Health promotion audit protocol

Version 6.0

10 May 2012

First published 2012.

Acknowledgments

We would like to thank all who participated in the research project '*A structured systems approach to improving health promotion in Indigenous primary health care'* and tool development, including:

Research team and consultants: Nikki Percival, Lynette O'Donoghue, Ross Bailie, Beverley Sibthorpe, Christine Connors, Paula Convery, Michelle Dowden, Bernadette Shields, Komla Tsey, Dorothy Morrison, James Smith, Vivian Lin, David Thomas.

Groups involved in the research and ABCD projects: Project management committee, Aboriginal and Torres Strait Islander Advisory Group and ABCD project management team.

Services and people who participated in the research and tool development

Wurli Wurlinjang Aboriginal Health Service, Katherine, NT

Gunbalanya Health Service team, Oenpelli, NT

Marthakal Homelands Health Service, Elcho Island, NT

Barunga team, Sunrise Health Service, NT

Participants at HP CQI workshop, Chronic Diseases Network Conference 2009, Darwin

Nunkuwarrin Yunti Inc. Adelaide, SA

One21seventy management and staff, especially:

Katrina Lonergan, Information Systems Coordinator, One21seventy

Barry Scrimshaw, IT Manager, One21seventy

Alison Laycock, Project Officer, Health Promotion CQI Tools and Resources

Reviewers:

Christine Connors	Program Leader, Chronic Conditions Strategy Unit, Northern Territory Department of Health
Alex Walker	Health Promotion Coordinator, Wurli Wurlinjang Health Service- Gudbinji, Katherine
Dagmar Schmidt	Program Leader, Health Promotion Strategy Unit, Health Services Division, Northern Territory Department of Health
Paula Convery	Project Officer, Discipline of General Practice, School of Medicine and Public Health, The University of Newcastle
Ru Kwedza	Statewide Coordinator, ABCD and Primary Health Care (PHC) Quality Improvement (QI) Primary Health Care Governance Team Office of Rural and Remote Health, Queensland Health
Jenni Judd	Senior Research Fellow, Building Indigenous Research Capacity (BIRC), School for Public Health Tropical Medicine Rehabilitation Science, James Cook University
Nicola Young	Manager, Health Promotion and Community Health, Procare, New Zealand

Graphics and artwork

Geoff Todd, Visual Artist

Inprint Design

Thank you to Broken Hill Centre for Remote Health Research and the Northern Territory Department of Health for permission to reproduce illustrations from their publications.

Other contributors Thank you to the Quality Improvement Program Planning System (QIPPS) and contributors Gippsland Lakes Community Health and Northern Territory Department of Health for consent to use project descriptions on the QIPPS site.

Contents

Tables

Figures

Version control

Version	Release date	description
Early drafts	2007-2008	ABCD health promotion audit tools
3.0	19 February 2009	Updated community based health promotion audit tool
4.0	18 May 2009	Health promotion and community based activity audit tool
4.1	14 April 2011	Formatting and minor adjustments
5.0	26 July 2011	Revised sections; refined questions; addition of sketches
5.1	28 September 2011	Adjustments following review
6.0	29 April 2012	Minor Formatting adjustments only for upload and testing phase
6.0	14 May 2012	Launch

Note: The versions relate mainly to audit tool development as part of the Menzies School of Health Research project titled *'A structured systems approach to improving health promotion in Indigenous primary health care*'. Protocols were developed with versions 5 to 6.

Introduction

Using an audit tool for health promotion

Performance assessment of health promotion using the audit and feedback process is a relatively new field. Many health care practitioners are familiar with clinical audits that collect information by reviewing patient records and comparing care delivered against specific criteria - usually best practice guidelines.

Health promotion audits work the same way. Information about health promotion activities is collected in a systematic way and service delivery is compared against specific criteria. **The findings can then be used by staff to set goals to improve practice.** When repeated at regular intervals, health promotion audits provide information on changes in the quality of health promotion practice.

The purpose of the *Health Promotion Activity Audit Tool* is to:

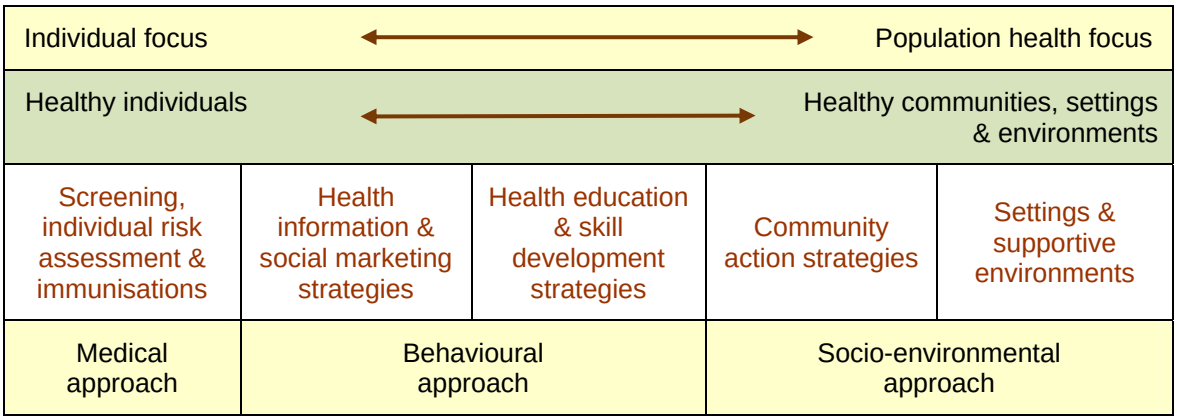
- determine how well health promotion activities align with best practice
- support services to assess and improve their practice.

The Tool has been developed using best practice guidelines, informed by mainstream and Aboriginal principles, key policy documents and through consultation with key stakeholders. As there is no universal consensus on what constitutes best practice in health promotion, this tool is based on the most commonly agreed elements and principles of good practice. It can help services align their service delivery efforts with these elements and improve understanding of effective health promotion in Aboriginal and Torres Strait Islander settings.

About health promotion

The Victorian Department of Human Services health promotion framework (Department of Human Services 2003:44) is useful for thinking about the range of approaches and strategies used in health promotion (see Figure 1). It illustrates the relationship between approaches and strategies, individuals and populations.

Figure 1 Approaches and strategies used in health promotion



(Adapted from DHS,Victoria 2003)

Five key elements and principles of good health promotion practice that have been identified are: planning, targeting, community participation, partnerships and evaluation. The elements come together into a health promotion planning cycle, with community participation central to successful practice (Figure 2).

Figure 2 Health promotion planning cycle

Planning: Detailed, collaborative planning processes are more likely to lead to successful health promotion activity design, implementation, monitoring and evaluation. A comprehensive plan will include a clear aim, goal and/or objectives and a range of strategies and actions. It will include a timeframe, people's responsibilities, evaluation measures and resource needs.

Targeting: Populations affected by a health issue need to be described and quantified. A distinction between a general population approach and the targeting of specific groups in higher risk categories is important. An alternative or complementary approach is to target settings associated with the groups at higher risk in order to change the environmental conditions in which choices are made and to develop relevant personal skills. Useful settings may include schools, workplaces and community facilities. Addressing specific health and lifestyle issues, especially those that relate to chronic diseases, is a priority.

Community participation: Research has demonstrated that 'the stronger the representation of the community and the greater the community involvement in the practical activities of health promotion, the greater the impact and the more sustainable the gains' (Lin and Fawkes 2005:34).

Partners: Health promotion activities should be linked to broader systems (especially education and health) as well as community-based organisations and groups (such as health boards) to be able to draw on necessary community vision, expertise and resources, and to link activities to other initiatives. Partners may reflect the range of social, economic, educational and other factors that determine health. (The records held by partner organisations may be important sources of information when doing an audit).

Evaluation: It is necessary to know how an activity is going or how it went, its affect and how it might be improved. Attention also needs to be given to achieving adequate coverage - that is, access by the target groups in numbers sufficient to achieve an impact. Other aspects that can be measured are changes in skills, knowledge and behaviours or in the health promotion environment, such as policy changes.

Summary

This protocol is an important resource for auditing and should be used in conjunction with *Improving the quality of primary health care: A training manual for the One21seventy CQI cycle*.

Health promotion auditing is designed to be a group process. Involve as many staff as possible.

Eligibility

The health promotion activity audit has been designed for use in a range of health care and related services.

To be eligible for inclusion in the audit, health promotion activities must have:

- involved at least one member of staff
- been implemented within the past 12 months
- involved groups of two or more people from your community
- some record or evidence of what was done.

Health promotion activities driven from outside the community or service **are eligible for inclusion** in the audit. For example, an activity facilitated by regionally based health promotion or health development staff, or an activity led by another organisation that involves your service as a partner.

One-to-one health promotion activities conducted in a health service, (e.g. brief interventions, immunisations and health advice to individuals) are not within the scope of this audit tool.

Information sources

Just as a clinical audit is based on client records, a health promotion audit is based on health promotion records. There are many possible sources of evidence of health promotion activities.

Methods of recording activities and documenting progress include activity plans, reports, minutes of meetings, field notes, posters or banners, spreadsheets, audio tape and film recordings, photos and paintings, media articles and journal articles about the activity. Other documentary evidence might be included in annual reports, program plans and updates, evaluation reports, reports to senior management or funding bodies. Your health centre/service may have other sources of evidence of the health promotion activity. Any of these types of evidence or sources of information can be used to complete the audit.

People outside your service who may have relevant information include:

- staff of services that keep relevant health promotion records
- people from partner organisations and groups involved in health promotion activities.

Information and evidence should be collated before the audit.

The importance of keeping records and gathering community information:

Some health promotion activities in the community may be led by other organisations or groups, but involve your clients and staff. These activities can be included in your audit, because of the service's role in linking clients with other health promoting services (e.g., Tobacco Action), and because staff provide local knowledge, expertise and community links for visiting workers. It is important to keep accurate records of these activities and of the contribution of your staff.

If you work in a health promoting agency that does not provide clinical services, you rely on accurate records about the communities and workplaces you serve and support in your day-to-day health promotion activities. Gathering and updating information about the community, program links, service networks and partnerships is important to working in a health promoting way.

Health services and related programs are often organised around different groups in the community (eg. well women, mums & bubs, people with particular health conditions, people who smoke tobacco). Regardless of the core business of your service, gathering information about the range of providers and programs for different population groups will provide a more complete picture of the range of primary health care services being delivered. This information is important for health promotion planning. It helps to ensure health promotion resources are directed where they are most needed.

If you currently lack records, improved record keeping can be a quality improvement goal that will also help with future audits.

Using the health promotion audit tool

A separate audit is completed for each health promotion activity.

This protocol provides:

- the rationale behind the questions in the audit tool and how they relate to best practice or current guidelines
- the questions to ask and a description of what information to look for in health promotion records
- an explanation of the options for selection.

The audit tool follows the health promotion cycle (Figure 2). Each of the six sections has a brief description to assist with collecting data.

Section 1	General information
Section 2	Planning of the activity
Section 3	Targeting of the activity
Section 4	Community participation
Section 5	Partners
Section 6	Evaluating the activity

Most questions have Yes/No/NA (not applicable) response options. For questions where more than one option can be chosen, circle or select the most relevant option. Some audit questions require the entry of free text information - be as brief as possible.

It is beneficial for the auditor to be familiar with local and national health promotion guidelines and principles, or to have basic health promotion knowledge. Some questions explain terms used. See the Health Promotion Glossary (Appendix 1) and the Health Promotion Resources section on the One21seventy website.

Although the audit tool can be completed by an individual with relevant experience, it is best when input comes from a group of people. Health promotion work involves all staff, and discussion encourages different perspectives, stories and resources to be brought to the process. The audit is one part of the quality improvement cycle, and is followed by reporting, goal setting and planning for improvement. A shared understanding about where the data came from is more likely to lead to team work and to commitment to quality improvement goals.

This protocol should be followed closely. The data collected on each question are validated when entered on the One21seventy website. Invalid entries will prevent progression to the next section.

Section 1 General information

This section describes characteristics of a health promotion activity delivered in the last 12 months, including the type of activity, how often it was delivered, whether it was part of a national campaign and the health promotion strategies used to conduct the activity.

Some general information may not be found in the records and will require some knowledge about the activity.

1.1 Activity ID

Assign a unique three-digit identification (ID) number for each health promotion activity audited, for example 001, 002. At data input, this three-digit number will be automatically prefixed with the tool and service IDs. To ensure each activity is only audited once in each cycle, the auditor should refer to the list of activities that includes each activity's key word and name. See examples in table 1.

1.2 Audit Date

The audit date should be recorded as the date you first start to audit your collection of records or information about the health promotion activity. It is recorded as dd/mm/yy

1.3 Name or title of the health promotion activity

Record the full name or title of the activity – the activity should be unique and distinguished from other activities.

1.3.1 Key word

This key word, or abbreviation, will be used to identify the health promotion activity in the summary report. It will be your team's 'identifying code' for the activity, making it easier to recognise the activity when comparing and interpreting data.

It is suggested you choose an identifying word or initials referring to the health issue, target group, strategy, setting, or partners. The number of characters is limited to eight. For example, **diabetes** is eight characters.

Table 1 Identifying word or initials for health promotion activity

1.3 Name of title or activity	1.3.1 Examples – key words
Community Healthy Skin Days Project	Skin
Keeping Men Well and Strong Project	Men
Community Diabetes Project	Diabetes
Youth Sexual Health Program	YSHP
Baby Health Calendar Project	Baby
Healthy Lifestyle Festival	Lfestyle
Learn and Play Program	Playgrp

If more than one activity addresses the same issue, use different key words. For example, two activities addressing smoking could be 'smoking1' and 'smoking2'.

1.4 How often was the activity delivered in the last 12 months?

Some health promotion activities are designed to be delivered once, while some are ongoing and are delivered regularly over a period of time. Knowing how often an activity is delivered influences our expectations of planning and record keeping, community participation and evaluation methods. It helps the team to interpret and use data about health promotion activities.

Was the health promotion activity a once-off activity - delivered only once and not expected to be done again?

Was it an ongoing, continuous activity - delivered on a regular basis throughout the year (e.g. monthly or weekly)?

Was the activity part of an ongoing and intermittent program (e.g., delivered once a year, each year)?

Is there another way to describe how often the activity is, or was, delivered?

Using the descriptions provided, **circle** the number next to the most appropriate description:

1-Once-off

2-Ongoing / continuous

3-Ongoing / intermittent, or

4-Other

If you circle **other**, write a word or phrase to describe how often the activity was delivered.

Table 2 How to determine the category for how often an activity was delivered

How often	Examples
Once-off activity	– 'Play and Learn', a health promotion activity that developed a guidebook for setting up and implementing themed weekly playgroup activities. – A community fitness event to celebrate the selection of a local football player onto a league team.
Ongoing, continuous activity	– A weekly education session at school. – A monthly interactive display at the football match. – A workplace or organisation policy. – Ongoing continuous diabetes education, information and skills development program,
Ongoing, intermittent activity	– World No Tobacco Day (held each year). – Annual Healthy Lifestyle and Cultural Festival. – Australia's Healthy Weight Week Activity.
Other	– Scabies campaign delivered when prevalence is high in the community. – Safe drinking awareness program timed to support policy changes in alcohol availability, with a follow on evaluation in three months.

1.5 Indicate the type of health promotion activity

Knowing how an activity is initiated contributes to an overall picture of the activity, which assists when comparing and interpreting data.

Was it part of a national campaign – such as a national awareness week or day for a health issue?

Was it part of a targeted regional or state program – such as a state government program to support nutrition and physical activity?

Was it locally initiated at the community level – such as by staff within an organisation or by community residents?

Is there another way to best describe how the activity came about?

Select the description that best matches the type of health promotion activity. Circle the corresponding number **1, 2, 3 or 4.**

If you circle **4-Other**, describe the type of health promotion activity delivered, based on how it was initiated.

Table 3 Examples to help determine the type of health promotion activity

Type of activity		Examples
1	Part of a national campaign (eg. awareness week for a health issue)	– Community awareness activity initiated and lead by health centre staff, as part of Australia's Healthy Weight Week. – Cultural and family events organised in partnership with a child care organisation to celebrate National Aboriginal and Islander Children's Day
2	Part of a targeted regional or state program	– Community Kitchens Program across four communities in a NSW region. – Resources and training from Queensland's Physical Activity and Nutrition Out of School Hours Care Program. – Smoke free workplaces campaign
3	Locally initiated	– Healthy Lifestyle Festival, covering a range of health and lifestyle issues and organised by community staff and volunteers. – 100 Quit Club, a quit smoking project initiated by health staff in response to local smoking data and targeting local residents. – Scabies education designed and delivered by Aboriginal Health Workers, using resources in local language. – Diabetes self-care support program, where people come together each week to cook healthy food and have lunch together, supported by the diabetes educator and other health staff.
4	Other	– An activity that does not fit clearly into any of categories 1 - 3, or works across two or more categories, such as (below) : – Healthy cooking demonstrations in the local store, initiated and presented by school students to complement a government nutrition education program.

1.5.1 If part of a national campaign, indicate how resources were developed or provided

Select the description that best matches how resources used in the activity were developed or provided.

Circle **1-if locally developed based on locally identified needs** or

Circle **2-if provided by the national campaign**

Circle **9-N/A** if the activity was not part of a national campaign.

It is possible that resources used as part of a national campaign activity are not accurately described by 1 or 2 (for example, if they came from some other source, such as an overseas or state campaign).

Circle **9-N/A** if this is the case.

Circle **1-**if locally developed resources are used to supplement resources provided by a national campaign**.**

Table 4 Examples of how health promotion resources were developed or provided

Resources		Examples
1	Locally developed based on locally identified needs	– Quit smoking brochures that include local stories about quitting, or data about how many local health centre clients have successfully quit, in addition to Quitline contact details.
2	Provided by the national campaign	– Generic Quitline materials and web resources provided by the national campaign.
3	Not Applicable	– Activity was not part of a national campaign – Resources were developed for use with Indigenous populations in another country, e.g., New Zealand, Canada

1.6 What health promotion strategies were used in the activity?

Four broadly recognised strategies are used in health promotion (with groups of people) (Figure 1, p 1).

1.6.1	Health information and/or social marketing*	Health information, mass media (or community wide media) are used to raise people's awareness and increase knowledge about health issues/problems and healthy lifestyles. An activity may use commercial marketing techniques to influence behaviour.
1.6.2	Health education and/or skill development	Health education and/or training are used to change people's health behaviours and/or develop skills to enable them to adopt healthier lifestyles.
1.6.3	Community action or development	Community action or community development strategies support and build people's capacity to decide their own needs and to help meet them through active participation and involvement.
1.6.4	Creating settings and supportive environments	Changes are made to the environments where people live, work, learn and play to support them to make healthy choices. Strategies include developing or making changes to policies, laws and regulations (eg. smoke free workplace policies, alcohol licensing laws).

Table 5 Health promotion strategies are put into action through health promotion activities

Health promotion strategy	Example health promotion activities
1.6.1 Health information and/or social marketing	World No Tobacco Day Australia's Healthy Weight Week Drug Action Week Cancer awareness campaigns
1.6.2 Health education and/or skill development	QUIT Healthy Cooking course AFL school holiday program Men's Sheds program (also see below)
1.6.3 Community action or development	Youth mentor program Women's camp Community health advisory committee Community alcohol action group
1.6.4 Creating settings and supportive environments	Smoke free workplace policy Healthy school canteen Liquor license conditions Men's Sheds program

Some health promotion activities focus on only one strategy (for example, education), but most use several strategies. Evidence tells us that using a range of health promotion strategies is more likely to result in people making and maintaining healthy choices.

Table 6 Many health promotion activities use two or more strategies.

Example Activity	Strategies that may be used
Community program to reduce alcohol related harm	– Media advertising / information about health and social effects of harmful levels of drinking (1.6.1) – Education and skill development about safe drinking (1.6.2) – Community action group lobbied the liquor licensing body and liquor outlets, leading to (1.6.3); – changes in local regulations to reduce the hours alcohol can be purchased (supportive environment) (1.6.4) – changes in local policy to restrict alcohol sales per person (supportive environment) (1.6.4)

Indicate the strategy, or strategies, used in the activity.

Circle **1-Yes** or **0-No** for strategies 1.6.1 to 1.6.4.

Circle **0-No** if you determine that none of the four strategies were used.

Remember - this audit does not include individual health promotion strategies such as screening, individual risk assessment and immunisation. Therefore, do not include one-on-one activities such as brief interventions and health checks, which are audited using One21seventy clinical audit tools.

1.7 Auditor initial & surname

Record the initial and surname of the person who has responsibility for completing the audit.

1.8 Other audit participants

Record initials, surnames and positions/roles of other people participating in the audit.

1.9 Indicate the information or evidence that will be used to complete this audit

Many sources of information or evidence can be used to complete the audit. Most sources of information can be grouped within four categories.

1.9.1 **Plans** can be health promotion activity plans, actions plans, business or strategic plans, budget estimations and so on. Plans might be recorded on an external database such as the health promotion and/or community development planning and evaluation template on the Quality Improvement Program Planning System (QIPPS).

1.9.2 **Reports and communication records** can be, for example, interim activity or project reports, reports for managers or funding bodies, field notes, meeting notes, audio recordings and emails, spreadsheets of money spent, photos, and evaluation summaries. Records may be from within your service, be kept by visiting staff, partner organisations or groups involved in health promotion activities, or be recorded on a database such as QIPPS or One21seventy.

1.9.3 **Health promotion activity products** can be, for example, posters, banners, paintings, community fact sheets, brochures, flip charts, booklets/guides, health calendars, film or audio products developed with/for the target audience as part of the activity. They might include websites, blogs, mobile phone messages, and social networking posts.

1.9.4 **Dissemination products** can be, for example, community presentations and feedback products such as PowerPoint slides, newsletters, policy briefs, journal articles and conference presentations about the activity. They can be media stories about the health promotion activity in newspapers, on radio or TV. Dissemination products tend to be those that aim to share information about the activity with a wider audience (beyond the activity's target group).

Sometimes it is difficult to decide how to categorise information. If this is the case, simply be consistent in the way you categorise information sources for each activity you audit. That way you may be able to observe a relationship between sources used and data quality, and to observe patterns in health promotion record keeping within your service.

Circle **1-Yes** or **0-No** for each of the four categories listed.

Circle **1-Yes** for **1.9.5 Other** if you are using a source of information that does not fit into any of the four categories. Specify the source of information in the space provided.

Section 2 Planning of the activity

This section describes the planning of each health promotion activity delivered in the last 12 months. It focuses on what was recorded as part of the planning process, and the sources of evidence or information used to plan the health promotion activity.

2.1 Is there a recorded plan for the activity?

Whatever your planning processes for health promotion activities, they should result in some record that outlines the proposed activity. A comprehensive planning process will ideally result in a detailed plan that includes what the activity is about, why you are doing it, what it is trying to achieve, how it will be implemented, where, when and with whom, what resources are needed, who will be involved in implementation, how long it will take, how you will find out if the activity did what it set out to do, and so on.

For examples of comprehensive plans, see the 'public library' section of the QIPPS site, *http://www.qipps.com/*. For a planning process and template, see the 2007 Northern Territory Public Health Bush Book, *http://www.health.nt.gov.au/Health_Promotion/Tools_for_Good_Practice/index.aspx*

Circle **1-Yes** if the activity was based on a structured plan, and if you have a record of that plan

Circle **2-No** if there is no recorded plan for the health promotion activity.

When entering the data online if you select **0-No**, or **9-N/A** for questions 2.1.1 to 2.1.6., **9-N/A** will automatically select.

If you selected **1-Yes**, indicate what is included in the plan, as follows. You must circle **1-Yes** for at least one of 2.1.1 to 2.1.6.

2.1.1 The aim or goal and/or objectives of the activity

Circle **1-Yes** if there is a clear statement of what this activity hopes to achieve. The aim or goal or objective is usually the planned, longer term outcome of the activity and should describe what will be different at the end of the activity. Some plans record an overall aim or goal, as well as objective for different strategies or parts of the activity. Objectives tend to include measurements and timeframes.

Either approach is acceptable for planning a health promotion activity. The terms used are less important than knowing what the activity intended to do or achieve.

Circle **0-No** if the plan does not include a goal, aim or objective.

Table 7 Examples of activity aims or goals and objectives

Activity aim or goal	Objectives	SMART Objectives are:
To improve the well-being of Health Service clients with type 2 diabetes through the creation of a supportive environment that promotes self-management and provides comprehensive care.	1. To increase participation of clients with type 2 diabetes in weekly cooking classes and lunches by 40% over the next 4 months. 2. To double patient participation in self-measurement and recording of BGL, weight and waist circumference, using the health centre's self-management trolley, over the next 12 months.	**Specific** **Measurable** **Achievable** **Realistic** **Timeframe**
Improving the health and well-being of local Koori Communities of [name] , [name] and [name].	1. Increase the capacity of local services to build trusting relationships and work with the local Koori community to address their health needs. 2. Increase Koori children's participation in structured physical activities, to contribute to the formation of regular patterns of participation. 3. Increase water safety skills and confidence in the water as a means of reducing the incidence of drowning among Indigenous children aged 0 to 5 years. 4. Increase the confidence of the local Koori community to access the YMCA facility and increase participation in swimming independently of the program. 5. Increase the capacity of the local Koori community to identify and address their own health needs (and those of their children) (QIPPS)	

2.1.2 The specific strategies that make up this activity

Circle **1-Yes** if there is a clear description of how the activity will be implemented.

