HIV, AIDS and Related Programs (HARP) Health Promotion workforce consultation on the NSW HIV, STIs and Hepatitis C Strategic Plans 2006 - 2010 and the supporting Implementation Plan for Aboriginal People.

Tuesday July 27, 2010

On Tuesday July 27, 2010 a group of twenty-nine workers that are engaged in the NSW health promotion response to HIV, STIs and hepatitis C met for a four hour workshop that aimed to inform the evaluation of the current strategic plans that are in place to focus the programmatic responses. The group included a diverse representation of metro Sydney, regional, rural and statewide HARP funded health promotion services.

The workshop was an initiative that aimed to inform the efforts to build the capacity and enhance the effectiveness of the health promotion response for HIV, STIs and Hepatitis C in NSW including those programs that are specifically targeted to Aboriginal people. Two main questions were put to the group:

- What are the priority issues and influences that are critical to our success?
- What are the *first* and *most important* things that we need to address to have a real impact on improving HIV, STI and Hepatitis C health outcomes for people in NSW?

The workshop followed the 2010 HARP Health Promotion Forum. Participants of the workshop self nominated to take part in the process. A list of attendees and the agencies that they are from is at the end of this document.

Daniel Madeddu and Scott Rutter from the AIDS/Infectious Diseases Branch, NSW Health facilitated and documented the workshop. Following are the outcomes of the discussions.

The group agreed for their feedback to be distributed to the HARP Manager's Network, the Senior HARP Health Promotion Officer's Network and to the consultants that have been engaged to conduct the evaluation of the NSW HIV, STIs and Hepatitis C Strategic Plans 2006 - 2010 and the supporting Implementation Plan for Aboriginal People

Consultation Methods

Participants worked through identifying *Strengths, Weaknesses, Opportunities and Challenges* which HARP Health Promotion Workforce has observed during the life of the NSW Strategies. The participants progressed through a series of exercises to identify, prioritise and progress future directions. This included:

1. **Brainstorming (Table 1)**
   a. **Free listing**
   Participants listed what they saw as the *Strengths, Weaknesses, