Table 4.4.

Table 4.5: Perceptions of personal knowledge and practice after the course

<table>
<thead>
<tr>
<th>Knowledge of HP</th>
<th>Effectiveness of the course in providing HP knowledge and skills</th>
<th>Being able to incorporate HP into my work</th>
</tr>
</thead>
<tbody>
<tr>
<td>No knowledge</td>
<td>0%</td>
<td>Not at all 4%</td>
</tr>
<tr>
<td>Some knowledge</td>
<td>15%</td>
<td>Quite helpful 34%</td>
</tr>
<tr>
<td>Good level of knowledge</td>
<td>68%</td>
<td>Very helpful 45%</td>
</tr>
<tr>
<td>Very high level of knowledge</td>
<td>17%</td>
<td>Invaluable 17%</td>
</tr>
</tbody>
</table>

Three quarters of respondents indicated that they had made use of the course materials and resources since undertaking the course, with 51% reporting using them occasionally and 21% reporting using them frequently.

Impact of the course overall

Respondents were asked to rate the impact of the course according to four domains (see Table 4.6) with a score of 1 being ‘not at all’ and 10 being a ‘definitely’. It is clear that participants were very positive about the impact of the course on their work. Of the four domains, the course was perceived to have the greatest impact on the way
in which people thought about their jobs. The course also affected the way people networked with other organisations, the way they did their job and the way they worked with colleagues from within their organisations.

<table>
<thead>
<tr>
<th>Table 4.6: Impact of the course</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statement</strong></td>
</tr>
<tr>
<td>It changed the way I think about my job.</td>
</tr>
<tr>
<td>It changed the way I do my job.</td>
</tr>
<tr>
<td>It changed the way I work with colleagues within my organisation.</td>
</tr>
<tr>
<td>It changed the way I network with people in other organisations.</td>
</tr>
</tbody>
</table>

Interestingly, an analysis was undertaken to compare the scores on all survey questions for participants from the four Melbourne DHS regions with the five rural regions, and statistically significant differences between metropolitan and rural were found on all four of the domains in Table 4.6. These differences are shown in Table 4.7.

<table>
<thead>
<tr>
<th>Table 4.7: Comparison of course in metropolitan and rural DHS regions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statement</strong></td>
</tr>
<tr>
<td>It changed the way I think about my job.</td>
</tr>
<tr>
<td>It changed the way I do my job.</td>
</tr>
<tr>
<td>It changed the way I work with colleagues within my organisation.</td>
</tr>
<tr>
<td>It changed the way I network with people in other organisations.</td>
</tr>
</tbody>
</table>

Rural respondents report a significantly greater impact of the course on their work and roles, both within and outside the organisations. Responses to question 22 also showed rural respondents are more likely to be involved in PCPs although this could be attributed to the fewer number of rural HP staff that have to undertake PCP work. On a scale of 1 (not at all) to 4 (all the time), rural respondents' mean score was 2.34 in comparison to metropolitan respondents' mean score of 1.95 (p = 0.055).

Most respondents felt confident in being able to apply their learning from the course in their current work practice: while 6% expressed 'no confidence', 36% were 'somewhat confident', 45% were 'quite confident', and 13% were 'very confident'. The majority also felt that their organisations provided opportunities for them to put into practice the health promotion knowledge and skills they had developed during the course. On a scale of 1 (no opportunity) to 10 (definitely), the mean score relating to such opportunities was 6.29. There was no significant difference between metropolitan and rural respondents.

**Impact of the course on work practices**

The survey asked participants to rate the level of change in a number of aspects of their own health promotion practice since undertaking the short course (question 25: 1 = no change; 5 = major change). While responses to all statements were positive, the greatest changes in practice were reported for aspects relating to Day 2 of the
program (Needs assessment and program planning) and were ‘developing clear goals and SMART objectives’ and ‘selecting effective approaches’. The least changes in practice were around PCP health promotion strategic planning and conducting needs assessments.

<table>
<thead>
<tr>
<th>Table 4.8: Reported changes in participants’ own work practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspect of health promotion practice</strong></td>
</tr>
<tr>
<td>Program planning: developing clear goals and SMART objectives</td>
</tr>
<tr>
<td>Program planning: selecting effective approaches</td>
</tr>
<tr>
<td>Collaboration with other organisations</td>
</tr>
<tr>
<td>Contributing to overall health promotion strategic planning</td>
</tr>
<tr>
<td>within your organisation</td>
</tr>
<tr>
<td>Impact evaluation</td>
</tr>
<tr>
<td>Process evaluation</td>
</tr>
<tr>
<td>Collaboration within the organisation</td>
</tr>
<tr>
<td>Networking for health promotion support</td>
</tr>
<tr>
<td>Program planning: working in multi-disciplinary teams</td>
</tr>
<tr>
<td>Outcome evaluation</td>
</tr>
<tr>
<td>Carrying out needs assessment</td>
</tr>
<tr>
<td>Contributing to overall health promotion strategic planning</td>
</tr>
<tr>
<td>within your PCP</td>
</tr>
</tbody>
</table>

Participants were also asked to rate the capacity of their organisations in relation to each of these aspects of health promotion practice, as well as a small number of additional aspects. They were thus contrasting their own expertise with the level of expertise available within their organisation. Table 4.9 presents this data.
Comparison of Tables 4.8 and 4.9 demonstrates that mean scores are significantly higher for organisational capacity than for individual changes in work practice, across all items that are common to both tables. In other words, participants believe that there is a sufficient level of expertise within their organisations to support their further development of health promotion practice.

### 4.2.3 Organisational capacity for health promotion

Contrasting importance and performance in aspects of health promotion capacity

The survey (question 27) asked respondents to rate the level of importance they attached to different aspects of health promotion capacity within their organisation (1 = not at all, 5 = very important), and to rate the level of actual performance of their organisation for each of these (1 = very poorly, 5 = exceptionally).
### Table 4.10: Contrasting importance and performance of aspects of organisational capacity for health promotion

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Importance - mean</th>
<th>Performance - mean</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback on health promotion performance</td>
<td>4.10</td>
<td>2.82</td>
<td>1.28</td>
</tr>
<tr>
<td>Access to internal funding for health promotion</td>
<td>4.04</td>
<td>2.82</td>
<td>1.22</td>
</tr>
<tr>
<td>Mentoring of new/inexperienced staff working in health promotion</td>
<td>3.96</td>
<td>2.82</td>
<td>1.14</td>
</tr>
<tr>
<td>Time for health promotion</td>
<td>4.24</td>
<td>3.11</td>
<td>1.13</td>
</tr>
<tr>
<td>Management support for my work in health promotion</td>
<td>4.37</td>
<td>3.25</td>
<td>1.12</td>
</tr>
<tr>
<td>Adequate IT infrastructure</td>
<td>4.59</td>
<td>3.55</td>
<td>1.04</td>
</tr>
<tr>
<td>Organisational policy about HP</td>
<td>4.10</td>
<td>3.24</td>
<td>0.86</td>
</tr>
<tr>
<td>Input into choice of health promotion activities</td>
<td>4.18</td>
<td>3.34</td>
<td>0.84</td>
</tr>
<tr>
<td>The organisation’s overall strategic plan covers health promotion</td>
<td>4.23</td>
<td>3.43</td>
<td>0.80</td>
</tr>
<tr>
<td>Professional development in health promotion</td>
<td>4.20</td>
<td>3.47</td>
<td>0.73</td>
</tr>
<tr>
<td>The extent to which health promotion is written into your job description</td>
<td>3.87</td>
<td>3.21</td>
<td>0.66</td>
</tr>
</tbody>
</table>

The level of importance placed by respondents on each of the domains was relatively high. Those deemed to be most important were IT infrastructure, management support for IT and having time for health promotion. Lowest scores were for the extent to which health promotion was written into job descriptions, mentoring of new and inexperienced staff, and having access to internal funds for health promotion.

Organizations’ perceived actual performance did not match the level of importance felt by respondents in any area of organisational capacity. Having said that, the highest ranked aspects of organisational performance was for IT infrastructure, provision of professional development, and incorporating health promotion into their strategic plans. Lowest ranked performances were for mentoring of new or inexperienced staff, access to internal funding for health promotion and receiving feedback on performance.

It has already been noted that importance always rated higher than organisations’ actual performance, and Table 4.10 is ranked in relation to this difference. The difference is a potential of the level of participant dissatisfaction over aspects of health promotion infrastructure and capacity within their organisations.
The greatest differences between importance and performance were for receiving feedback on their health promotion performance, having access to internal funding for health promotion, mentoring for new and inexperienced staff, having time for health promotion and feeling that they had management support for their health promotion work. There was least dissatisfaction with the level to which health promotion was written into their role descriptions, and the incorporation of health promotion within the organisations’ strategic plans.

In the context of providing supportive environment for the enhancement of health promotion professional practice, 40% of participants reported having joined or developed a network after completing the course.

### 4.2.4 Uptake of further study

It is significant that 17% of respondents (n=26) reported that they had enrolled in related courses or training programs as a result of their participation in the Short Course. These included formal post-graduate study, other short courses, half-day workshops, a VicHealth conference, and a women’s health course. Some respondents said their organisations were currently seeking out training programs for delivery within their organisations.

In relation to formal postgraduate study, the most popular responses were for off-campus study with both face-to-face and on-line learning (n=61), on-campus study in multiple blocks (n=42) and off-campus study with on-line support (n=30). Least popular was on-campus study arranged as a single block (n=11).

### 4.2.5 Responses to open-ended survey questions

The survey gave respondents opportunities to provide more information on a number of questions. Seventy per cent of respondents took the opportunity to write comments. This data was transcribed and analysed thematically. Themes that emerged indicated enthusiasm about the course; the value placed on the course by participants; their desire for on-going health promotion training opportunities while recognising the need for organisational change to facilitate increased health promotion action; and the variable quality of training experiences across DHS Regions.

The value of the course as a workforce development strategy:

- Frequent comments were made about the value of networking that arose from the course, the opportunity to acquire the concepts and language used in health promotion, the sharing of experience; skills in planning; and the longer term vision of health promotion as a health development strategy for public health outcomes.

- Confidence levels were increased and this enabled respondent’s involvement in networks and projects outside their own organisation. Networks were being accessed for professional support and as a strategy for health promotion activities. In some cases, it seemed new health promotion networks had been formed as a result of course participants meeting each other during the course.
The value of the training materials as a resource:

- Respondents appreciated the quality of the course materials provided to them, and talked about their value as a resource once respondents had returned to the workplace, particularly the planning models, websites and other resources to which they had frequently returned, to sustain their health promotion work
- Many respondents had used the materials such as the Ottawa Charter, to resource other people in the organisation

The need for ongoing training opportunities for participants to acquire more depth and breadth particularly in skill development for:

- Program evaluation
- Needs assessment
- Research skills
- Program planning
- Best practice
- General refreshers for up to date information about health promotion developments
- Comments were made about the need for other people in the organisation to undertake the course to embed the language and processes of health promotion into the organisation and for the course to be available for new staff
- The need for management to have opportunities to acquire more understanding of health promotion concepts and planning processes

Enthusiastic comments about the quality of the course were tempered by comments about the occasional poor quality of delivery in a couple of Regions, indicating the variability in training quality. This is useful in identifying the factors that contribute to less than optimal training experiences. The final chapter of this report summarises the factors that create optimal training experiences in the context of recommendations about the future of the Core Health Promotion Short Course. Major themes from the survey will also be revisited in the final chapter.

4.3 Summary

The survey response rate of 29% was lower than anticipated but given that the Evaluation project was commissioned in mid 2003, for some people, one or two years had elapsed since they completed the Short Course. Time lapses of this nature tend to decrease the interest of people in completing surveys. The skewing of response rates from particular Regions is related to the lists of Course registrants that were kept by training providers. In a couple of Regions, those lists were only partial and in many cases across several Regions, incomplete contact details were kept of participants. These factors reduced the likely success rate of the survey and kept the response rate down.
Community health services had the highest participation rate at 44%, with 11% coming from local government and 7% from within the DHS. The remaining participants came from a range of other sectors and this spread of participants was felt by both participants and training providers, to be of immense value. Participants developed an appreciation of the capacity of organisations other than their own, to health promotion and the importance of the involvement of a range of organisations for integrated health promotion. Although 8.4% of participants said that management had required their attendance at the Short Course, they did not complain about that requirement! Most participants volunteered themselves to attend the Short Course and management supported most of them. There was an occasional participant who took annual leave in order to complete the Short Course.

Participants perceived a considerable change in their knowledge and skills as a result of undertaking the Short Course and more than 60% of participants indicated that the Short Course changed the way they think about their work. This is an important result for the reorientation of organisational cultures towards health promotion. Further, slightly less than 60% reported that the Short Course changed the way they actually do their work.

Significantly, the Short Course increased the confidence and enthusiasm of participants, in health promotion work. Over 90% of participants indicated that their confidence had markedly increased. Nonetheless, participants were clear in their identification of their professional development needs in relation to health promotion, which also demonstrates their appreciation of the complex range of skills and knowledge that are required for competent health promotion work.

One of the major findings of the survey is the degree of fit between the level of health promotion they would like to see, and the level of organisational capacity for health promotion. Participants commented on the quality of the training in particular Regions and indicated their appreciation of the quality of course materials provided to them.
5.0 Interviews and focus groups

This chapter reports on the analysis of 56 in-depth and focus group interviews, which were conducted by the research team in accordance with the methodology described earlier in this document. These interviews were conducted with a diverse range of respondents including RHPOs, CEOs/managers, participants, and the short course providers. The interview schedules for each of these groups are provided in Appendix 3. It should be noted that interviewers did on occasion deviate from these specific themes, in order to follow an emerging or important issue raised by a respondent, in keeping with recognised qualitative approaches to data collection.

Data was analysed through coding processes, using the qualitative software program, N-Vivo (QSR 2003). The data was analysed into key themes. In this chapter, the data is discussed and where appropriate, a summary of key points raised by respondents is provided in table format, though tables are intended to be indicative of a the range of comments uncovered in the data, rather than a comprehensive audit of responses. In addition, quotes that encapsulate the essence of respondents’ observations or opinion have also been included.

5.1 Perceptions of the Short Course

'The short course was a wonderful thing to happen… it was timely. The experience has been very positive. It’s also been a catalyst and there is now some shared understanding that wasn’t there before.'

Respondents were asked to comment on their impressions of responses to the course, whether from a personal level as a participant, or at a broader organisational or regional level, if interviewing CEOs/managers or RHPOs. Remarks ranged from general perceptions to more specific issues around delivery of the Short Course, its administration and content.

A significant theme was that overwhelmingly, respondents felt very positive about the Short Course. Further, participants felt that they had increased their knowledge, understanding and skills around health promotion and had gained more confidence to tackle health promotion projects with a new level of sophistication. Several noted that the course had legitimised their work and given them a sense of purpose and a framework to more forward. Others observed that learning the language of health promotion helped overcome barriers, particularly with respect to accessing networks and developing meaningful partnerships.

Criticisms for the most part centred around poor communication between administrators of the courses and organisations/participants, with short lead times being universally cited as a difficulty for potential participants and their agencies. While the majority of respondents applauded the presentation skills and breadth of knowledge of their course facilitators, respondents in a couple of Regions were clearly less effusive. A summary of the main issues raised in response to this question is presented in Table 5.1.
Table 5.1 Perceptions of the Short Course

**General perceptions**

- The response has been overwhelmingly fantastic. There is a feeling that it's one of the better initiatives of the DHS. In fact people are worried about sustainability... will it continue?
- The course provided an understanding of HP in the broader context rather than as just being the domain of the HP worker.
- The response in our organisation has been very positive.
- The feedback about the course has generally been very positive.
- We want everyone to do it - it's not an option.
- We like the fact that so many different disciplines have been included.
- I am confident that the short course has added value in terms of change management around HP.
- The course plonked me in a field and it marked the territory for me ... it signposted everything I needed to know and from there I was able to pick it up and do my own follow ups... go to useful resources, websites, texts and so on identified in the course.
- The course provided basic knowledge and understanding for all staff (managers and others), whether their job description includes HP or not.
- We all need to know this stuff.
- The course helped to open doors for staff, like using their material to get out other information.
- The course has legitimised what they do. It has added value to their work by working across the organisation.
- The course is good but the organisation has worked to make it real for staff.
- It's probably useful if you don't have much to do with HP or a background in it.
- It legitimises our work and the way we are spending our dollars.
- It affirms the benefits of HP.
- This course helps us in trying to build an evidence base and to promote that to our schools who don’t necessarily see that HP is a key function in their setting.
- Once the staff had a follow-up day I think it all came together for them... to apply the theory and learnings to their own contexts and issues was an important reflective exercise.
- We as an organisation are committed to the HP Short Course... we have sent about 12 out of 150 staff so far.
- Responses from the agencies in the region have been very positive.

**Influence on work practice**

- Increased internal collaboration around projects... this has influenced policy.
- We have developed policy around kits on asthma for example.
- They see the need to look at policy before skilling up.
- The course influenced the language people use... they are now on the same wavelength, though this might be about other things than just the short course.
Table 5.1 Perceptions of the Short Course

<table>
<thead>
<tr>
<th>Organisation/logistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I’m not sure whose fault this is but the organisation of the courses could be more streamlined. The dates need to be set further in advance and one day per week would be better for our staff.</td>
</tr>
<tr>
<td>• The timeline for the course was ridiculous. Our staff need time to organise their program and they can’t be expected to just abandon their day to day tasks without a decent lead time. This has been a limitation from our perspective.</td>
</tr>
<tr>
<td>• Two days per week is a problem for our staff… one day a week would be better though we understand the difficulties this might incur for the providers.</td>
</tr>
<tr>
<td>• Communication between us and the provider (a university) has not been good.</td>
</tr>
<tr>
<td>• The five-day block was not well received. This is not really an appropriate delivery model for this course.</td>
</tr>
<tr>
<td>• Some participants were annoyed that they didn’t receive the certificates at the end of the course. This shouldn’t be difficult to organise.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Content and delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• It is useful for course participants to be able to identify target groups and how to work with them… the course takes them from the broad into the narrow and focuses on the doable.</td>
</tr>
<tr>
<td>• I think there should be a greater focus on the social model of health, and issues around access and equity in the first two days of the course. This did not happen with our facilitator.</td>
</tr>
<tr>
<td>• There needs to more time for feedback and to wrap up key learnings, particularly after completing activities. We were often too rushed to do this.</td>
</tr>
<tr>
<td>• The social marketing component of the course is really good. Everyone in our team has really embraced theories of social marketing through the course.</td>
</tr>
<tr>
<td>• The facilitator has not really made an effort to include the needs of all the participants in the course… this is disappointing.</td>
</tr>
<tr>
<td>• Our facilitator limits discussion to community health exemplars and this is not particularly inclusive of his audience.</td>
</tr>
<tr>
<td>• The main criticism in our region (rural) was that the quality of the presenters was not what it should have been in terms of their knowledge and their capacity for application of theory of health promotion into the field. Their lack of ability to value-add to the materials was disappointing.</td>
</tr>
<tr>
<td>• The presenters in our region were not good. They read from the notes and were clearly not prepared! They didn’t have the knowledge to draw the links back from the theory to people’s work practice.</td>
</tr>
<tr>
<td>• While some don’t like the two days in a row delivery model, I think participants are more inclined to really get involved in the learnings.</td>
</tr>
</tbody>
</table>

Trainers commented on the value of the inclusion of case studies from the field, and where this was done, it was achieved through various models:

• Some trainers invited practitioners known to them to assist with course delivery but there were advantages and disadvantages of this model. Where the practitioner was also a skilled facilitator, the Short Course delivery was enhanced but when this was not the case, the model was not regarded favourably either by the training provider or the participants;

• Another training model invited practitioners to make a 15 minute presentation about a health promotion project in which they were involved – again, this model requires careful preparation to ensure that the material presented is relevant and presented in an engaging manner;
A third option is for facilitators to draw on the experience from among the participants. This model requires a skilled facilitator who is able to engage participants to the point where they feel confident talking about the work in which they have been involved and feeling comfortable in having their project(s) used by a small group as an exemplar for learning, where critical thinking about the project is encouraged. Trainers who use this approach have found that participants have welcomed this approach as it actually helps them to problem solve and develop their projects and it enhances the relevance of the course.

5.2 Participant expectations of the Short Course

'I had no expectations but found the course to be fantastic! I developed skills and a level of understanding that took my approach to HP work to a whole new level... I now have the confidence and impetus to make changes to what we have traditionally done'.

Participants generally reported that their expectations of the Short Course were either met or exceeded, though several respondents observed that they had ‘no real expectations prior to attending the course’. This was most common among participants who had been directed to attend by managers, while those who had initiated involvement in the course themselves, were invariably very satisfied with the 5-day program.

Of interest to the researchers were the meanings that respondents attributed to expectations of the Short Course. When asked to elucidate on this issue, responses ranged from predictably wanting to increase knowledge, understanding and skills around HP, to seeking access to local networks and potential partners. Some were keen, as one respondent put it, for a ‘kick start to implementing HP in (their) work practice’, while others were hoping to gain useful resources. Only a couple of participants reported that they had not really gained much from the Short Course. In both instances, these respondents added that their skills and experience for the most part were already beyond the level of the Short Course. They did however concede that the opportunity to update their knowledge and to engage with others from their Region was somewhat useful.

A summary of comments about participants’ expectations is presented in table 5.2.
Table 5.2 Participant expectations of the Short Course

<table>
<thead>
<tr>
<th>Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of my main objectives was to develop networks, as I was new to the position. This happened.</td>
</tr>
<tr>
<td>I took away an excellent resource folder, which is very useful.</td>
</tr>
<tr>
<td>Yes my expectations were met… in fact they were exceeded… it was an excellent course.</td>
</tr>
<tr>
<td>I had no real expectations prior to attending the course but was delighted with it. It broadened my knowledge, understanding and skills… it also increased my awareness of what was happening in my region and I have build on the networks developed during the course.</td>
</tr>
<tr>
<td>The course was fantastic in introducing me to health promotion…I had very limited knowledge prior to attending the course.</td>
</tr>
<tr>
<td>It gave me food for thought.</td>
</tr>
<tr>
<td>The sequence of the course made sense and brought us along at a manageable rate… the presenter was very skilled in this regard.</td>
</tr>
<tr>
<td>I didn’t get a lot out of it… except for the day on evaluation… that was useful.</td>
</tr>
<tr>
<td>I was forced to attend and I didn’t want to… I couldn’t see the relevance… afterwards I thought it was fantastic… I learnt so much!</td>
</tr>
<tr>
<td>It gave me more information.</td>
</tr>
<tr>
<td>It gave me the opportunity to get my head around the social determinants of health and the social model of health.</td>
</tr>
</tbody>
</table>

5.3 **Barriers to attendance**

‘There are three main types of barriers to attending: **self-perceived barriers** such as not seeing the relevance; **organisational barriers** such as resistance to releasing staff to attend; and **structural barriers** such as a lack of funding for rural people to travel, to pay for accommodation and backfill’.

When asked to comment on barriers to attending the Short Course, issues around impact on staff workload and backfill were recurring themes, particularly for those from rural and remote settings, as well as those from smaller agencies.

Self-perceived barriers were discussed by managers in terms of resistance. A comment from one manager was echoed by several others, that ‘some staff are reluctant to extend their waiting lists while they attend professional development. This is not just about the short course’. Other managers were of the view that there was a degree of resistance among staff who could not see the relevance of the Short Course to their work, or were resentful that the Short Course was likely to lead to demands on them to change existing work practices. Organisational barriers were related to the costs of backfill or the lack of available relieving staff to provide backfill. Responses to issues around backfill with either that clinicians from smaller agencies were commonly unable to backfill due to lack of funding, or because of a lack of availability of suitably qualified staff. In contrast, those working in non-clinical roles or in larger organisations were less concerned about this issue.

The delivery model appeared to impact on the capacity of some potential participants to attend the course, with part-time workers and those in rural and remote settings most disadvantaged by block or two day per week models. Others however acknowledged that, while two days away from the office resulted in a backlog of
tasks to attend to upon return, nevertheless, they felt that this concentration of time enhanced their engagement in the learning process.

‘I know some organisations struggled to release staff for 5 days but it was important to be away from work and really reflect on what it is we currently do and how we do it… we needed to time away to realise that changes could be made for the better… to work smarter and better’.

Some respondents suggested that one day per week would be better for their agencies, while others would prefer 2-day block delivery. Unanimous agreement however centred around the need to plan and advertise the course dates well in advance in order to allow agencies and individuals to better organise their attendance at the course and cover their absence from the workplace. Several respondents were disappointed with the long waiting lists to attend a Short Course, which reflects the demand for the Course.

5.4 Who benefited most and whose needs weren’t met?

When asked to comment on who had benefited most from the short course, participants were quick to reply that they had indeed benefited significantly from the 5-day program. Several managers, CEOs, and RHPOs were less certain, with some admitting that they were not at all sure who had benefited most from this workforce development initiative. This seeming lack of awareness at managerial level was surprising, and could be indicative of the communication issues between managers and workers that were raised by several respondents. Other respondents nominated specific sectors as benefiting most from the Short Course, such as local government, community health and various non-health sectors such as education, welfare, migrant services, housing and aged care.

The majority of respondents were unable to shed light on whose needs were not met, though some respondents nominated managers, Indigenous workers, those in rural and remote settings, and part-time workers, as ‘groups who had not been reached or included in this initiative’. Respondents felt that the needs of those who actually attended the course were for the most part met during the program but many people who could have benefited were not captured by the roll out of the Short Course. This finding has implications for targeting future courses. A summary of comments about whose needs were met or not met is presented in table 5.3.
Table 5.3 Who benefited most and whose needs were not met by the Short Course?

<table>
<thead>
<tr>
<th>Who benefited most?</th>
<th>Whose needs weren’t met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participants and hopefully there is a flow on effect to their organisations and communities.</td>
<td>• Indigenous people.</td>
</tr>
<tr>
<td>• Neighbourhood house staff benefited.</td>
<td>• Managerial level.</td>
</tr>
<tr>
<td>• Local government staff, particularly those with a planning or policy role.</td>
<td>• Those working with CALD groups or marginalised groups.</td>
</tr>
<tr>
<td>• Non-health sectors joining in a course with predominantly health sector workers was terrific. This is where the real gains in health are likely to occur in the future.</td>
<td>• Rural, remote and part-time workers were not necessarily well catered for.</td>
</tr>
<tr>
<td>• Very few allied health workers do health promotion in their course…they benefited from the short course.</td>
<td>• Smaller agencies were discriminated against to some extent.</td>
</tr>
<tr>
<td>• The course was pitched at such a level that all participants benefited…our facilitator was very skilled at reaching and including everyone.</td>
<td>• I think anyone who attended a course in our region had their needs met by the course and the facilitator.</td>
</tr>
<tr>
<td>• The DHS should not underestimate the extent to which they have increased capacity for health promotion as a consequence of this workforce development initiative. The impact has been very significant.</td>
<td></td>
</tr>
<tr>
<td>• The welfare sector benefited.</td>
<td></td>
</tr>
<tr>
<td>• I benefited because there was no cost…this was a deciding factor in my boss allowing me to attend the course.</td>
<td></td>
</tr>
<tr>
<td>• Community health, local government and the PCPs benefited.</td>
<td></td>
</tr>
</tbody>
</table>
5.5 Outcomes from attendance at the Short Course

“We now see HP as everybody’s business… this is a big cultural shift for us.