Circle **0-No** if there is no record of how the activity will be (or was) implemented.

In the context of planning the health promotion activity, the strategies are the methods used to achieve the activity's aim/goal or objective - the 'how' or 'what will be done'. Take care not to confuse these 'strategies', or planned actions, with the broad health promotion strategies described in Section One.

Combinations of health promotion strategies are usually more effective in achieving change, as the following examples indicate.

Table 8 Examples of strategies used to achieve a health promotion objective.

Objective	Related strategies included
Improve understanding of key elements of group self-management models essential to supporting sustained behaviour change and community control in remote Aboriginal communities in relation to preventable chronic disease	Whole of community approach: – Softball competition to be set up. – Establish transport between Outback Store and [station] to improve access to nutritious food. Group strategies to be based on what women asked for: – Education sessions on: healthy meals, how much a family should eat in a day, what the medications are for, how food and exercise work to control diabetes, softball coaching, kidney health, options for exercise, other education needs [that] arise over time. – Increasing physical activity and exercise: walking softball, aerobics, yoga, relaxation. – practical sessions for preparing easy healthy meals with ingredients that are not too expensive and are usually available at either the station store or [the community] store. Multi sectoral approach: – Diabetes educator, nutritionist, sport and recreation officer, health promotion officer, Aboriginal health worker, community based workers and remote area nurse to contribute cooperatively. (adapted from QIPPS)
Implement a smoke free workplace policy at the Health Service within 6 months	Offer a range of strategies to support staff to quit smoking. Staff set up a quit support group Put up signs about the policy to inform patients and visitors about the policy. Give staff tips about ways to remind each other and patients/visitors, about the policy when necessary. Combine these strategies with brief intervention training for staff and regular updating of referral and quit support information.

2.1.3 The people responsible for implementing each specific strategy

The people responsible could be staff from the health centre or from other agencies/organisations, volunteer members of the community or interest groups, visiting health promotion officers or outreach workers, and so on.

Circle **1-Yes** if there is a clear statement of who will take responsibility for implementing each of the strategies.

Circle **0-No** if there is no record of who is responsible for putting each strategy into action.

If there are names against some strategies and not others, circle the answer that reflects the majority one way or the other.

2.1.4 A timeframe for completion of different strategies

Circle **1-Yes** if there is a clear statement of when the strategies are expected to be completed.

For example: convene a project advisory group meeting within the first month; implement the healthy school canteen policy by the end of term two; complete and publish resources within a specified timeframe; conduct 'healthy community day' on a specific date; establish a vegetable garden at the supported care facility by the end of the project.

Circle **0-No** if there is no record of a timeframe or timeline.

2.1.5 Criteria or indicators to measure progress in achieving the activity's goal

These criteria or indicators are the **evaluation measures**, or how you will measure what has changed as a result of the activity.

Circle **1-Yes** if there is a description of any criteria, indicators or measures that will be used to see whether the activity is or has been, successful. The information collected needs to indicate whether the activity is on track to achieve the aim (goal, objective), or whether the aim has been achieved. See the table below for examples of some measures.

Circle **0-No** if there is no record of the measures that will be used to monitor or evaluate the activity.

Table 9 Examples of criteria or indicators to measure change

Focus of aim/goal or objective	Criteria or indicators to measure change
Changes in health outcomes	How many and which population groups have diabetes?
	How many and which population groups have died from heart disease?
	How many babies are /aren't growing well?
	Prevalence of scabies?
Changes in healthy lifestyles	How many people smoke tobacco (males, females, ages)?
	How many people drink alcohol at safe levels? (males, females, ages)?
	How many people in target group participate in regular exercise?
Changes in service delivery	Provision of preventive services.
	Number of people in particular population groups accessing services.
	Number of clients identified as Aboriginal and/or Torres Strait Islander.
	Percentage of people with type 2 diabetes successfully using self–management techniques.
Changes in environments	What people buy from the store. Has food supply or quality improved?
	What percentage of the population have a safe and functional home?
	How many people in community/population have access to recreational facilities? Restricted access to tobacco & alcohol.
Changes in knowledge, skills and attitudes	Knowledge about which foods are low in sugar; what smoking does to the body; how drinking alcohol affects diabetes; how medications and other drugs interact.
	What do people feel about others who drink a lot of alcohol? Do people drink alcohol and drive?
	How are families supporting people with mental health problems?
Changes in community participation and empowerment	People participating in community meetings; people talking about their community and planning together; people lobbying for services; community groups taking on decision making power and responsibility.
	Which groups and how many are participating in cultural and sporting activities?
	Which groups and how many are working together on a health promotion activity?
Changes in policy, legislation, resource allocation and organisational practice	No smoking policies
	Policies about percentage of high fat foods and low fat alternatives available at takeaway food outlets and/or school canteens.
	Close the Gap measures to resource smoking cessation activities and to increase access to mainstream general practices and health care by Aboriginal and Torres Strait Islander people.
	Increase in number of health promotion positions, such as Tobacco Action Workers, Healthy Lifestyle Workers, Health Promotion Coordinators within services.

Note: For information about types of evaluation and how they relate to the listed criteria or indicators, see 'Section 6, Evaluating the activity'.

2.1.6 Budget and/or resources

The budget plan may include an allocation of project funds or a spreadsheet of estimated costs, such as staff time allocated, travel costs, purchase of equipment (e.g. sports equipment) and consumables (e.g. food for cooking sessions), venue hire, health promotion activity products, evaluation costs, dissemination costs such as conference presentation costs and so on.

A statement of resources may include existing resources in the organisation, which are needed to implement and evaluate the activity. They might include, for example, charts, guidelines, clinic equipment, audio-visual equipment and resources, computers, butcher paper and pens, a storytelling board or painting, use of a health centre vehicle and meeting room, printing facilities and so on.

Circle **1-Yes** if the plan included a budget and/or statement of resources needed to deliver the health promotion activity.

Circle **0-No** if the plan does not include a budget and/or statement of resources.

2.2 Is there a record of sources of information used to identify the issue addressed by this activity?

Sources of information used to identify issues are important because they help to justify and prioritise health promotion issues and activities. For example, while smoking is likely to be just one of several identified health issues, your records may indicate that smoking was the highest priority for health promotion. Information used to identify the health issue may have come from a community consultation, from the health board's strategic plan, from a regional or state-wide initiative, from local health centre statistics or other sources.

Sources of information may be reflected in the activity goal or objectives (refer to question 2.1.1) - look at what the activity hoped to achieve and where the information came from (e.g. the activity may have aimed to reduce smoking rates by a specific percentage, starting with baseline data about what percentage of adults smoke).

Circle **1-Yes** if your health promotion records document the sources of information used to identify the health or lifestyle issue addressed by this activity.

Circle **0-No** if you have no records of the sources of information used to identify the health or lifestyle issue**.**

If you circle or select **0-No**, circle **9-N/A** for 2.2.1 to 2.2.6.

If you circle **1-Yes,** answer 1-Yes or 0-No for 2.2.1 to 2.2.6. (You must circle or select **1-Yes** for at least one).

2.2.1 Community stories

Local people tend to know what the issues and problems are, how to solve them and who needs to be involved. Long term residents tend to know community history, local service history and what ideas and approaches have and haven't succeeded in the past.

For example, you may have field notes of interviews with local residents, or audio tapes, which helped to identify the issue. Or you may have a photo of a painting that told an important story, which became the focus of the activity. A consumer questionnaire, or a focus group, may have identified the issue addressed by the activity? A series of photos taken in the community may have highlighted the issue.

Circle **1-Yes** if there is a record that information obtained from the community was used to determine the issue or problem address by this activity.

Circle **0-No** if there is no record of community stories informing the issue.

2.2.2 Other programs or activities

Other programs or activities can be important when determining the issue to be addressed by a health promotion activity, for example; school programs, cultural activities, store records, employment agency data, economic or environmental development programs, information about previous or current programs or research projects in the community. Results or outcomes of previous efforts in the community could have been important in justifying the issue or problem addressed by this activity.

Circle **1-Yes** if there is a record that information from other activities and/or programs was used to determine the issue or problem.