The interview question about what outcomes resulted from participant attendance at the Short Course produced a diverse range of responses. Regardless of whether they were participants, managers, CEOs or RHPOs, several respondents became quite animated as they enthused about the changes they had made to their work practice, or about the networks they had accessed during and since the program. Analysis of the data revealed six main themes: shifting perceptions and changing work practices; building capacity; effecting organisational change; networking, partnering and collaboration; accessing the language of HP; and future opportunities that have emerged as a consequence of the Course. Each of these themes is signposted and discussed in detail in this section.

5.5.1 Shifts and change in work practices

“We are now seeing a shift in the culture of community health to a more HP framework. This might have happened anyway but the course has provided the impetus for it to happen more quickly and with a shared vision and purpose’.

Several respondents commented on the shifts at individual and organisational levels, around the meaning of health promotion, its breadth, and capacity to influence the ways that we work. That there is the development of a shared understanding of health promotion, was a recurring theme. A number of participants noted that their knowledge and understanding of health promotion prior to the course was either limited or incorrect, and that the Short Course had enabled them to develop a working knowledge of health promotion and its applications to their work. Furthermore, the Short Course had been inspirational, as one respondent put it, to ‘adopt more health promoting approaches in their planning processes and engendered a passion and commitment to health promotion’.

“We thought we were doing HP but really we were just doing health information and health education…now we are really doing HP’

‘Personally I now have a better understanding of HP and of HP planning, of identifying community needs, of addressing priority areas in the BoD, of implementing and evaluating more effectively. Rather than just doing haphazard HP weeks and screenings, we now know what is effective, what works, what doesn’t and why’.

The biggest shifts in work practice appear to have occurred around a better understanding of the determinants of health, conducting needs assessments, program planning, and evaluation, as well as delivery of better health education programs, influence on policy, advocacy, networking and partnering. One respondent commented that she realised after the course that her organisation ‘…had been doing HP, but that (they) were now doing it much better, and were able to articulate (their) endeavours in the language of HP.

However, a couple of respondents cautioned that participants could walk away from the Short Course ‘believing that they were now experts in health promotion, but
beneath the surface, the knowledge and understanding is superficial’. The majority of participants believed that they still had much to learn and were eager for further training. A summary of the comments around shifting perceptions and changing work practice is presented in table 5.4.

**Table 5.4 Shifts and changes in work practices**

### Shifting perceptions around the meaning of health promotion
- Staff are now more aware of what health promotion is… before this course, they thought health education and HP were interchangeable terms.
- Our staff are seeking opportunities to publish reports about what they do… they now recognise that they are doing good work and are motivated to get the message out there to the field… this is terrific!
- I handed out the Ottawa Charter at a team meeting!
- Health promotion is building it’s own sense of self that can be exclusive. I think it would be better to think about health promotion in the context of its parts. There is some confusion around health promotion – it’s not a silo.
- I now grasp issues around where we could change service delivery…move it more upstream.
- It has raised the profile and awareness of health promotion in the sector.
- People often think health promotion is about marketing/promotion. There is now more of a shared definition and understanding of health promotion out there.

### Changing work practice
- We now as an organisation think about the determinants… the iceberg. This is a big shift and it has improved the way we work.
- I use the manual to teach others at work about health promotion… there has been a ripple effect.
- I use the manual and learnings from the course to help me target my programs and develop plans more effectively.
- I have a more professional approach to needs assessment and program planning since the course. I had no idea how haphazard my previous approach had been. I would now like to develop more confidence around evaluation.
- I now have changed careers …am in a more health promoting role and this is a consequence of the Short Course… it opened my eyes to possibilities.
- The language gained during the Short Course gave me an advantage at interview when applying for a new position.
- It has led to greater advocacy for health promotion and it has contributed to lifting the status of health promotion.
- I used to work one-to-one…suddenly I’m running groups with a focus on health promotion!
- We are a bit more sophisticated now. Health promotion used to be based on the health calendar. We have come a long way since then. People now know their budgets and are doing plans.
5.5.2 Building capacity

‘The Short Course is developing a more confident workforce’.

Issues around capacity building tended to produce a dichotomy of responses, focusing on either the capacity of the individual or, alternatively, on the capacity of the organisation. Individuals generally applauded the course in building their knowledge, understanding and skills, and in so doing, improved their capacity to ‘do health promotion’.

‘I now have a deeper understanding of a range of health promotion issues such as needs assessment, program planning and evaluation. When it came time to do my planning, I found the work planning template inadequate and went back to the one we had used in the Short Course. It was far more comprehensive’.

Others noted that learning the language of health promotion was in itself capacity building, in that it provided them with the confidence to access networks, and a knowledge and evidence base that was previously beyond their reach.

From an organisational perspective, capacity building is occurring, though the extent to which this is happening is currently mediated by a range of factors, including systemic and structural barriers, managerial support, and funding. A summary of issues around building capacity is presented in table 5.5.

<table>
<thead>
<tr>
<th>Table 5.5 Outcomes: building capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We have now set up a working group which comprises people who have completed the HP short course. This group works on the Health Promotion Plan, discusses projects, identifies potential collaborations and so on.</td>
</tr>
<tr>
<td>• We applied for and got funding using the skills developed during the short course. This has really helped build my confidence. I wouldn’t have known how to go about this previously.</td>
</tr>
<tr>
<td>• The organisation is now building in infrastructure for health promotion… this is a big shift in culture.</td>
</tr>
<tr>
<td>• We have capacity building in our Health Promotion Plan and we will be doing more.</td>
</tr>
<tr>
<td>• There are significant community building programs going on that all staff are involved in.</td>
</tr>
<tr>
<td>• I have trained staff in my organisation around some of the key issues covered in the course… I am very committed to it.</td>
</tr>
<tr>
<td>• It's part of the general conversation…gains in terms of terminology, language, social determinants of health and participatory health promotion effort.</td>
</tr>
<tr>
<td>• I have been better able to advocate for it (health promotion and the social model of health).</td>
</tr>
<tr>
<td>• The Short Course has influenced policy change and the infrastructure for health promotion is increasing.</td>
</tr>
</tbody>
</table>
5.5.3 Effecting organisational change

‘Health promotion planning is no longer just the responsibility of the health promotion workers… we now embrace the social model of health across the organisation’.

Several respondents were able to cite examples of organisational change that had occurred as a consequence of the Short Course, with a number reporting new appointments that they had made to strengthen the implementation of health promotion strategic planning and practice. Others spoke of the development of a shared understanding of health promotion across the organisation and of the role that each worker could play in moving the health promotion agenda forward. This was described as a significant shift from previous perceptions that health promotion was the exclusive domain of the health promotion worker. Several respondents provided concrete cases of changes that had occurred and were clearly proud of this outcome.

‘We have released one of our allied health staff one day a week to do more health promotion, saying if we’re going to make a difference we have to intervene earlier. It was a risk because the DHS still want targets for individual contacts. The HACC bucket hasn’t changed in response to health promotion agenda’!

A recurring theme around organisational change involved the barriers to implementing such change back in the workplace, once course participants had completed the 5-day program. The barriers were most commonly described as systemic, structural or funding based.

‘I could tell you about one participant who went back into her organisation after the course wanting to effect change. She felt like her wheels were spinning…the systems simply weren’t in place to support the change despite expectations put on her’.

When asked to speculate on solutions to these inhibitors to change, managerial level respondents argues that the changes need to occur from top down, while course participants were more inclined to argue for the need to develop skills in ‘managing up’!

‘We believe that for change to occur in organisations, it needs a more top-down approach, working with management and systems first before staff do the Short Course. Otherwise staff feel like victims and tend to say they can’t change their organisation’.

A summary of comments made around effecting organisational change is presented in Table 5.6.
### Table 5.6 Outcomes: effecting organisational change

- Since the Short Course, we are now more aware of making our organisation a health promoting setting.
- Staff attending the Short Course has definitely influenced the development of our Health Promotion Plan.
- We are setting up a mentoring system to support growth of health promotion in our organisation.
- We have now appointed a Health Planner.
- It is not just organisations that need to change. This course has made us more aware of the inadequacies of the current funding arrangements, particularly where funds are tied to specific targets that are not about health promotion.
- Our organisation (a neighbourhood house) no longer focuses on health education.
- We have new adjunct roles in our hospital… the hospital now has more people doing health promotion.
- We have set up inter-disciplinary health promotion teams and they are working very well.
- Silo approaches make it hard to effect the changes we now know we need to make at the organisational level.

### 5.5.4 Networking, partnering and collaboration

“There has been an appreciable increase in networking and partnering within and across organisations since the short course… When people are together for a period of 5 days things happen”.

Respondents were asked to comment on their perceptions about outcomes from the Short Course, and the significant themes that emerged were about networking, partnering and collaboration emerged. For some, the opportunity to meet and develop a working relationship during the course with others from their Region was important, and some were able to report that these informal networks had progressed to more formal partnerships, alliances and collaborative endeavours with contractual obligations.

A greater awareness of PCPs and the role that the RHPO could play in assisting individuals and agencies in adopting health promotion approaches was raised as an unexpected bonus from attending the Short Course. Another advantage of attending the Short Course was the link made with the providers, particularly where they were university based, because they were seen as able to provide additional support to participants though further training or consultation.

Several respondents lamented the difficulties in capitalising on the networks built during the Short Course. Most commonly respondents cited travel and time issues for those in rural settings, lack of support from managers, the pressures associated with daily workloads, particularly for those in a clinical role with appointments to service and targets to meet. A summary of the main points raised about networking, partnering and collaboration are presented in Table 5.7.
The Short Course clearly provided participants with a grounding in the ‘language of health promotion’, and in so doing, served to increase participants’ confidence, access to networks, capacity to contribute to planning processes, as well as increased their awareness of opportunities to access funding. One informant described how the course had ‘...provided a framework for consistent discourse and common understanding of health promotion...people can have a conversation where they understand each other...previously people saying common things but meaning quite different things’. Many respondents, particularly those with roles involving inter-agency interactions, welcomed this access to the language of health promotion and the benefits it brought. They felt, as one respondent put it, that the Short Course provided them with ‘...a currency... a vehicle for articulating meaning at a level that generated greater influence.’ Some clearly felt better equipped to contribute to strategic planning, and to better articulate the need to justify changes to work practice to their bosses.

‘Now that I have the language I can justify programs and the reasons for doing things certain ways. I can back this up with an evidence base that I previously was unaware of. Being able to talk the talk has made an enormous difference’.

5.5.5 Health promotion: a common language

‘The whole organisation is now speaking the same language’.

Table 5.7 Outcomes: networking, partnering and collaboration

<table>
<thead>
<tr>
<th>Outcomes: networking, partnering and collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The time allocated to networking during the course was very valuable. Sometimes this was informal such as during breaks, but the opportunity to work with different people during the course was also important.</td>
</tr>
<tr>
<td>• There has been greater involvement in PCP activities…our staff are now more inclined to collaborate. They are active in a range of forums.</td>
</tr>
<tr>
<td>• I have undertaken projects in partnership with people I met in the course.</td>
</tr>
<tr>
<td>• I have expanded my networks as a result of the short course.</td>
</tr>
<tr>
<td>• I am now part of a group that works on social health planning.</td>
</tr>
<tr>
<td>• We are now linked into our RHPO and she has been terrific in helping us in a range of ways.</td>
</tr>
<tr>
<td>• Previously we had information sharing across sectors… now we have partnerships.</td>
</tr>
<tr>
<td>• We have implemented programs from the groups formed during the five days of the course… we really bonded and that has flowed into program planning and implementation across agencies.</td>
</tr>
<tr>
<td>• We need to move beyond networking for support ... there needs to be a specific purpose, and as the workforce becomes more skilled around HP this will happen.</td>
</tr>
<tr>
<td>• Time is needed to network but the organisation doesn’t necessarily understand the importance of this in doing HP.</td>
</tr>
<tr>
<td>• It is harder in rural and remote areas to capitalise on the networking opportunities from the course…the travel aspect is limiting.</td>
</tr>
<tr>
<td>• Networking and partnership outcomes are seen to be nebulous in our sector (divisions of general practice) though it is highly desirable in others.</td>
</tr>
</tbody>
</table>
However, the gap between espoused theory and theory into practice was raised as a concern by some CEOs/managers and RHPOs. One RHPO commented that ‘...some participants have come away from the course with the jargon, but when you scratch the surface they have a limited understanding of the practical implications.’ Others were in fact critical of the degree to which the course included ‘jargon’, and felt that this only perpetuated the ‘limiting and excluding nature of the language around health promotion’ for the majority of the workforce. Others applauded the facilitators for introducing the language in ‘...manageable doses’, and recognized that progress from speaking the language to implementing principles in practice was probably on a continuum, and that this course had significantly moved most people along that continuum.

5.5.6 Outcomes: future opportunities

'We now have to make sure we embed health promotion across our organisation and that our work is evidence-based'.

While several participants enthused about the potential to implement new programs and to work with new partners both within their own organisations and across organisations, there was a recurring theme around the barriers inhibiting future innovations that pervaded the discourses of many respondents. Given that these respondents had undertaken the course in 2001, some lamented the slow pace of change within their agencies. Others were more philosophical in recognising that ‘...workforce development and policy reform takes time, particularly when we are asking people to change the way they have been trained and expected to work over a number of years.’

To move forward, issues around leadership, the need for local exemplars that demonstrate successful applications of the theory into practice, and opportunities to work with providers and consultants were all seen as mediating factors. Several respondents remained optimistic that changes could occur, but those working in rural or remote settings were more inclined to feel the changes would take longer to filter though to their Regions. A summary of comments about future opportunities resulting from the short course are presented in Table 5.8.
Table 5.8 Outcomes: future opportunities

- We need to do more around evaluation… this is our weakness and since the course we are more aware of this and want to address it.
- My observation is that the changes have been mostly at the practitioner level and there is still work to be done at managerial level with respect to building knowledge and understanding about health promotion.
- The risk is that some participants think that because they have attended a short course that they are expects in health promotion. We need to keep building the knowledge and skills and not let it stand still.
- They (managers) are driven by program outcomes. The DHS needs to change this… they need to build in health promotion outcomes. Despite the rhetoric organisations are ultimately driven by throughput.
- I had hoped champions would emerge in our region but this is not the case yet.
- I would like to see some real, local examples using the social model of health or a settings-based approach for disadvantaged people. I have been working on a project around rooming houses and I am hoping to promote this project.
- There also needs to be more understanding around wellbeing and more promotion of the evidence-base of the social model of health. We need more hard evidence to illustrate the benefits of health promotion.
- We need to effect political change … we need those in power to understand the social model of health and its implications.
- We need the leadership program to get off the ground and work side by side with the Short Course.
- In rural settings there can be difficulties getting a cohesive approach to health promotion collaboration… history, politics and personalities can get in the way. We have opportunities from the Course to change this.
- I have so many new ideas… now I need the time to make some of them happen!
- In some ways rural people are used to sharing resources. This course provided the networks to facilitate this process.
- There needs to be a connection between theory and practice. I work on projects that are auspiced by other agencies and so I couldn't effect change. Having a shared understanding is both an opportunity and a barrier.
- I would like a course provider to work with our team around developing our HP guidelines and to contextualise our planning template.
- The opportunities to link in more closely to the PCP are now emerging for us… before the short course we weren’t really aware of the PCP or its function.

5.6 Post Short Course: enablers and barriers

'I am now exploring options for further study. I would never have entertained the thought of this prior to the short course'.

When asked to cite specific examples of their experiences and observations back in the workplace immediately following the short course, participants mostly described the impact of the Short Course in terms of it being ‘…empowering and validating’ and its impact on ‘my enthusiasm to effect change’. Others were inspired to investigate options for further training and post-graduate study. When asked to comment further on what they perceived would be the enablers to acting on this newfound energy for health promotion, a range of responses emerged, mostly around access to further training, and support from colleagues, managers, and experts in the field such as the providers.
Barriers to implementation of learnings from the Short Course back in the workplace were described variously, but centred around lack of understanding about health promotion by managers and colleagues, lack of managerial support, insufficient time to make the changes, as well as resistance within organisations to change long standing practices.

‘We still have a long way to go to change perceptions. Here the doctor is still God and nurses are the angels…and the community health workers don't really do much’.

‘I came away every afternoon thinking that this is what I want to do for the rest of my life. But back at work people just don’t get it, it’s a different language. HP is a term used indiscriminately. We don’t have good examples of what works. We still do supermarket displays and people put lots of effort into them for not much reward or even attention’.

A summary of the findings with respect to experiences, observations, enablers and barriers to implementing change following the course is presented in Table 5.9.

<table>
<thead>
<tr>
<th>Table 5.9 Post Short Course: enablers and barriers to effecting change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experiences and observations</strong></td>
</tr>
<tr>
<td>• I came out of the course having learnt a lot and wanting to know more!</td>
</tr>
<tr>
<td>• We are now thinking about evaluation right from the start… how will we know we have been successful? How will we measure this and report on it?</td>
</tr>
<tr>
<td>• I am now more aware of my place in the big picture and how my role contributes to it.</td>
</tr>
<tr>
<td>• I realise that I need to evaluate my programs but I’m not really sure how to do that with some of them. I now want more training in evaluation.</td>
</tr>
<tr>
<td>• We are now more aware of the need for a change management process.</td>
</tr>
<tr>
<td>• We now feel confident to tap into the local university (our provider) for support and professional advice. This is a real bonus.</td>
</tr>
<tr>
<td>• I want to hear about what others are others are doing since the short course. How have others applied the learnings?</td>
</tr>
<tr>
<td>• I am more aware of qualitative evaluation methods, which are more appropriate for certain programs rather than always using quantitative methods.</td>
</tr>
<tr>
<td><strong>Enablers</strong></td>
</tr>
<tr>
<td>• Access to follow up training in specific areas would be good. I now know what I don’t know… I need to know more about evaluation. These should be one-day courses rather than half days to make it really worthwhile.</td>
</tr>
<tr>
<td>• More workforce development around the determinants of health and evaluation is required. The course has given people a taste… now we need to build on this.</td>
</tr>
<tr>
<td>• It would be good to link those who have done the short course together… maybe through a newsletter about what has changed for them since doing the course… this could be very motivating and an excellent vehicle for publishing the benefits of attending the course.</td>
</tr>
<tr>
<td>• I am better equipped to talk to the committee of management about health promotion.</td>
</tr>
<tr>
<td>• I have access to great electronic links from the course.</td>
</tr>
</tbody>
</table>
Table 5.9 Post Short Course: enablers and barriers to effecting change

<table>
<thead>
<tr>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Time to implement the changes and key learnings will always be a barrier.</td>
</tr>
<tr>
<td>• You become inspired by the course, but then you slot back into the workplace and you are a voice in the wilderness.</td>
</tr>
<tr>
<td>• Our policies and procedures are written in old text… this is a barrier to effecting change.</td>
</tr>
<tr>
<td>• DHS funding structures limit the extent to which we can implement new ideas.</td>
</tr>
<tr>
<td>• Trying to do health promotion in the acute sector is very isolating.</td>
</tr>
<tr>
<td>• The whole system around targets needs to be renegotiated…particularly if they want us to do quality health promotion.</td>
</tr>
<tr>
<td>• Lack of interest from colleagues in the learnings from the Short Course once I went back into the workplace.</td>
</tr>
<tr>
<td>• We need to be able to keep networking… it would be good to have access to an email list of the people from my course… this was meant to happen but never did.</td>
</tr>
<tr>
<td>• Some people are protective of their territory and unwilling to look at embracing new ways…it will take time and a shift in culture but it will happen.</td>
</tr>
<tr>
<td>• The acute sector in our hospital don’t see the point of health promotion…they remain focussed at the treatment end of the spectrum.</td>
</tr>
<tr>
<td>• We lack the baseline data to build on… we need someone in our region with these skills but this is sometimes hard to get in the rural settings.</td>
</tr>
</tbody>
</table>

Many respondents made comments about the need for managers, CEOs and Boards of Management to have access to some form of capacity building in health promotion because they perceived the need to upskill them in knowledge and understanding. One course participant said:

‘There are CEOs who have fantastic management skills but absolutely no health promotion knowledge or skills. They don’t need to attend a 5 day short course around health promotion…they don’t need that detailed level of knowledge. That’s what they employ staff for. What they do need however is to have an understanding of what it means and how it impacts on their organisations… what the benefits are for them’.

Further responses are presented in table 5.10.
Table 5.10 Capacity building for CEOs, managers and Boards of Management

<table>
<thead>
<tr>
<th>Those in favour…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I think they (CEOs/managers) need to do this course before the management extension course. It should be a prerequisite and could be more targeted.</td>
</tr>
<tr>
<td>• A workshop manual for executives and boards is critical… we need a top-down approach.</td>
</tr>
<tr>
<td>• Until the managers get it the changes won’t happen.</td>
</tr>
<tr>
<td>• Managers should do a targeted version of the course.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I attended a course and I found there was not much about how to roll out health promotion within an organisation. I’m not sure this course is that relevant to CEOs and managers in its current format.</td>
</tr>
<tr>
<td>• Managers need to understand how to embed health promotion into their organisations and to be convinced of the benefits for them. This can be done through presentations at conferences such as the Australian Primary Care Conference; the VCHA (Victorian Community Health Association Conference); the VHA (Victorian Health Care Association) … it would be good to get it up as a keynote and to include case studies that show how it can be done better.</td>
</tr>
<tr>
<td>• They won’t attend a 5-day course but a communication strategy to engage them does need to be developed, as they are crucial to moving health promotion forward.</td>
</tr>
</tbody>
</table>

Respondents were asked to comment on key findings from analysis of the survey, which had been conducted prior to the commencement of interviews. In particular, the gap between perceived importance and actual performance around a range of issues such as internal funding of health promotion, management support for health promotion, feedback on health promotion performance, mentoring, IT infrastructure, the capacity to have input into developing health promotion activities, and access to professional development were raised at interview.

Some respondents were either unwilling to comment on some of these issues or felt inadequately informed to make definitive statements. Others however reported that they were not surprised by the survey results, and commented that these results in fact reflected their own experiences in the field. A recurring theme around an appreciable gap between the expectations of the DHS and the realities in the field emerged in several interviews. It would appear that much of this is fuelled by the central systems and structures, particularly around reporting and meeting targets, with several respondents observing that these systems are simply not consistent with a health promotion philosophy. A sample of comments about each of these issues from the survey is presented in table 5.11.
<table>
<thead>
<tr>
<th><strong>Table 5.11 Participant responses to findings from the survey</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal funding of HP</strong></td>
</tr>
<tr>
<td>• It's all about perceptions. How management portrays the allocation of funding for health promotion is critical…does it see the money as being for the health promotion worker or is it spread across the organisation?</td>
</tr>
<tr>
<td>• The HARP* money is leaning towards treatment models. If primary care agencies were more active then they could see more health promotion through HARP.</td>
</tr>
<tr>
<td>• We have no funding for health promotion but we try to build it in.</td>
</tr>
<tr>
<td>• This result surprises me… it doesn’t ring true.</td>
</tr>
<tr>
<td>• This issue is all about the level of commitment from management.</td>
</tr>
<tr>
<td>• I think there has been a lot of HP siphoned off to funding other programs. Upper management don't understand. They see it as a free bunch of money that can be utilised. They might say they do immunisation programs (treatment) but claim it on HP.</td>
</tr>
<tr>
<td>• Some CEOs have unreasonable expectations about what you can expect for your HP dollar.</td>
</tr>
<tr>
<td>Funding is an issue even for someone like me who is very interested in and supportive of HP. Each year we get productivity cuts. Where the funding is actually increased, it tends to be for very targeted non-HP projects such as employing a dentist. In contrast, we are always pulling back on the community health budget and to a large extent this is set from the department.</td>
</tr>
<tr>
<td><strong>Management support for HP</strong></td>
</tr>
<tr>
<td>• Managers who understand HP provide good support in different ways across the region.</td>
</tr>
<tr>
<td>• HP is our core business so support is strong.</td>
</tr>
<tr>
<td>• Managers need to support a team approach to HP. They are happier to compartmentalise roles.</td>
</tr>
</tbody>
</table>
Table 5.11 Participant responses to findings from the survey

**Feedback on HP performance**
- Feedback is a problem and this is not specific to health promotion.
- There is little time or opportunity for this.
- I am not in the health field and health promotion is technically not my core business but I can see the importance of it. It would be good to hear about case studies that demonstrate how health promotion can be done well in other sectors such as sport.
- The DHS could do more to market the success stories around HP. Sometimes its long term and the perception is that it isn’t working when in fact we just need to get the good news stories out there to the organisations and the staff in the field.
- The feedback has been good so far, we are a new unit and I think that we are therefore receiving more attention than might otherwise be the case.
- People feel that there is not an appreciation of what they do, it's not valued. I feel this too. That which is valued is one-on-one and reducing waiting lists. There are a lot of malnourished health promotion workers. They get a pat on the back for doing screening - that's where they get their nourishment.

**Mentoring of new or inexperienced staff**
- We put a lot of effort into orientation.
- We are encouraging the staff to buddy up and we are trying to provide support.
- We are encouraging the staff in regions to form their support networks… this is happening around specific projects and mentoring is a spin off from this arrangement.
- Mentoring can happen in the workplace if you have senior staff that really understand health promotion. They have the capacity to effect change and they take others along with them.
- This isn’t happening…the health promotion gurus in the organisation are too busy to mentor our team and the managers don’t necessarily know enough about health promotion to take on this role.
- I have a more proactive approach to mentoring since doing the course. I mentor the managers above me with respect to health promotion and they welcome this!
- Mentoring often scores low because people have waiting lists and they see it as a burden… this is a limited view of what mentoring can look like.
- Mentoring can’t happen without a health promotion specialist… boundaries won’t be pushed.

**IT infrastructure**
- This has always been a bugbear but it is improving significantly now.
- Some workers don’t have access to the Internet and this is very limiting, particularly for rural and remote workers.

**Input into health promotion activities and professional development in health promotion**
- This (input into health promotion) is low… we ask them to be involved but we don’t ask them to generate activities.
- We can’t get enough PD. There is also not enough that’s relevant. If there was more we would do more because you need to keep coming back.
- We now recognise our weaknesses. We need more health promotion professional development, particularly around evaluation.

* HARP: Hospital Admission Reduction Program
5.7 Sustainability of health promotion in the workplace

'I see three things as being important: (1) Ongoing opportunities for participants to get together and reinforce their skills; (2) Opportunities for others to do the course to build momentum; and (3) Courses for senior management'.

When asked to comment on issues around sustainability of the course and of the degree to which it could contribute in moving HP forward, the overwhelming response from respondents was that the Core Health Promotion Short Course must continue to be delivered.

The question of what the course might look like in future iterations was the subject of debate in focus groups, and drew a range of diverse suggestions from other respondents. (These issues are discussed in more detail in section 5.9 of this chapter). Who should fund further training was also contested, with many arguing that the DHS must continue to subsidise the program, while others agreed with the view of one respondent that said ‘…it was not unreasonable to expect agencies to pay for their staff to attend training’. Respondents from all categories raised issues around the provision of expert support from providers and universities as desirable: participants, managers, CEOs, RHPOs and the providers themselves.