Circle **0-No** if there is no such record.

2.2.3 Literature / books / reports

Information from journal articles and other literature, books and reports can describe background details, causes and factors that contribute to the problem or issue.

Items might include best practice guidelines, government reports and publications, project evaluations and your service's previous One21seventy health promotion activity audit reports. Formats might be hard copy, DVD or web publications.

Reported research findings may identify priority issues that need to be tackled. The health promotion activity may be part of research transfer strategy (using health research for change).

Circle **1-Yes** if there is a record that information from literature, books and reports was used to determine the issue or problem addressed by this activity.

Circle **0-No** if there is no such record.

2.2.4 National, regional and/or local community health and surveillance data

These types of data include, for example, how many people live in the community and ages; how many people have jobs; how many and which population groups are affected by an issue or problem, or have factors that put them at greater risk of developing a particular health problem.

The data might be obtained from the Australian Bureau of Statistics, Australian Institute for Health and Welfare, state and territory government departments, health service or community population registration lists, health and other information systems (eg. Ferret, Communicare, Medical Director).

When you compare local health surveillance data with state/territory and national data sets, you may find that the community or population group follows trends, is doing better in some measures, or compares poorly for some measures. This evidence can justify tackling a particular issue through health promotion, or can identify several issues which can then be presented to community representatives to prioritise.

Table 10 Examples of using health and surveillance data to determine the issue addressed

Health promotion activity addresses:	Health and surveillance data used
Chronic disease self-management	Clinical audit tools and a systems assessment tool were used to collect data on how the health service was performing, as part of the service's quality improvement system. When the service team interpreted the data, chronic disease self-management was identified as an area that needed to be improved. A comparison of health service data with data from the local 'cluster' and the state confirmed the service's decision to prioritise improvement efforts in this area.
Child health and growth	Local community health data: Child health surveys over several years indicated a continuing increase in the percentage of children who are failing to thrive, identifying child health and growth as a problem to be addressed. National data: Comparing national data sets for the general population and data about Aboriginal and Torres Strait Islander Australians helped to highlight health inequities and confirmed that child health and growth is a priority issue for health improvement nationally.

Circle **1-Yes** if there is a record that information obtained from data sets or statistics about community or population health status was used to determine the issue or problem addressed.

Circle **0-No** if there is no record of data use.

2.2.5 Conferences, seminars, meetings, training

Information about health issues is shared at conferences, seminars, meetings, training sessions, or in conversations with experts or professionals in the field.

Circle **1-Yes** if there is a record that information obtained by talking with, or hearing from, other people at such events was used to determine the issue or problem addressed by this activity.

Circle **0-No** if there is no record of this source of information being used.

2.2.6 Other, please specify _____

Circle **1-Yes** or **0-No** to indicate whether other sources of information were used to determine the issue or problem.

If **1-Yes**, please specify the source/s in the space provided (maximum of 250 characters)

2.3 Is there a record of the sources of information used to determine what was done (strategies) to address the issue?

Planning how an issue will be addressed (the way we go about an activity) is important. You need evidence that the strategy you used was the best way to deliver this activity. You may have referred to what other people had reported on, or what had previously been done to achieve change in your community. If necessary, check the activity strategies (refer to question 2.1.2 – the planned actions). Think about how you decided on those strategies and not others, and whether you have a record of that process.

Circle **1-Yes** if information sources were used to determine how the activity was implemented (the strategies).

Circle **0-No** if there is no recorded use of information to determine the strategies, or what was done.

If you circled **1-Yes**, which of the following sources of information were used to determine the strategies?

You must circle or select **1-Yes** for at least one of 2.3.1 to 2.3.6.

If you circle **0-No**, circle **9-N/A** for 2.3.1 to 2.3.6.

2.3.1 Community stories

Circle **1-Yes** if there is a record of information being obtained by talking with community people about services or strategies that have been implemented, or by finding out from people in the community about how they wanted the issue to be addressed. Community stories may also have described the relationships people have in the community, and the most appropriate people to implement particular strategies.

Circle **0-No** if there is no record of community stories being used to determine what was done.

2.3.2 Other programs or activities

Other programs or activities may have provided information on useful and appropriate strategies, and about what has worked well in this community, or in similar communities and population groups, in the past.

Circle **1-Yes** if there is a record that information obtained about other programs within your organisation, or other organisations' activities, programs or research, was used to determine strategies for this activity.

Circle **0-No** if there is no record of using other programs or activities to determine strategies.

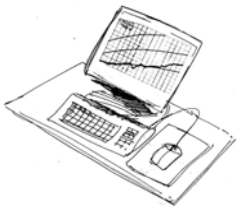
2.3.3 Literature / books / reports

Best practice guidelines, government reports and publications, project evaluations, research reports, your service's previous One21seventy health promotion activity audit reports and other publications (in various formats) might have provided information on strategies that have worked well when tackling similar health issues with similar population groups.

These documents might have provided background information about particular strategies, theoretical frameworks, and other contextual information to help inform the development and design of the health promotion strategies used in this activity.

Circle **1-Yes** if there is a record of information being obtained from literature, books and reports to determine strategies.

Circle **0-No** if there is no such record.



2.3.4 National, regional and/or local community health and surveillance data

Circle **1-Yes** if there is a record of community statistics or population health status data being used to determine the strategies for this activity.

Circle **0-No i**f there is no record of using community statistics, health and surveillance data to determine strategies.

Table 11 Examples of using health and surveillance data to determine strategies

Health and surveillance data used	Determining health promotion strategies
Data about how many people have jobs in a community, gender of workers, types and places of employment.	Can help the team decide if it is worthwhile to work on changing workplace policies, and to use workplace education strategies, to tackle a particular issue (e.g.alcohol use). It can help to identify workplaces to target. It can help determine whether parents can be accessed through childcare services.
Data about how many people, and which population groups, in the local community have the highest incidence of diabetes.	Might be the starting point to: – target social marketing messages – plan and promote food shopping 'tours' of the local supermarket – determine whether to offer healthy cooking classes, based on how many people live independently and cooking facilities available to them – decide when would be the best time to offer activities, such as exercise programs.

2.3.5 Conferences, seminars, meetings, training

Professional sharing of information underpins many of the decisions we make about what to do and how to do it. Strategies for health promotion are presented and discussed at conferences, seminars, meetings, training sessions, or in conversations with experts or professionals in the field.

Events may be local, regional national or international. They may be part of a formal study program or offered through informal networks. Events may be specific to health promotion, to other health approaches, or may involve professional disciplines that relate to the broader social and economic determinants of health.

Circle **1-Yes** if there is a record that information obtained by talking with, or hearing from, other people at such events was used to determine the strategies used in this activity.

Circle **0-No** if there is no record of this source of information being used to determine strategies.

2.3.6 Other, please specify _____

Circle **1-Yes** or **0-No** to indicate whether other sources of information were used to determine strategies for this activity.

If **1-Yes**, please specify the source/s in the space provided (maximum of 250 characters).

2.4 Is there a record of the sources of information used to determine how the activity was (or will be) evaluated?

The idea for the evaluation method may have come from information about evaluation methods used effectively in the past. For example, you may have had evidence to suggest an evaluation questionnaire worked better when someone known to participants asked the questions or, in contrast, when privacy could be assured. It may be necessary to check the activity evaluation plan (refer to question 2.1.5), which might include a record of what you planned to measure and how the information would be collected.

Circle **1-Yes** if information sources were used to decide how this activity was (or will be) evaluated.

Circle **0-No** if there is no recorded use of information to determine evaluation methods.

If **1-Yes**, which of the following sources of information were used to determine the evaluation methods for this activity? You must circle **1-Yes** for at least one of 2.4.1 to 2.4.6.

If you circle **0-No**, circle **9-N/A** for 2.4.1 to 2.4.6.

2.4.1 Community Stories

Local people can help decide what information to collect when evaluating the activity, and the best way for this to be done in their community, group or setting.

For example, you might seek advice about whether most participants would prefer to be part of a focus group evaluation, or for responses to be confidential. Community residents might advise on best times to evaluate, based on knowledge of business that closes a remote community to outsiders or takes many people away. Health workers may have decided that, to gather meaningful information about what people have learnt or do differently, it was important to conduct the evaluation in local language. Observation of daily activities may help to determine evaluation methods.

Circle **1-Yes** if there is a record that information obtained by talking with community people about what, how and when to evaluate this activity was used to determine evaluation methods.

Circle **0-No** if there is no record of community stories being used to determine evaluation.

2.4.2 Other programs or activities

Knowing what and how other program or activity evaluations were done, and what information gathering tools were developed and used successfully, is useful when planning how to evaluate health promotion. Information may have come from mail-out advice (for example from a national campaign) or a resource kit sent to your service. You may have downloaded an evaluation tool, or read about evaluation methods successfully used by other program areas, or for similar activities.

Circle **1-Yes** if there is a record that information obtained from other activities or programs was used to determine how this activity was evaluated.

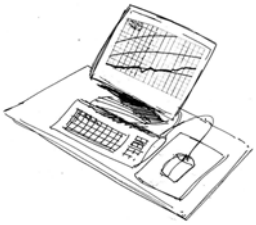
Circle **0-No** If there is no record of using other programs or activities to determine evaluation methods.

2.4.3 Literature / books / reports

Information from literature, textbooks and reports can provide information about effective evaluation methods with similar population groups, settings and issues. Publications might include best practice guidelines; government or organisation reports and discussion papers. Evaluation reports about other projects and your service's previous One21seventy health promotion activity audit reports can be particularly useful.

Circle **1-Yes** if there is a record that information obtained from literature, textbooks and reports was used to determine evaluation methods for this activity.

Circle **0-No** if there is no such record.



2.4.4 National, regional and/or local community health and surveillance data

Data can be useful when developing indicators, criteria or measures to show changes that have resulted from health promotion activities. An example is the gathering of baseline community or health data before the activity starts and after the activity has been completed, in order to measure change.

Circle **1-Yes** if there is a record of community statistics or population health or clinical indicator data being used to determine evaluation methods for this activity.

Circle **0-No** if there is no record of using community statistics, health and surveillance data to determine evaluation.

2.4.5 Conferences, seminars, meetings, training

Evaluation approaches and outcomes are regularly presented and discussed at conferences, seminars, meetings and training sessions. Specialised professional development events and access to evaluation experts in the field can provide practitioners with additional opportunities to learn about what evaluation methods are likely to work well in specific settings and with particular groups, issues and activities.

Circle **1-Yes** if there is a record that information obtained by talking with, or hearing from, other people at such events was used to determine evaluation methods for this activity.

Circle **0-No** if there is no record of this source of information being used to determine evaluation methods

2.4.6 Other, please specify_____

Circle **1-Yes** or **0-No** to indicate whether other sources of information were used to determine evaluation methods for this activity.

If **1-Yes**, please specify the source/s in the space provided (maximum of 250 characters).

Section 3 Targeting of the activity

Targeting health promotion activities helps to focus efforts and increases the likelihood of good results. It can ensure that efforts are directed where needed and where there is most potential for benefit.

Groups and gender: Targeting helps develop the right messages and actions, and the best way of sharing or implementing them with a particular group. For example, you would share stories and messages about the effects of smoking in a different way with a group of primary school students and a group of pregnant women. When working with family groups, messages and strategies might be strengthened by the support and leadership of participating elders. Activities are often designed around gender based groups in order to respect cultural norms.

Settings: Health promotion can be done anywhere and it is best done where the group is comfortable, and in settings that relate to the messages or actions (eg. an activity about healthy food choices and labelling conducted at the store). There are many possible settings for health promotion, such as schools, health centres, workplaces, bush camps, outstations, women's centres, men's sheds, youth centres, sports venues, stores/supermarkets, resource, art or cultural centres, churches. Suitable settings can be places of significance for skin/clan or family groups.

Specific health and lifestyle issues: Evidence tells us that more Aboriginal and Torres Strait Islander peoples have chronic conditions, such as diabetes and heart disease, than the general Australian population. Addressing commonly known contributors of chronic diseases, such as smoking, poor nutrition and lack of exercise, is important to reduce the numbers of people developing chronic conditions.

3.1 Do records indicate the group of people the activity intended to benefit?

Circle **1-Yes** if there is a record of the group of people the activity intended to benefit.

Circle **0-No** if there is no record of the target group for this activity.

If you circle **0-No**, circle **9-N/A** for 3.1.1 to 3.1.10.

If you circle **1-Yes,** you will need to circle **1-Yes** or **0-No** for each group as listed below. You must circle **1-Yes** for at least one of 3.1.1 to 3.1.10. Many health promotion activities target two or more groups.

3.1.1 General Population	3.1.6 Young Adults
3.1.2 Infants	3.1.7 Adults
3.1.3 Pre-school Children	3.1.8 Elderly people
3.1.4 School Children	3.1.9 Parents
3.2.5 Adolescents	3.1.10 Families

3.2 Do records indicate the gender of the target group?

Circle **1-Yes** or **0-No**.

If you circle **0-No**, circle **9-N/A** for 3.2.1.

If you circle **1-Yes,** Circle 1, 2 or 3 for question 3.2.1, to indicate whether the activity was for males only, females only, or both males and females.

3.3 Do records indicate where or in what setting/s the activity was delivered?

As described above, community settings can be places of significance for skin/ clan or family groups, schools, workplaces, bush camps, outstations, women's centres, men's sheds, youth centres, sports venues, community stores/supermarkets, resource or art centres, cultural centres, churches, childcare centres, residential care facilities and many other possible settings.

Circle **1-Yes** if there is a record of where (or in what setting/s) the activity was delivered.

Circle **0-No** if there is no record of the delivery setting.

If you circle **0-No**, circle **9-N/A** for 3.3.1.

If you circle **1-Yes**, Circle 1, 2 or 3 for question 3.3.1, to indicate whether the setting was the health centre, a community setting, or whether the activity was delivered in both health centre and community settings.

3.4 Do records indicate whether the activity addressed specific health and lifestyle issues?

Circle **1-Yes** if records indicate the activity addressed specific health and lifestyle issues.

Circle **0-No** if there is no record of issue/s addressed.

If you circle **0-No**, circle **9-N/A** for 3.4.1 to 3.4.7.

If you circle **1-Yes,** you will need to circle **1-Yes** or **0-No** for each issue as listed below. Some health promotion activities target two or more health and lifestyle issues. You must circle **1-Yes** for at least one of 3.4.1 to 3.4.7.

3.4.1 Tobacco Smoking
3.4.2 Nutrition/Diet
3.4.3 Alcohol/drinking
3.4.4 Physical Activity/exercise
3.4.5 Mental Health/social and emotional well-being
3.4.6 Environmental and living conditions
3.4.7 Other, please specify_____ (maximum of 250 characters)

If you circle **1-Yes** for question **3.4.7 Other**, specify the issue addressed by the activity. For example, strong culture, injury prevention, ear health, sexual health, gambling.

Section 4 Community participation

Community participation is central to 'bottom up' health promotion approaches that enable people to identify their issues, solutions and actions and to determine program design, delivery and evaluation. Community participation enables individuals and groups in the community to contribute to debate and decision-making. This leads to people having greater control over the social and environmental determinants of health. Participation is the foundation of individual and community capacity building*.

There are a range of opportunities for community members to participate in health promotion activities. These might include community meetings, interest groups, health boards, committees, reference groups, employment in health services or other relevant community organisations and services (eg. education, housing, business development, landcare, justice), as researchers and in activity implementation.

There are varying levels of community participation, ranging from minimal (eg. consulted to identify the issue addressed); to equal partnership in decisions and actions; to community initiated action and control (eg. initiating, managing and implementing the entire activity). The questions in this section do not ask you to determine the **level** of participation, only the **areas** of participation (activity stages).

There are many ways that community people may have been involved in the activity. They include lobbying, advising, brokering, decision making, providing leadership, mentoring less experienced workers, implementing strategies, conducting evaluation and so on. Think about the varying roles as you respond to questions in this section.

4.1 Do records indicate whether community people participated in planning, implementing and evaluating this activity?

Community people may have been responsible for implementing different parts of the activity. Decisions may have been made following discussion in a meeting of the community health board or other local group. Check your response to question 2.1.3. The health promotion plan may list the people responsible for implementing actions, including community people.

Circle **1-Yes** if there is a record of community people participating in planning, implementing and/or evaluating the activity.

Circle **0-No** if there is no record of community participation.

If you circle **0-No**, circle **9-N/A** for questions 4.1.1 through 4.1.5.

If you circle **1-Yes,** you will need to circle **1-Yes** or **0-No** for each area of participation as follows.

4.1.1 Identifying the problem or issue

There is often community participation in identifying the issue to be addressed by a health promotion activity. For example, focus group discussions may have identified priority issues for health promotion; the community health board may have identified the issue through health centre reports. The store committee may have suggested partnering to tackle food supply and nutrition education needs, or the regional alcohol action group may have raised concerns about alcohol trading hours, as the starting point for health promotion activities to reduce alcohol related harm.