'We need access to secondary consultation and assistive audits. It would be good if someone like the universities could review our plan, compare it against the DHS objectives, interview staff and give a full and frank assessment of the positives and negatives, strengths and weaknesses. They could tell us areas that need more work and areas where we could publish journal articles. The DHS might argue that they have this role but you don’t always want to air your dirty laundry with DHS. It would be good to annualise the process and continue to do so in a continuous quality improvement way'.

Issues around the development of better communication strategies to engage managers were discussed by a number of respondents. One respondent commented on the need to move the ‘…shared understanding from a basic level to a higher plain… this will only happen through further training, mentoring and support from above’. The ‘knowledge vacuum’ around health promotion at managerial and board level was seen as being a crucial factor in influencing and sustaining change, though solutions to this dilemma were not always forthcoming from respondents, when pressed for options. Others insisted that the only way to move forward was to demonstrate commitment by resourcing HP through further workforce development, upskilling managers and boards, setting up a formal mentoring program, and providing access to experts for consultation.

‘With all the goodwill in the world, the 5 day Short Course is not sustainable without resources. We can be creative about those resources, but in the end it isn’t sustainable’.

One respondent speculated on the impact of including the Short Course certificate in key selection criteria for new appointees. He argued that ‘…this would continue to move things forward and make the shifts around HP more sustainable.’ In addition, the need to develop better communication within organisations was considered essential in building sustainable health promotion practice.

‘I see one of the ongoing barriers as inadequate communication strategies. Management simply does not filter the information down to the workers. Since doing the Course I am more acutely aware of this information void and I find it very frustrating’.
Management understanding and support for health promotion action was a recurring theme in advancing health promotion with issues around the need to effecting change raised in several interviews. Participants often expressed frustration at what they perceived as the lack of understanding by managers about health promotion. One informant stated that:

‘My manager still thinks health promotion is about handing out pamphlets. This is very frustrating and limits what I can achieve despite the course’.

In some instances, CEOs and managers were also aware of the limited understanding and support for health promotion that existed among their peers. The need for both top down and bottom up change reverberated through these interviews.

‘I heard one manager say last week that health promotion is just that warm fuzzy stuff that you can’t prove makes a difference. This highlights the need for a top-down approach to up-skill managers about health promotion’.

5.8 Sustainability of the Short Course

‘When you think about the amount of resources that have been put into developing the Course, it would be such a waste to not keep using this Course in some form’.

When asked to comment on possible options with respect to delivering health promotion workforce development in the future, key themes emerged. These centred around delivery models, funding options for future courses, and the specific training requirements that should be included in planning professional development for the workforce. Overwhelmingly, respondents argued that the Short Course should continue in some form beyond the 2003 roll out. Optional models for delivery of the Short Course ranged from the repeating the current approach with the Course delivered by trained facilitators, to the RHPOs taking a more active role in training and facilitation. Some agencies articulated a desire to participate in a train-the-trainer approach, while other agencies expressed opposed such a delivery model, believing that the quality of facilitation would suffer, and that the agencies running the program would in some way gain an advantage over them, particularly when negotiating contracts and other arrangements with the DHS.

Most respondents considered that cost recovery with respect to funding the program was not realistic, but those from rural and remote settings, and smaller agencies were more inclined to think that the DHS should continue to provide subsidy at some level. A sample of the comments made about delivery models and funding options to sustain the Short Course is presented in Table 5.12.
Table 5.12 Sustainability of the Short Course

<table>
<thead>
<tr>
<th>Delivery models</th>
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<tbody>
<tr>
<td>• It would be good to continue to run it about once per year in each region.</td>
</tr>
<tr>
<td>• When new staff start work they should have to do a basic course in health promotion.</td>
</tr>
<tr>
<td>• There is no question the course needs to continue…the question is in what format? Maybe a 3-day version would be funded by agencies. This would be more manageable in terms of cost and time release.</td>
</tr>
<tr>
<td>• I think RHPOs could run the course in the future though not everyone will agree with this.</td>
</tr>
<tr>
<td>• Perhaps we could move to self-paced web-based learning though there are obvious advantages to people attending in person such as networking. Setting up web-based learning would also be quite expensive.</td>
</tr>
<tr>
<td>• Offer it in the organisational context where it is targeted to the organisation’s needs. This could be delivered by the RHPOs.</td>
</tr>
<tr>
<td>• I think you need to do the 5 days to really make the shifts in thinking and in confidence. I would hate to see it watered down.</td>
</tr>
<tr>
<td>• We need to think about more flexible delivery modes for the future.</td>
</tr>
<tr>
<td>• We need to ensure that rural and remote people continue to have the opportunity to attend a Health Promotion Short Course.</td>
</tr>
<tr>
<td>• Train-the-trainer would not work. We only ever use this model when we aren’t prepared to fund things properly. For an intensive course like this it wouldn’t work. It needs to be delivered by skilled facilitators.</td>
</tr>
<tr>
<td>• I think the train-the-trainer model could work and would be more cost effective than employing a university to deliver it.</td>
</tr>
<tr>
<td>• RHPOs should be able to deliver the course if they have the training background and confidence to do so.</td>
</tr>
<tr>
<td>• We need to look at other delivery models such as including local contexts from local agencies in a shared facilitation role with providers such as universities.</td>
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</table>

<table>
<thead>
<tr>
<th>Funding options for future courses</th>
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<tbody>
<tr>
<td>• The DHS could fund the course as part of its targets around professional development.</td>
</tr>
<tr>
<td>• It could be done as fee for service. It would be good if it were part of a funding requirement…this would help organisations up to speed.</td>
</tr>
<tr>
<td>• The course must continue and the DHS should continue to subsidise it to some extent though I think organisations could now be expected to contribute to meeting the cost.</td>
</tr>
<tr>
<td>• If it (the short course) was not going to continue then there will be a gap. It was a great learning tool. It enhances what were trying to do around community engagement and participation. It gives us some tools around how to do that rather than just the rhetoric. It needs to be funded!</td>
</tr>
<tr>
<td>• The DHS should fund a refresher… I now have more knowledge and skills…my confidence is building. I’m ready for the next phase.</td>
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</tbody>
</table>

5.9 Further training for Short Course participants

*People are thirsty for opportunities. It was fantastic for DHS to fund this stuff. It increases the profile of health promotion. I now want more training and we are looking at different models that other agencies are using to continue to build capacity.*

Participants were asked to describe the types of professional development they are seeking, following the Short Course. Further training around needs assessment, program planning and evaluation were the most recurring responses. Some respondents were asked whether they felt that the Short Course had therefore been inadequate in these areas, and the responses were universally that the Short Course
had given them knowledge and skills, or as one participant said ‘...the course has opened my eyes to these aspects of HP practice and I now ready for the next phase of training.’ A summary of participant responses to the professional development courses of interest is presented in Table 5.13.

<table>
<thead>
<tr>
<th>Table 5.13 Further training for participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• My agency would be prepared to pay for me to attend a refresher course. They can see the benefits.</td>
</tr>
<tr>
<td>• A follow-up course could be about best practice... examples of where health promotion is being done well...let's showcase what's working well and get the message out to the field.</td>
</tr>
<tr>
<td>• We need to offer articulation of PD including the short course into further study and actively encourage this to happen. This is particularly the case in rural and remote areas. This wasn't mentioned in the course held in our region.</td>
</tr>
<tr>
<td>• We need targeted follow-up professional development.</td>
</tr>
<tr>
<td>• We need to do a needs-analysis of what their training needs are... they will be better equipped to articulate this having done the course.</td>
</tr>
<tr>
<td>• More about how to do evaluation and how to write evaluation reports.</td>
</tr>
<tr>
<td>• More about program planning and needs assessment.</td>
</tr>
<tr>
<td>• More about report writing to influence policy and access funding.</td>
</tr>
<tr>
<td>• Training on how to do a literature review.</td>
</tr>
<tr>
<td>• Training in project management.</td>
</tr>
<tr>
<td>• A health promotion course for health educators would be good.</td>
</tr>
<tr>
<td>• Training in developing campaigns and in public speaking.</td>
</tr>
<tr>
<td>• The course needs to be included in the training calendar and marketed better.</td>
</tr>
<tr>
<td>• I think hospital people should do the course...there are opportunities there for change and maybe the DHS should push for it.</td>
</tr>
</tbody>
</table>
6.0 Exemplars of organisational change

Organisational change is a key theme to emerge from this evaluation research. In order to illustrate the dynamics of organisational change and reorientation towards health promotion, we developed exemplars which are presented here as exemplars. Four organisations originally agreed to be profiled but only two actually provided the necessary documentation to allow the organisational profile in relation to health promotion, to be developed. We asked organisations to provide us with documents such as their most recent Annual Report, Strategic Plan, Health Promotion Plan and Health Promotion Planning pro formas. These documents were used in conjunction with the interviews conducted with staff from the organisations.

6.1 Exemplar 1: Dianella Community Health Service

Service profile
Dianella Community Health Service (DCHS) covers the southern area of the Hume region extending from Craigieburn in the north to the fringe of Moreland in the south. It therefore services metropolitan and urban-fringe populations. DCHS incorporates five sites: Meadow Heights, Broadmeadows, Craigieburn, Finchley Support Services and Dallas.

DCHS employs staff across seven key program areas:

- Health Promotion;
- Adult Day Activity Support Service
- Broadmeadows Multidisciplinary Team
- Finchley Support Service
- Neighbourhood Sites Team (allied health, community health and social support services)
- Medical Practice
- Dental Service

Health promotion in the organisational structure
The organisation funds the position of Director of Health Promotion. Health Promotion sits as one of the key program areas for DCHS but is also seen to operate across all program areas. The Health Promotion Plan states that health promotion ‘underpins all our collective and individual activity as a primary health service provider’.

There is recognition of a need to focus on the social determinants of health. As a result work has been undertaken with housing, education and local government sectors. The Director of Health Promotion has been active in receiving grants for projects focussing on access, and the development of health promotion resources. The CEO suggested that this position was also responsible for promoting the Short Course internally.

Structures for Health Promotion (policy, plan, WGs, HPO)
Health promotion at DCHS is supported by a Director of Health Promotion, a Health Promotion Plan and a Health Promotion Working Group. The Health Promotion plan identifies 5 key priority areas:
Goals, objectives and strategies for addressing each of these issues are described. Where appropriate, links with other relevant plans, including those from Local Government and PCP, are provided. A commitment to evaluation is evident and is supported by the Health Promotion Working Group (HPWG), program frameworks and individual evaluation systems. The Health Promotion Plan incorporates each program goal into the DHS Health Promotion program plan template.

Interviews with staff revealed that DCHS is committed to organisational change. About three years ago, DCHS undertook a strategic planning process and concluded that they needed to divert more attention to preventative and community health services. As a result, a full time Director of Health Promotion was employed and was supported by a Health Access and Diversity Coordinator. With support from the Board, the Director of Health Promotion made a commitment to moving staff from a clinical approach to adopting a broader perspective of their work. This commitment to change was communicated through a Change Management Committee. Change was then integrated through different levels of the organisation on a one-on-one basis. Performance indicators were attached to this process, which has generally been very well received within the organisation.

Short Course in Health Promotion outcomes and future directions

The 2001-2002 Annual report states that several staff from various disciplines undertook the Short Course in Health Promotion. Interviewees commented that this assisted with ‘improving our understanding and shared visions around our work’. It was also suggested that the Short Course has ‘aided the development of the health promotion plan’. The Short Course has also had an impact on staff involvement in PCP activities. Workers are more inclined to collaborate and are more active in a range of forums. According to the respondents, one of the highlights of the course was an understanding of the key aspects of upstream service delivery. Workers are now thinking about how to measure the success of their programs rather than relying on intuition. However, this remains an issue for many staff external to this organisation, as ‘their managers don’t understand the processes that is required around embedding health promotion practice into the organisation’. In dealing with this issue it was suggested that managers need more education around health promotion. While traditional short course structures may not be appropriate, there might be opportunities to use existing forums. For example, education can be provided through keynote presentations at conferences. These might include The Australian Primary Health Care Conference or activities run by the Victorian Community Health Association or the Victorian Health Care Association. Interviews highlighted that ‘the management group need to understand the implications for embedding health promotion into their organisation’.

While backfill was not identified as an issue in the interview, it was acknowledged that some staff have appointments 2 months ahead and find it difficult to fit something like the Short Course into their schedules.

It was acknowledged by respondents that workers often come away from courses and get lost in their work. The development of a Health Promotion Working Group supported workers who had attended the course but also welcomed those who had not. This group
provides a forum to discuss the organisation’s health promotion plan, current projects, PCP activities and ideas for future work. Networking external to the organisation was also a benefit of the Short Course. Staff suggested that ‘the opportunity for personal contact with other people with similar roles, interests, needs is important and the possibilities that emerge during the course are apparent’.

Sustainability of the course was seen to be crucial. Respondents suggested that refresher courses or advanced certificates might assist. It was also suggested that it might be appropriate to list the Short Course as a key selection criteria for new employees.

**Summary**

Health promotion is well supported within this organisation at both management and worker level. Workers are provided with opportunities to discuss and collaborate both internally and external from their organisation. Together with other organisational activities, the Short Course has assisted in the development of the health promotion plan, assisted workers in thinking about evaluation and encouraged networking and partnerships.
6.2 Exemplar 2: Portland and District Community Health Centre

Service profile
Portland is situated on Victoria’s south west coast. Portland and District Community Health Centre (PDCHC) offers a range of services to meet the local community’s needs including:

- Community health nursing
- Dietetics
- Podiatry
- Health promotion
- Social work
- Women’s health
- Youth services
- Family planning
- Drug and alcohol counselling, advice and education
- Men’s health
- Social monitoring and support
- Community transport
- Injury prevention and farm safety
- Adolescent health
- Social transport

The Centre also has a range of visiting services including Aged Care Assessment, Maternal and Child Health and Workcover Conciliation.

In March 2002, a shared management arrangement was established between Portland and District Hospital and Portland and District Community Health Centre. There is some sharing of staff across the two organisations for health promotion programs and closer integration in the future is anticipated. One hospital staff member commented that she is looking forward to the opportunities for more integrated health promotion as the organisations strengthen their relationship.

Where health promotion fits into the organisational structure
Health promotion is seen to be an integral and complimentary part of PDCHC service provision. PDCHC states that its vision is to ‘continue to respond to consumer needs and priority health areas (as set out by the State Government, local municipality and Primary Care Partnerships) to enable community members of the Glenelg Shire Region to take responsibility for their health and wellbeing’. This will be achieved through ‘the development, implementation, maintenance and evaluation of health promotion activities’.
Structures for health promotion

A part-time Health Programs Coordinator and a Health Promotion Management Plan support health promotion at PDCHC. While the Coordinator position is responsible for the ongoing coordination of health promotion program activities, all staff members are asked to undertake health promotion programs and activities. Over the last 12 months, 35-50% of staff time has been spent on "researching, developing and implementing evidence based health promotion programs" to meet the needs of the community. The Health Promotion Management Plan sets out several objectives focussing on the community and the internal and external environments (PCP, Local Government policy) impacting on health promotion and includes a draft budget.

After examination of key documents, PDCHC has identified four priority areas
- Cardiovascular disease
- Cancer prevention and management
- Mental health and wellbeing
- Chronic disease

There is a commitment to intersectoral collaboration with HP partnerships developed with service providers around the region.

Short Course in Health Promotion outcomes and future directions

Across the organisation, one of the benefits of the Short Course was that it “enabled the whole organisation to speak the same language”. This ability to use the language of health promotion has assisted the organisation in accessing funding. Improvement in the quality of health promotion has also been noted. The number of people from this organisation having attended the course was therefore seen to be of benefit by a staff member interviewed.

There has also been a shift away from 'haphazard' health promotion to that which is planned and based on evidence. Links to community needs have also been made. The Health Promotion Coordinator feels that the Short Course has assisted in these developments. One staff member commented ‘if anything, the course has taught me about the opportunities to quality planned health promotion, not quantity health promotion’.

Following the Short Course the organisation identified that it needed to change the way in which it thought about health promotion. It provided them with an opportunity to ‘throw out the old and bring in the new’. There were barriers associated with this process. One staff member commented ‘people get set in their ways, and taking the blinkers off means taking the time to implement the change’. Organisational change was also hindered by the fact that staff had undertaken the course but management had not. The same level of health promotion understanding and language was therefore not shared.

The opportunity to network at the Short Course was also a benefit, ‘we put faces together, they have become part of our local network. We remember people talking about things at the course and we can contact them after the course’. This has facilitated a more sophisticated collaborative approach.

Like many others, this organisation has had to consider changes to their organisation to meet new DHS funding requirements. This has prompted them to make changes to policies and procedures and undertake strategic planning. The Health Promotion Coordinator suggested "the Short Course gave us the skills to meet what the DHS wanted".

Summary
This organisation has made some significant changes to the way it thinks about, plans and delivers health promotion. The Short Course has assisted in this process of change. It has provided staff with the language of health promotion and provided them with the skills to develop good quality health promotion programs. The Short Course has also made staff of this rural CHS more aware of other contacts within the region. The result has been a more collaborative approach to health promotion.
7.0 Conclusions

Previous chapters have comprehensively presented data analysis from the research conducted for the evaluation. In this final chapter, findings of the evaluation will be used to summarise and address the specific objectives for the research project as outlined in the DHS project brief. Options for sustainability of the Short Course in Health Promotion as a specific workforce development initiative are provided in the context of these findings. This is followed by discussion of key issues arising from the evaluation, and finally four recommendations are made.

It is important to re-state that this evaluation was primarily concerned with the beneficial impact of the Short Course, its ability to provide an introduction to health promotion and to meet needs for health promotion training, delivered equitably across the state, and with quality resources. The evaluators were concerned with how the content of the Short Course was viewed by both participants and their managers, how the administration of the Short Course was conducted, whether the needs of Short Course participants were met and to identify the facilitators and barriers to Short Course participation. While organisational change is likely to be a key outcome of the implementation of the Short Course, this is not an area that has been examined in detail in this report. The brief for this evaluation clearly articulated that the impact of the Short Course should be the primary consideration of the evaluation team.

The evaluation raised issues about the complexities of administration of registrations and the maintenance of participant lists, tasks which were by and large, conducted within DHS Regional Offices for Round 1. For the 2003 round of course delivery, course providers were given responsibility for the conduct of administrative functions and for liaising with DHS staff. This seems to have been the preferred model but of course, the 2003 round of Short Courses were not included in this evaluation.

7.1 Evaluation objectives

Each objective focuses implicitly on the evaluation framework components; effectiveness, satisfaction, appropriateness, acceptability and equity.

7.1.1 Objective 1: To determine if the Core Health Promotion course was successful in achieving its stated aims and objectives, including:

- Does the Core Health Promotion Short Course provide an introduction to health promotion for community and primary care workers in Victoria?
- To determine if the Core Health Promotion Short Course had a beneficial impact on health promotion practice and the health promoting work capacity of the target group across the different settings and Regions;
- To determine if the model of delivery of the Core Health Promotion Short Course met the needs of the target group;
- To evaluate the content of the Core Health Promotion Short Course;
- To evaluate the appropriateness and value of the resources and materials.
This evaluation research, which has been conducted with a wide range of stakeholders, has demonstrated convincingly that the DHS Short Course in Health Promotion has provided a good quality introduction to health promotion for community and primary care workers in Victoria.

With over 90% of respondents identifying the course as relevant to their needs, the Short Course has had a beneficial impact on participants and vicariously, for their organisations, although it is not possible to measure the degree to which organisational change has been effected by the Short Course. The level of satisfaction from respondents was high, demonstrating that they found benefits from the course, for both for their own professional work and for their interactions within their organisation and for their collaborations with external agencies.

The recommended model of delivery, which was for 5 days spread over 3-4 weeks with at least a 2-day block for days 1 & 2, was considered effective as a learning model and appropriate in that it met the needs of target groups. Indeed, when some trainers changed the model of delivery to a 5-day intensive over 1 week, participants felt the delivery mode was inappropriate. Trainers felt that participants benefited more from the first two days being run together because the intensity of the content of Day 1 is put into some context by the immediate follow-on of Day 2.

Stakeholders have provided solid support (83%) for the content of the Short Course as appropriate and relevant for their organisations, whether community health, acute hospitals, local government, the sports sector, school nursing or neighbourhood houses. The waiting lists for upcoming Courses and rates of participant attendance through the five days of the Course, are strong indicators of its appropriateness and relevance to participants. The rates of completion at approximately 85%, must be seen within the context of the pressures of the day-to-day workloads of participants, which did not disappear because participants were undertaking the Short Course.

Resources and materials were considered by training providers to be very good, with comment made by training providers about the higher standard of presentation achieved in the revised (2nd) edition of the Short Course that was produced for the 2003 round of delivery. Health promotion is a dynamic field that is constantly evolving so any training materials will have a shelf-life of perhaps only three years before they need updating. The relevance of the materials for participants was underscored by the number of respondents who talked about the folder of materials in terms of a resource for their work, and described the opportunities they had taken to share some of the resources with other staff in the organisation. They had also used the websites listed in the Short Course materials and joined e-lists for the purposes of networking.

7.1.2 Objective 2: To identify on going need for further training and development activities in the Victorian health promotion sector

Respondents to the evaluation were able to clearly identify further training needs in health promotion for participants of the course. Research skills to support needs assessment and evaluation were the most commonly identified training needs. Continued organisational change in terms of capacity building for health promotion was clearly identified as a need in the Victorian health promotion sector. Interestingly, the evaluators noted that respondents did not identify ‘submission writing’ as a future learning need. Further exploration of the need for this skill is required.
As previously mentioned, respondents identified future health promotion training initiatives that were a priority for them, particularly in-depth study of needs assessment, evaluation methods and research. These could well be collapsed under the general heading of Research Methods for Health as both needs assessment and Evaluation require knowledge and skills in Research Methods. Most health professionals take courses in Research Methods during their undergraduate degrees so it would seem that respondents are seeking revision and extension of those studies with practical application to health promotion. Such a course could feasibly be offered in much less than 5-days, although a two or three day intensive is likely to be required to cover the required content.

A regular theme that emerged from the evaluation was the view that managers and Boards of Management needed some form of professional development health promotion program to enable their management of the reorientation of their organisations towards health promotion. A 5-day course with its focus on knowledge and skill development was considered excessively detailed for this purpose. A few organisations provided information about their adaptation of some aspects of the Short Course materials into a series of two or three 2-hour modules for the purposes of Boards and management training in health promotion.

7.1.3 Objective 3: To identify barriers and enabling factors for prospective Short Course participants

Barriers and enabling factors for potential participants are interpreted as those that might preclude future participation in Short Courses. Two were most clearly identified – in rural areas, travel is a barrier and for smaller organisations generally, whether urban, urban-fringe or rural, there is a lack of backfill to take over the appointment schedules of participants while they are away from work. The biggest barrier to prospective participants is less than optimal quality training and the relevance of the Short Course content. It is critical for optimal quality that trainers are competent – this is discussed further in 7.1.

Enabling factors include the support of management and colleagues, sufficient notice of upcoming courses to allow work schedules to be rearranged, and good quality training that is encouraging, participative, relevant, responsive and adaptive, to participant’s needs.

Funding for core and advanced health promotion training is an investment in quality for all agencies but subsidy for the travel and backfill of rural and remote staff will enable participation.

7.1.4 Objective 4: To determine if this model of program delivery is suitable for application to future health promotion training initiatives

Certainly, the availability of quality advanced health promotion training is vital for the maintenance of the momentum towards evidence based health promotion in Victoria. The 5-day Short Course is a resource-intensive model that was specifically designed to introduce foundation knowledge and skills that are necessary elements of integrated health promotion proficiency. Respondents discussed the considerable commitment required from participants and from organisations, for staff to undertake the Short Course. Nonetheless, the value placed on the Short Course by participants is demonstrated by a number of indicators including waiting lists for future Short Courses, completion rates of about 85% and comments from CEOs/managers that want all staff to be complete the Short Course, that it is essential that staff have knowledge and skills in health promotion to enable the organisation to meet its health promotion goals.
An option for consideration is the model developed for the Leading the Way: Councils Creating Healthier Communities. This was a VicHealth funded professional development initiative aimed at senior managers and councillors. The purpose was to highlight the relationship between the social determinants of health, Municipal Public Health Plans and the broader role of council. A series of briefings, workshops, forums, seminars and a website were some strategies used to deliver the course material (Dibly & Jolley 2003). The emphasis on intersectoral health promotion would be of interest to future re-developments of the Core Health Promotion Short Course particularly in relation to up-skilling of managers.

7.1.5 Objective 5: To develop sustainability options for continuing the Short Course in Health Promotion at the completion of the current (2003) funding cycle

The DHS has advised that it does not anticipate future funding will be available centrally for the Core Health Promotion Short Course but it is interested in alternative arrangements for the provision of the DHS certified Short Course.

Training providers, DHS staff, CEOs and managers were specifically asked questions about sustainability options for the Core Health Promotion Short Course. In their responses, consideration was given to the continuing need for professional development in health promotion taking account of existing staff who would benefit from the Short Course and of new staff. Some managers felt that the Short Course was essential for their organisation and that it should be incorporated as requirement for new positions or that all new staff should be mandated to attend the Short Course. Table 5.8 documents the responses provided to the questions about future options and possible funding structures.

7.2 Costs of delivery of the Short Course in Health Promotion

The cost of delivering a DHS Short Course in 2002 for 30 people is about $15,000, including venue hire, catering, all course materials (folders, photocopying) and training provider delivery fees (preparation, delivery and preparation of report). This works out at $500 per participant for 5 days of high quality training, which is competitive and cost-effective. The cost assumes the materials for the trainer are already developed, albeit requiring incremental updates.

7.3 Sustainable funding for future the DHS Short Course

The question of sustainability of the Short Course was of particular concern to the DHS and thus, to the organisations and workforce concerned with health promotion in Victoria. The DHS is not anticipating direct funding for further delivery of the Core Health Promotion Short Course. Nonetheless, funding is key to the sustainability of the Short Course.

Drivers for sustainability of the Short Course are likely to be those with vested interests in workforce development for health promotion. The Primary and Community Health Branch of the DHS have primary interests in a strong workforce to assist with ongoing building of capacity in the community based sector for health promotion, particularly community health and women’s health services, and particularly for efforts to reduce health inequalities at the level of local communities through integrated primary health services.
7.3.1 Market for Short Courses

A number of different types of organisations will have vested interests in the sustainability of the Short Course, in order to ensure they have a skilled workforce to deliver on health promotion goals and targets. These organisations are not limited to community and women’s health but will also include local government, community/neighborhood houses, Divisions of General Practice, and non-government organisations with core interests in health issues. These organisations have the need for quality skills across the whole range of health promotion practices, and so are likely to be motivated to purchase Short Course training. In order for organisations in Victoria to respond effectively to local communities and contribute to sustainable health outcomes, high quality, accredited core training courses in health promotion need to be available for new and existing staff who are moving into jobs that require health promotion knowledge, skills and competencies. Drivers for health promotion workforce development will also be the Regional Health Promotion Officers in the DHS who see ‘graduates’ from the Short Course as the champions for health promotion in local areas.