Circle **1-Yes** if there is a record of community participation in determining the issue or problem this activity addressed.

Circle **0-No** if there is no record of community involvement.

4.1.2 Determining strategies (deciding what to do) about the issue/problem

There are many ways in which community people may have been involved in determining strategies. For example, a collaborative process may have been used with a community group to draw a ‘visual map’ of the health promotion activity, how the various actions and groups would connect and who would be involved. Aboriginal Health Workers may have met with key people to discuss possible ideas, before bringing ideas and advice to a team planning meeting. The health team may have worked with teachers to engage school children in planning a community campaign, as a drug education activity. The health board might have advised staff about strategies that had or hadn’t worked in the past, prior to the health team doing further research and proposing health promotion strategies for endorsement at the next board meeting.

Circle **1-Yes** if there is a record of community participation in deciding the strategies (or what was done) for this activity.

Circle **0-No** if there is no record of community involvement.

4.1.3 Implementing the strategies/activity (doing the work)

Individuals may have managed parts of the activity, such as collecting information, taking notes and/or organising meetings. Groups may have approached policy makers and/or politicians, to lobby for change. Young people may have taken on peer educator roles; people may have volunteered to work in a community kitchen program. Grandparents/parents may have shared parenting stories with new mums and dads.

Further examples might include development of health promotion products, such as the translation of written health messages into local language, scripting of an audio or film clip, or a local artist making purpose specific artwork.

Circle **1-Yes** if there is a record of individuals or groups being involved in implementing the activity.

Circle **0-No** if there is no record of community involvement.

4.1.4 Evaluating the results of the work

Evaluation can involve community members in various ways. For example, local workers or volunteers might have collected stories from others about how well the activity went; local workers/trainees/students may have recorded how many people attended the activity. There may have been peer assessment of skills learnt through the activity. Residents may have been involved in analysing and/or interpreting information. There may have been involvement in preparing reports and/or presenting feedback.

Circle **1-Yes** if there is a record of community involvement in determining how, what and when to evaluate in the activity, or in conducting the evaluation.

Circle **0-No** if there is no record of community involvement.

4.1.5 Other, please specify_____

Circle **1-Yes** if there is a record of community involvement in some other aspect of the activity, which is different to the above areas.

For example, there may have been community involvement in follow on work that was not planned as part of the initial activity, in order to sustain changes. Community residents may have participated in tailoring outcomes of the activity to meet the needs of different practitioners or community groups. Community members may have been involved in sharing activity success stories with others at a conference, or when visiting other communities.

Do not include activity participants (targeted groups). If the activity used participatory action research methods, participant involvement should be reflected in answers 4.1.1. to 4.1.4.

Circle **0-No** if there is no record of community involvement.

Section 5 Partners involved

Partnerships with other organisations and community-based agencies are important for drawing in necessary knowledge, skills and resources and links to other activities and initiatives. Health practitioners and teams cannot be expected to have all the necessary knowledge and skills to facilitate all strategies well. Partnerships with others usually lead to more successful health promotion.

It is especially important to form partnerships with organisations from sectors outside health (inter-sectoral collaborations) such as education, housing, justice, the local government council or store. Partnerships outside the health service usually strengthen health promotion with different perspectives, areas of expertise and ways of doing things, as well as additional resources. Through partnerships, health promotion activities are more likely to address the social and environmental determinants of health that are outside the control of the health sector.

Partnerships may be informal or formal. Formal arrangements often have a memorandum of understanding and/or contractual obligations. In many communities and services, health boards or health management committees are important partners in strengthening commitment to, and success of, health promotion activities.

5.1 Do records indicate that individuals and/or organisations external to the health centre/service were involved in planning, implementing and evaluating the activity?

Partners involved in a health promotion activity may be informal partners collaborating in the activity. They may be involved through a formal partnership arrangement, such as a signed agreement. A formal structure, such as a health board, may be a partner in providing support and making decisions.

If necessary, check your response to question 2.1.3. Where the project plan lists the people responsible for implementing various tasks, partner organisations may be indicated.

Circle **1-Yes** if there is a record that other organisations or services were involved in planning, implementing and/or evaluating the activity.

Circle **0-No** if there is no record of other partners being involved.

If you circle **0-No**, circle **9-N/A** for questions 5.1.1 through 5.1.3.

If you circle **1-Yes,** you will need to circle **1-Yes** or **0-No** for each type of partner, as follows:

5.1.1 In the local community
5.1.2 Beyond the local community
5.1.3 Beyond the health sector

Table 12 Examples of partnership types for health promotion

Partnership	Examples
5.1.1 In the local community	– The community health board had input into decisions about the health promotion activity. – The remote community store, school and health team worked together to reduce tobacco sales to under 18s.
5.1.2 Beyond the local community	– The National Heart Health Day activity was planned and resourced in partnership with the outreach worker from the Heart Foundation. – Aboriginal health workers and community education/liaison workers worked together to conduct the activity with Aboriginal students at the regional TAFE college.
5.1.3 Beyond the health sector	– Aboriginal health workers and community education/liaison workers worked together to conduct the activity with Aboriginal students at the regional TAFE college (two types of partnership for this one activity) – The activity involved the health team implementing education strategies about home maintenance, in step with the housing corporation's repair program, with meetings to coordinate and update progress.

Section 6 Evaluating the activity

Evaluation is about looking critically at what is happening or has happened, or what has changed as a result of the activity and making judgement about its value, worth or benefit. It is important because it can tell us how the activity is going, what effect it is having, what changes are needed to improve it, or whether the activity achieved its aim/goal or objectives.

Types of evaluation include process, impact and outcome evaluation. **Process evaluation** focuses on the process of delivery – the strategies and actions, the quality of resources, who the project is reaching and the views of participants. Counting the number of participants and asking about participant satisfaction is process evaluation. **Impact evaluation** measures the immediate effects of the activity and whether objectives are being reached. Assessing knowledge and understanding at the end of the activity is impact evaluation. **Outcome evaluation** measures the longer term effects or changes, such as changes in behaviours, application of skills learnt, and changes to policies and environments.

Success in achieving the aim or objectives can only be measured if you know what the aim and/or objectives were – what the activity set out to achieve, who the target group was, and so on. This knowledge comes from good planning processes and a recorded plan

6.1 Do records indicate that any change has been, or is being, measured or evaluated?

You may have planned an evaluation strategy when planning the activity, documented the methods used and kept the results of evaluation. However, if records are minimal, check the activity goal recorded in the plan (question 2.1.1). The goal or objectives may indicate what was intended to be achieved, or the change you were aiming for. For example, your aim may have been to get 100 people involved over five sessions; attendance records would provide an evaluation record. Also check your response to question 2.1.5., the criteria or indicators you may have used to measure change.

Circle **1-Yes** if there is a record that change has been, or is being, evaluated.

Circle **0-No** if there is no record of evaluation.

If you circle **0-No**, circle **9-N/A** for questions 6.1.1 through 6.1.5.

If you circle **1-Yes,** you will need to circle **1-Yes** or **0-No** for each area of evaluation, as follows:

6.1.1 Number of people participating in the activity

For example, is there a record of how many people attended an education session, how many attended a cooking class? Is there a record of how many people logged onto the HITnet health kiosk? How many girls went on the grandmothers bush camp and how many leaders were involved? (This is process evaluation.)

6.1.2 Participant satisfaction with the activity

For example, do you have transcripts of interviews with participants about how they felt the activity went? Do you have completed evaluation forms? Is there a photo of the whiteboard or butchers paper capturing participants feedback/ comments? Is there film footage of participants reflecting on the activity? (This is process evaluation.)

6.1.3 Knowledge and understanding

This is a more complex measure. It involves assessing what people have learnt through the activity.

For example, did you listen to, assess and record whether participants could recount accurate health information (eg. of safe drinking levels, of factors that contribute to a disease)? Do you have copies of questionnaires completed before and after the activity? Do you have records of presentations or storytelling, through which participants demonstrate knowledge and understanding of the issue addressed by the health promotion activity? (This is impact evaluation.)

6.1.4 Health related skills and behaviour

This can be a complex measure. It involves assessing what skills people are able to apply, and what they do differently, as a result of the activity.

For example, are there photos of meals people prepared during low fat cooking classes? Is there a record of people's weight loss or ongoing participation in an exercise program, as a result of the activity? Do records indicate that people quitting smoking as a result of the health promotion activity? Have you recorded how many clients with diabetes are using the self-management trolley, following the group teaching/ learning sessions? (This can be impact and outcome evaluation.)