The market for Short Courses has to date, primarily been from DHS funded agencies. Given that health promotion is increasingly understood to be everybody’s business, there is likely to be a wider market beyond DHS agencies, for the Short Course. Local government is a major player in health promotion, which did send staff to Short Courses, but remains a much untapped opportunity for workforce development in health promotion. The environmental health sector has much scope for workforce development in relation to health promotion. Other markets include non-government organisations with a focus on health issues, hospitals, the family and community support sectors, aged care, disability and home care services. Project staff in major DHS platforms of Neighbourhood Renewal and Best Start as well as VicHealth funded projects, are also potential markets for the Short Course. There are also likely to be regional areas of Victoria where distance has to date, precluded a strong participation of local workers in a Short Course.

The organisations, which comprise these sectors, may need some encouragement, or even a motivational pull, to ensure their staff have access to a Short Course. Such encouragement could be tied to project funding.

Thus, funding and delivery of future Short Courses is likely to be devolved in some way. There were views expressed during the evaluation that organisations placed such high value on the Short Course that they would be willing to contribute to meeting Short Course costs. Organisations such as Local Government, non-government organisations, neighbourhood houses, and non-health government sectors such as housing and education, are all likely purchasers of Short Courses in Health Promotion. It is worth emphasizing the importance for health promotion outcomes, of the networking, collaborations and partnerships that can be seeded by intersectoral training opportunities.

In order to maintain momentum in capacity building for health promotion, the DHS has the option of requiring DHS funded organisations to set targets for completion of the Short Course in relation to professional development. Even without such mandating, organisations are nonetheless, likely to find the need to put staff through a Short Course in order to ensure a critical mass of staff who can ensure the organisation can meet its targets for health promotion outcomes. To some extent, the market is likely to be a driver for competitiveness in the pricing for Short Course delivery, with certification of training providers either by the DHS or another organisation to ensure that quality is maintained.
One of the most likely funding options is therefore for shared funding arrangements between providers and purchasers. In summary, these could comprise:

- DHS Regional budgets for health promotion with or without contributions from local organisations who send participants;
- Organisations in partnerships purchasing a Short Course from a certified training provider.

VicHealth has demonstrated its interest in purchasing adapted Short Courses for particular purposes. In 2002, VicHealth purchased such a course for the Regional Sports Assemblies. VicHealth has a contract with Deakin University for the preparation of a Short Course in Mental Health Promotion, which is tailored for non-health sectors such as justice, transport and finance so it is possible that VicHealth may purchase specific purpose Short Courses in Health Promotion in the future.

7.4 Quality provision

Quality rests on course content, and course delivery that maintains the integrity of the 5 day Short Course. It is important that the investment made by the DHS in the development of the Short Course continues to contribute to workforce development in Victoria. This section discusses quality issues relate to providers as separate from issues of funding.

While some respondents suggested that Short Courses could be provided for a particular organisation so that content is tailored to that organisation’s needs, this kind of professional development has different intentions to that of the Short Course. The DHS Short Course has a strong emphasis on skills in partnerships and collaborative practice. Participants are encouraged to think about systems for health promotion outside their own practice and their own organisation. As awareness is raised in organisations about health promotion frameworks, some internal organisational development may well be required to focus on structures and planning to facilitate health promotion practices. But the Short Course is not designed for single organisations, however large. The Course is intended to promote a broad view of health promotion as a process to address the health of vulnerable groups and the need for integrated health promotion approaches within a region or sub-region.

The DHS does wish to maintain quality control over the Course to ensure that any participant provided with the DHS Certificate has been provided with the Short Course as approved by the DHS. This suggests that training providers should also be certified as having the appropriate range of knowledge, skills and experience to provide a quality training experience although clearly it would not be in the interest of the DHS to have a plethora of training providers who are certified to provide the DHS certified course. It is also important that the Short Course continues to be provided by trainers and organisations that have a track record in intersectoral health development to ensure that this important health promotion professional development program is not perceived as ‘belonging’ or being controlled by, one particular sector.

The licensing of the Short Course by the DHS should be considered. Such licensing would be available to organisations, which have the requisite skills to provide the DHS certified Short Course. In relation to certification of future Short Courses, we propose that:

1. A limited number of training providers be invited to apply to the DHS for certification, given for a specific period (two or three years). This would allow a period of time with which to monitor the performance of the trainers.
2. The life of the Short Course is likely to be 3-4 years as long as there are updates to ensure relevancy with policy changes. This could coincide with the re-certification process.
3. Applicants for certification would need to meet broad criteria for quality, experience, knowledge, skills and proven expertise in facilitation of training programs. Certified trainers would have access to the DHS Short Course training materials and course participants would be entitled to be awarded the DHS Certificate of Attendance.

7.5 **Short-short Course for managers**

A number of respondents suggested that a course specific to health service managers would be of benefit to organisational development and capacity building. The 5 day Short Course is written for practitioners and is not completely suitable for managers and Boards of Management who do not need the level of practical detail in the current Short Course. A short version of the Course that covers theory and concepts as well as organisational infrastructure and planning processes would be a useful tool for upskilling of managers and Boards of Management. It should therefore fit within a policy frame, rather than one focussed on practice. A course of this nature should aim to assist managers to manage the balance between direct service to individuals and health promotion. The creation of service systems that are sensitive to this balance are integral to achieving health outcomes. A level of quality control is important to ensure appropriate certification of the DHS course.

7.6 **Recommendations**

Based on the discussion above, we make four recommendations:

**Recommendation 1:**
We recommend that DHS Regions in partnership with relevant agencies, consider the provision of at least one Short Course each year.

**Recommendation 2:**
We recommend that the DHS develop a quality control framework to enable participants to be awarded the DHS Certificate of attendance and therefore have access to opportunities to articulate the Short Course into postgraduate studies.

**Recommendation 3:**
We recommend that the DHS provide licensing for a period of two years to certified providers to offer the DHS Short Course.

**Recommendation 4:**
We recommend that the DHS support the development of a shortened and more targeted Course in 3 x 2 hour modules that is about Health promotion for Managers.
Attributes of a good trainer /facilitator

Participant feedback clearly identified that the delivery of some Short Courses was less than optimal. The reasons for this were either a mode of delivery that was too intensive over five consecutive days or a lack of training skills in the training providers. The competencies of a good trainer are also issues about quality. To inform future decisions about the provision of quality Short Course delivery, we provide a list of training provider competencies in Table 7.1:

<table>
<thead>
<tr>
<th>Focus</th>
<th>A highly skilled professional trainer/facilitator:</th>
</tr>
</thead>
</table>
| Credibility, engagement and adaptability... creating the right learning environment | - establishes credibility and rapport from the outset through competence, confidence, credentials, and an engaging training style  
- is articulate, enthusiastic, and exhibits highly developed interpersonal communication skills  
- is participant-focused, flexible, and able to be spontaneous  
- is organised and able to present information in ways that make sense to participants  
- is passionate, empathic, and sensitive to participant reactions  
- is curious about participants' opinions and experiences  
- self-perception is that of a facilitator of learning rather than an authority figure and controller of content/knowledge  
- can respond appropriately to unexpected events  
- is able to create a safe yet challenging atmosphere in which participants feel motivated to engage and willing to take risks  
- is able to pace, lead and build (i.e. can work the space/time/resources/group/activities) through appropriate pacing of the delivery; by leading debate and encouraging participant contributions; and, by building knowledge, skills and confidence  
- is skilled in managing the dynamics of the group and is able to handle difficult interactions with integrity  
- recognises and responds positively to uncertainty or confusion  
- is aware of the importance of the training space or environment in facilitating the learning process  
- is responsive to participant needs with respect to breaks, room climate, furniture setup, lighting, access to audio-visual aids, refreshments, etc. |
| Attention to content | - is sufficiently familiar with the content to achieve the learning objectives  
- is well prepared and has thoroughly researched the content prior to delivery  
- is able to incorporate case studies and exemplars relevant to the group  
- is able to diverge from the script in order to better meet the groups' needs  
- recognises that administration and process issues are as important as content in optimising outcomes |
| Ensuring relevance | - constructs meaning for the participants by contextualising, illustrating, demonstrating, including  
- recognises that learning occurs when participants identify relevance to their own contexts  
- seeks opportunities to draw on the experiences of participants  
- does not feel threatened by the knowledge, skills, and experiences of the participants |
| Training methods | - can employ and adapt a range of methods (e.g. group processes; case studies; audio-visual demonstrations; problem solving; brainstorming; nominal group technique; role play; modelling; scenarios; didactic presentations; participant reflections; interactive challenges; other)  
- identifies which methods best suit the content, the group, the training space, the time available, and the learning objectives  
- is not unduly reliant on formulaic training techniques (e.g. ice breakers, gimmicks to gain attention, ways of dividing participants into groups) |
References


Department of Human Services, 2002a. *2002-2003 community and women’s health program guidelines*. Community Health Unit, Department of Human Services, Victoria.


Qualitative Solutions and Research Pty Ltd (2003) NUD.IST Vivo, Melbourne, QSR.


Appendices
**Appendix 1 Course outline**

**Core Short Course in Health Promotion**

<table>
<thead>
<tr>
<th>Module A</th>
<th>Morning</th>
<th>Health Promotion Concepts and Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Afternoon</td>
<td>Community Development and Community Participation</td>
</tr>
</tbody>
</table>

| Module B          | All day                      | Needs Assessment and Program Planning |

| Module C          | All day                      | Skills and Strategies in Health Promotion |

| Module D          | All day                      | Evaluating Health Promotion |

<table>
<thead>
<tr>
<th>Module E</th>
<th>Morning</th>
<th>The Policy Context for Health Promotion and PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Afternoon</td>
<td>Working in a Collaborative Environment</td>
</tr>
</tbody>
</table>
Appendix 2 Survey

Core Health Promotion Short Course

Evaluation Survey

Instructions:

Please tick or circle (as indicated) the response that most closely relates to you and reply by description when prompted. This survey should take approximately 20 minutes of your time to complete.

When completed, please place in the reply paid envelope provided and post as soon as possible.

We would appreciate receiving this back by Monday, 28 April

Thank you for your time!
Section A  Demographics

1. Please state your professional background. ___________________________

2. Gender:  □ 1 Male    □ 2 Female

3. Age group:
   □ 1 < 20   □ 2 20-29   □ 3 30-39   □ 4 40-49   □ 5 50-59   □ 6 >60

4. How many years have you been a health worker or involved in health related roles in your occupation?
   □ 1 0-2 years  □ 2 2-5 years  □ 3 5-10 years  □ 4 more than 10 years

5. Which title best describes the sector you work in (select one only)?
   □ 1 Community Health
   □ 2 Acute health service
   □ 3 Alcohol and drug services
   □ 4 Local government
   □ 5 State government
   □ 6 Rural health service
   □ 7 Community house
   □ 8 Housing
   □ 9 Education
   □ 10 Other (please specify) ___________________________

6. (a) In which DHS region is your organisation based?
   □ 1 Barwon SW
   □ 2 Eastern Metro
   □ 3 Gippsland
   □ 4 Grampians
   □ 5 Hume
   □ 6 Loddon Mallee
   □ 7 Northern Metro
   □ 8 Southern Metro
   □ 9 Western Metro
(b) Where is your organisation located?

- Metro Melbourne
- Provincial City
- Rural City
- Outer-fringe Melbourne
- Rural Town

7. Is your organisation a member of a Primary Care Partnership (PCP)?

- Yes  If Yes, which PCP? ___________________________
- No
- Don’t know

8. Which modules of the course did you attend?

<table>
<thead>
<tr>
<th>Module</th>
<th>A (Day 1)</th>
<th>B (Day 2)</th>
<th>C (Day 3)</th>
<th>D (Day 4)</th>
<th>E (Day 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Promotion Concepts and Approaches</td>
<td>Needs Assessment and Program Planning</td>
<td>Evaluating Health Promotion</td>
<td>Working Towards Change</td>
<td>Actions for Health Promotion</td>
</tr>
<tr>
<td>Attend</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Section B  Prior to attending the course:

9. How did you find out about the course?

- Work
- Advertisement
- Recommended
- Other (please specify) _______________________________

10. Why did you attend the course?

- Compulsory
- Voluntary, but strongly encouraged
- Voluntary
- Other (please specify) _______________________________

11. Rate your level of knowledge of Health Promotion prior to the course.

- No knowledge
- Some knowledge
- A good level of knowledge
- A very high level of knowledge
12. Rate your level of **experience** in Health Promotion prior to the course.

   - 1. No experience
   - 2. Some experience
   - 3. A good level of experience
   - 4. A very high level of experience

13. Rate your perception, prior to the course, of the **need** for Health Promotion within the work of your organisation.

   - 1. Not needed
   - 2. Needed on some occasions
   - 3. Needed on most occasions
   - 4. Core business of our organisation/service/agency

14. What were you hoping to gain from the course?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

**Section C  After attending the course**

15. To what degree was the course **relevant** to you?

   - 1. Not relevant
   - 2. Somewhat relevant
   - 3. Quite relevant
   - 4. Very relevant

16. Rate your level of **knowledge** of Health Promotion after the course.

   - 1. No knowledge
   - 2. Some knowledge
   - 3. A good level of knowledge
   - 4. A very high level of knowledge
17. To what extent was the course **effective** in providing you with the necessary knowledge and skills to enable you to incorporate health promotion into your work?

- 1. Not helpful at all
- 2. Quite helpful
- 3. Very helpful
- 4. Invaluable

18. To what extent have you actually been able to **incorporate** health promotion into your work since completing the course?

- 1. Not at all Please explain the barriers to this (see below)
- 2. Occasionally
- 3. Frequently
- 4. All the time

If not at all, please explain:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

19. To what extent have you made use of the **materials and resources** provided during the course?

- 1. Not at all
- 2. Occasionally – please indicate what materials or resources below
- 3. Frequently – please indicate what materials or resources below
- 4. All the time – please indicate what materials or resources below

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

20. Rate the **impact** of the course on your work (please circle one number in each part of this question).

(a) It changed the way I **think** about my practice

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Definitely</td>
</tr>
</tbody>
</table>
(b) It changed the way I do my job

1 2 3 4 5 6 7 8 9 10
Not at all Definitely

(c) It changed the way I work with colleagues within my organisation

1 2 3 4 5 6 7 8 9 10
Not at all Definitely

(d) It change the way I network with people in other organisations

1 2 3 4 5 6 7 8 9 10
Not at all Definitely

Give an example of any of the above

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

21. How confident are you in applying the learning from the course in your current work practice?

☐ 1. Not at all confident
☐ 2. Somewhat confident
☐ 3. Quite confident
☐ 4. Very confident

22. In the time since the short course, to what extent have you been involved in activity related to your Primary Care Partnership (PCP)?

☐ 1. Not at all
☐ 2. Occasionally – please provide an example below
☐ 3. Frequently – please provide an example below
☐ 4. All the time – please provide an example below

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
23. Were there any aspects of the course that did not meet your expectations or needs? Please give details.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Section D  Health Promotion Practice and Capacity

24. Rate the opportunity for you to put into practice in your workplace, the knowledge you gained from the course (circle one number).

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Definitely</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. Please circle the number that most closely relates to any changes in your own health promotion practice since undertaking the short course (1 = no change; 5 = significant change).

<table>
<thead>
<tr>
<th>Aspects of health promotion practice</th>
<th>Rate the level of change in your own health promotion practice since the course</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrying out Needs Assessment</td>
<td>No change</td>
<td>Major change</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td>0</td>
</tr>
<tr>
<td>Program Planning</td>
<td>No change</td>
<td>Major change</td>
</tr>
<tr>
<td>i) developing clear goals and SMART objectives</td>
<td>1 2 3 4 5</td>
<td>0</td>
</tr>
<tr>
<td>ii) selecting effective approaches</td>
<td>No change</td>
<td>Major change</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td>0</td>
</tr>
<tr>
<td>iii) working in multi-disciplinary teams</td>
<td>No change</td>
<td>Major change</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td>0</td>
</tr>
<tr>
<td>Process Evaluation</td>
<td>No change</td>
<td>Major change</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td>0</td>
</tr>
<tr>
<td>Aspects of health promotion practice</td>
<td>Rate the level of change in your own health promotion practice since the course</td>
<td>N/A</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Impact Evaluation</td>
<td>[No change, 1, 2, 3, 4, 5 (Major change)]</td>
<td>0</td>
</tr>
<tr>
<td>Outcome Evaluation</td>
<td>[No change, 1, 2, 3, 4, 5 (Major change)]</td>
<td>0</td>
</tr>
<tr>
<td>Collaboration</td>
<td>i) within the organisation [No change, 1, 2, 3, 4, 5 (Major change)]</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>ii) with other organisations</td>
<td></td>
</tr>
<tr>
<td>Networking for Health Promotion support</td>
<td>[No change, 1, 2, 3, 4, 5 (Major change)]</td>
<td>0</td>
</tr>
<tr>
<td>Contributing to overall health promotion strategic planning within your organisation.</td>
<td>[No change, 1, 2, 3, 4, 5 (Major change)]</td>
<td>0</td>
</tr>
<tr>
<td>Contributing to overall health promotion strategic planning within your PCP.</td>
<td>[No change, 1, 2, 3, 4, 5 (Major change)]</td>
<td>0</td>
</tr>
</tbody>
</table>

26. Please circle the number that best indicates the practice and capacity of your organisation to undertake particular aspects of health promotion.

<table>
<thead>
<tr>
<th>Aspects of health promotion practice and capacity</th>
<th>Your organisation’s health promotion practice and capacity</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrying out Needs Assessment</td>
<td>[No capacity, 1, 2, 3, 4, 5 (Significant capacity)]</td>
<td>0</td>
</tr>
<tr>
<td>Aspects of health promotion practice and capacity</td>
<td>Your organisation’s health promotion practice and capacity</td>
<td>N/A</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Strategic planning for health promotion: eg developing annual health promotion plans and priorities</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Program Planning</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>i) develop clear goals and SMART objectives</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>ii) selecting effective approaches</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>iii) working in multi-disciplinary teams</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Process Evaluation</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Impact Evaluation</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Outcome Evaluation</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Collaboration</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>i) within the organisation</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>ii) with other organisations</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Networking for Health Promotion support</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Providing health promotion leadership across agencies and services</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
<tr>
<td>Identifying sources of funding and applying for funds</td>
<td>No capacity</td>
<td>Significant capacity</td>
</tr>
</tbody>
</table>
27. Please complete both sides of the chart below concerning your views on the importance of different aspects of health promotion capacity, and on your organisation’s actual performance.

<table>
<thead>
<tr>
<th>Aspects of health promotion capacity</th>
<th>How important is this aspect for you?</th>
<th>In reality, how well does your organisation perform in this aspect?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding to new policy initiatives</td>
<td>Not at all</td>
<td>Very poorly</td>
</tr>
<tr>
<td>Developing and implementing organisational policies relevant to health promotion</td>
<td>Not at all</td>
<td>Very poorly</td>
</tr>
<tr>
<td>Management support of my work in health promotion</td>
<td>Very important</td>
<td>Exceptionally</td>
</tr>
<tr>
<td>Organisational policy about health promotion</td>
<td>Very important</td>
<td>Exceptionally</td>
</tr>
<tr>
<td>The organisations overall strategic plan covers health promotion</td>
<td>Very important</td>
<td>Exceptionally</td>
</tr>
<tr>
<td>Access to internal funding for health promotion</td>
<td>Very important</td>
<td>Exceptionally</td>
</tr>
<tr>
<td>Extent to which health promotion is written into your position description</td>
<td>Very important</td>
<td>Exceptionally</td>
</tr>
<tr>
<td>Adequate IT infrastructure (e.g. email, www)</td>
<td>Not at all</td>
<td>Very important</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time for health promotion</th>
<th>Not at all</th>
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<th>Very poorly</th>
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<tr>
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<tr>
<th>Mentoring of new or inexperienced working with health promotion</th>
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<tr>
<th>Feedback on health promotion performance</th>
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28. Have you joined or developed any health promotion networks (either within your own organisation or with other organisations) since completing the course?

- [ ] Yes
- [x] No

Please give details.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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__________________________________________________________________________________________
29. What further training in health promotion do you think you personally need?

________________________________________________________________________

________________________________________________________________________

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30. What health promotion training is needed in your organisation?

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________________________________________________________________________

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________________________________________________________________________

31. Have you enrolled in any other related courses or training as a consequence of the course?

☐ 1. Yes - If Yes, please give details below.

☐ 2. No
32. If you are thinking of enrolling in another related course or training, at what level would you be interested?

- Workshop
- Short Course
- Graduate Certificate (one year of part-time study)
- Graduate Diploma (two years of part-time study)
- Masters (three years of part-time study)

33. If you were to enrol for formal study in health promotion, which modes of study would you prefer (tick up to two)?

- On-campus classes on a weekly basis
- On-campus classes arranged in short blocks (say, 2 x two-day teaching blocks)
- On-campus classes, arranged as a single block
- Off-campus study with on-line learning, including on-line discussion groups
- Off-campus study with on-line learning and discussion groups, but some face to face teaching.

34. Please make any other comments relating to the course that you feel are important.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Thank you for your assistance in evaluating how effective and appropriate the Health Promotion Short Course has been in building the health promotion capacity of the health and community sectors.
Appendix 3 Interview questions
Evaluation of the DHS Core Health Promotion Short Course

Questions for course participants

Describe your role and it’s connection with health promotion.

Were your expectations of the health promotion short course met?

What were the outcomes of the course - for you, for your organisation?

What were the opportunities and barriers you faced at work after undertaking the short course?

What support do you/your organisation need to keep advancing health promotion?

What support would be helpful in maintaining or improving your confidence around health promotion?

In the mail survey we asked short course participants about the importance of different aspects of health promotion and their organisation’s actual performance on those aspects. The question and some preliminary results are provided below. Why do you think these differences exist?

*Please complete both sides of the chart below concerning your views on the importance of different aspects of health promotion capacity, and on your organisation’s actual performance.*

**Importance:** 1 = Not at all  5 = Very important

**Performance:** 1 = Very poorly  5 = Exceptionally

### Contrasting importance with performance

<table>
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<tr>
<th>Aspect</th>
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<th>Performance - mean</th>
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<td>Internal funding for HP</td>
<td>4.05</td>
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<tr>
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<td>Mentoring of new/inexperienced</td>
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<tr>
<td>Time for HP</td>
<td>4.21</td>
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<tr>
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<td>3.94</td>
<td>3.30</td>
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Evaluation of the DHS Core Health Promotion Short Course

Questions for RHPOs

Describe your role and it’s connection with HP in the region.

Have you undertaken the course yourself?

What has been the response within your region to the short course?

From your perspective, what were the outcomes of the short course?

In the mail survey we asked short course participants about the importance of different aspects of health promotion and their organisation’s actual performance on those aspects. The question and some preliminary results are provided below. Why do you think these differences exist?

“Please complete both sides of the chart below concerning your views on the importance of different aspects of health promotion capacity, and on your organisation’s actual performance.”

*Importance: 1 = Not at all, 5 = Very important; Performance: 1 = Very poorly, 5 = Exceptionally*

Fig 23. Contrasting importance and performance

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What do we need to make sure the outcomes of the course are sustained and people can move forward?

Who benefited most from the short course and whose needs weren’t met?
Evaluation of the DHS Core Health Promotion Short Course

Questions for course providers

Describe your role and its connection with health promotion.

Which courses did you deliver?

Have you had any feedback about the course?

How do participants’ responses to the course change over the 5 days?

How did you find the course materials? Were they sufficient/appropriate?

What do we need to make sure the outcomes of the course are sustained and people can move forward?

In this context, was ‘articulation into tertiary study’ a popular option with participants? Did they express interest in further formal study in health promotion?

Who benefited most from the course and whose needs weren’t met?

What guidelines should there be for the future delivery of the course, such as:

  o Options for future delivery/alternative ways of using the course materials?
  o Qualifications and accreditation of providers?
  o Is there a role for organisations such as VCHA as an auspicing body?
Evaluation of the DHS Core Health Promotion Short Course

Questions for CEOs/program managers

Describe your role and its connection with HP.

Have you undertaken the course yourself?

What has been the response within your organisation to the short course?

From your perspective, what were the outcomes of the short course?

What were the barriers to your staff undertaking the course? Was backfill an issue?

In the mail survey we asked short course participants about the importance of different aspects of health promotion and their organisation’s actual performance on those aspects. The question and some preliminary results are provided below. Why do you think these differences exist?

“Please complete both sides of the chart below concerning your views on the importance of different aspects of health promotion capacity, and on your organisation’s actual performance.”

Importance: 1 = Not at all 5 = Very important

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Fig 23. Contrasting importance and performance

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What do we need to make sure the outcomes of the course are sustained and people can move forward?
Evaluation of the DHS Core Health Promotion Short Course: DHS staff

What was the impetus for developing and implementing the short course?
What was DHS hoping it would achieve?
From DHSs perspective, what has changed as a result of the short course?
How is the short course positioned within the workforce development strategy?
What is the potential of the short course – where is it going?
How sustainable is the short course?
Appendix 4: Articulation into tertiary study (Deakin University)

Deakin University
School of Health Sciences
DHS 5 day Core Short Course in Health Promotion
Articulation into postgraduate courses

Requirements
Each application will be negotiated on an individual basis and may be for the Unit HSH 703 Health Promotion or for an elective in the Graduate Certificate/Graduate Diploma of Health Science (Health Promotion). An exemption will only be considered if participants have completed all five modules of the Short Course. Trainers of each Short Course have kept records of attendance for all participants which have been forwarded to the DHS and is available for the verification of applications for articulation.
In addition to Short Course attendance, applicants are required to complete a piece of reflective writing of 4500-5000 words, incorporating a practice activity about the implementation of the content of at least one module of Health Promotion short course into their role/organisation. This will involve:

Part One: Journal/Diary (equivalent of 2000 words)
  a) The keeping of a journal/diary about processes of change relative to health promotion, such as organisational issues, planning, barriers, enablers, capacity building, skill development, what changed, what you learnt or best practice issues.

Part Two: Summation and analysis (2500-3000 words)
  b) An analytic assignment component that incorporates links the journal/diary your work role and desired changes to broader frameworks of health promotion theory and research, and is based on understandings of published literature.

These two parts can be organised in either order. For example, you may identify an aspect of your practice to develop, consult the literature widely on good practice in this area (Part Two above), plan and implement change in your work role, and maintaining a reflective journal that allows you to reflect on how successful you have been in using the literature to effect change, facilitators, barriers etc (Part One above).

Alternatively, you could use the content of the short course to plan change in your work practice and implement it, maintaining a reflective journal (Part One). You could then analyse your experience of implementing change in your role and organisation, with reference to the published literature (Part Two).

The details of your reflective practice assignment must be negotiated with the relevant university before you commence it.

Contacts for further information:
Mr Bernie Marshall, School of Health Sciences, ph 92446822 or marshall@deakin.edu.au or Dr Helen Keleher, Coordinator, Postgraduate Studies, ph: 03 9244 6688 or hkeleher@deakin.edu.au