6.1.5 Policy and environments

Measuring changes and keeping records of changes in policies and environments can be straightforward or complex, depending on the activity. (This is outcome evaluation.)

For example, a change in policy might be indicated by keeping a copy of the smoke free workplace policy that was introduced as a result of the activity. A photo of the canteen menu may be adequate to show that it has changed policy to offer low-fat alternatives and is supporting students or workers to eat more healthily.

For example, records may show that less intoxicated people are taken into protective custody, because of assistance offered by the night patrol. A survey may indicate that since brief intervention training sessions, more practitioners feel confident to do brief interventions for alcohol, and more people have taken up offers of support and treatment to change their drinking. Records of these strategies would provide evidence that the environment has been changed to support alcohol harm reduction.

Note: There is a specific Systems Assessment Tool for health promotion. The results of the health promotion audit and systems assessment should be linked and interpreted together before setting goals for improving health promotion service delivery.

Appendix 1 Glossary

Note: This is not a comprehensive glossary. It explains health promotion terms used in the protocols. We encourage use of the World Health Organisation Health Promotion Glossary (1998). A list of 'Useful resources for health promotion goal setting, planning and evaluation' can be found in the health promotion section of the One21seventy website.

Term used	Explanation
Bottom-up health promotion approaches	Bottom-up approaches in health promotion are associated with concepts of community empowerment, beginning with issues of concern to particular groups or individuals. In contrast, top-down approaches are more associated with disease prevention and involve health agencies defining issues and activities.(Lavarack and Labonte 2000)
Capacity building	Capacity building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities. WHO modified definition (Skinner, 1997; Hawe et al., 2000; Catford, 2005)
Community development	Community development refers to the process of facilitating the community's awareness of the facts and forces which affect their health and quality of life, and ultimately helping to empower them with the skills and needed for taking control over and improving those conditions in their community which affect their health and way of life. It often involves helping them to identify issues of concern and facilitating their efforts to bring about change in these areas (Hawe et al, 1990: 203)
Comprehensive primary health care	Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation (Australian Primary Health Care Research Institute 2005).
Contributing factors	Any aspect of behaviour, society or the environment, or anything else which contributes to a risk factor for a health problem, e.g., not having easy access to purchase condoms is a contributing factor for having sex without a condom, which is in turn a risk factor for contracting HIV… (Hawe et al 1990: 204)
Downstream / upstream approaches	Health promotion uses multiple, complementary strategies to promote health at the individual (downstream), community and population (upstream) level.
Empowerment	In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health. (WHO 1998)
Focus group	Focus groups consist of semi-structured discussion with 8–12 participants, lead by a facilitator who follows an outline and manages group dynamics. Proceedings are typically recorded. Focus groups have certain strengths as a data collection method: they provide in-depth information, they can be inexpensive to implement and require a minimum of specialised skills.(Victorian Government Dept of Human Services 2003: 7).
Health education	Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve *health literacy*, including improving knowledge, and developing *life skills* which are conducive to individual and *community health*.(WHO 1998)

Health promotion	.Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being (WHO 1986)
Inter-sectoral collaborations	A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve *health outcomes* or *intermediate health outcomes* in a way which is more effective, efficient or sustainable than might be achieved by the *health sector* acting alone. Intersectoral action for health is seen as central to the achievement of greater *equity in health*, especially where progress depends upon decisions and actions in other sectors … (WHO 1998)
Research transfer	Research transfer is about getting knowledge and information out into the community and into use by health services, governments and others. This means ensuring the research is done in a way that makes it most likely to be relevant and of use—and to be used—to inform and bring about positive change (CRCAH 2009) Other terms with similar meaning are research uptake, knowledge exchange, knowledge utilisation and knowledge translation,
Risk factors	Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury (WHO 1998).
Social determinants	Social determinants of health include the social gradient ([whereby]… life expectancy is shorter amd most diseases are more common further down the ladder in each society): stress; early life; …(development and education); social exclusion, work; unemployment; social support; addiction; food; transport (WHO 2003: 10-29) .
Social Marketing	Social marketing is the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the behaviour of target audiences in order to improve the welfare of individuals and society. (WHO Modified definition: Andreasen 1995).
Sustainable health promotion actions	Sustainable health promotion actions are those that can maintain their benefits for communities and populations beyond their initial stage of implementation. Sustainable actions can continue to be delivered within the limits of finances, expertise, infrastructure, natural resources and participation by stakeholders (WHO 1998).
Target group	Those members of a community for whose benefit a health goal is constructed and a health intervention carried out (Hawe et al 1990: 215)

References

Davies, J. K., G. MacDonald, et al. (1998). Quality, evidence and effectiveness in health promotion: striving for certainties. London, Routledge.

Department of Health and Community Services (2007). The Public Health Bush Book: A resource for working in community settings in the Northern Territory. Darwin, Northern Territory, Department of Health and Community Services.

Glasgow, N., Sibthorpe, B., Gear, A. (2005). Primary Health Care Position Statement, a scoping of the evidence, The Australian Primary Health Care Research Institute and Australian Divisions of General Practice, Australian National University, Canberra

Groene, O., S. Jorgensen, et al. (2005). "Standards for health promotion in hospitals: development and pilot test in nine European countries." International Journal of Health Care Quality Assurance **18**(4): 300-307.

Hawe, P., Degeling, D., Hall, J. (1990). Evaluation health promotion: A Health Worker's Guide, McLennon & Petty, Sydney

New South Wales Health. (2002). "Principles for better practice in Aboriginal health promotion."

Howie, R. J. (2004). Formative Evaluation of the Kuwinyuwardu Aboriginal Resource Unit: Gascoyne Healthy Lifestyle Program. Subiaco, Telethon Institute for Child Health Research.

Johnson, A. (2007). Tool 2: Health Promoting Health Services: Organisational and Activities/Practice Assessment Tool. In Health Promotion and Health Services: Management for Change. Melbourne, Oxford University Press**:** 221-232.

Lavarack G, Labonte, R., (2000). "A planning framework for community empowerment goals within health promotion." *Health Policy and Planning* **15**(3). 255-262

Lin, V., S. Fawkes, et al. (2005). "Achieving effectiveness in health promotion programs: evidence, infrastructure and action" in *Behavioural Change: An evidence based handbook for social and public health.* Sydney, Elsevier Churchill Livingstone: 17-43

National Aboriginal and Torres Strait Islander Health Council. (2003). National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments. Canberra**:** 1-40.

National Health and Medical Research Council (1996). Promoting the Health of Indigenous Australians: A review of Infrastructure support for Aboriginal and Torres Strait Islander health advancement. Canberra, Australian Government Publishing Service**:** 1-55.

Shannon, C., J. Wakerman, et al. (2003). "Achievements in Aboriginal and Torres Strait Islander Health." Cooperative Research Centre for Aboriginal Health (CRCAH) on behalf of Standing Committee on Aboriginal and Torres Strait Islander Health

van Driel, W. G. and J. F. E. M. Keijsers (1997). "An instrument for reviewing the effectiveness of health education and health promotion." Patient Education and Counseling **30**(1): 7-17.

Victorian Department of Human Services (2003*).* Integrated Health Promotion: A practice guide for service providers. Melbourne, Victoria, DHS

World Health Organisation (1998). Health Promotion Glossary, WHO, Geneva

World Health Organisation (2003). Social Determinants of Health*,* The Solid Facts, (2nd Ed), WHO, Geneva.

World Health Organisation (1986) Ottawa Charter for Health Promotion, WHO Geneva

Quality Improvement Program Planning System. Online planning and evaluation tool for health promotion and community development managed by the Victorian Community Health Association. *www.qipps.com*

European Quality Instrument for Health Promotion (EQUIHP) and User Manual. Developed by Flemish Institute for Health Promotion (VIG) and the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ) for the Getting Evidence into Practice Project, September 2005.

Health Promotion Effect Management Instrument, Preffi 2.0 Assessment Package and Explanatory Guide. Developed by NIGZ Netherlands Institute for Health Promotion and Disease Prevention, Woerden 2003.

Health promoting health services: Guidance for a Health Promoting Health Service. Developed and published by the National Health Service, Health Scotland, 2005.

National Public Health Performance Standards Program: Local Public Health Performance Assessment Instrument Version 1.0. Developed by the USA Centre for Disease Control and Prevention in collaboration with 5 public health organisations. *http://www.cdc.gov/od/ocphp/nphpsp/*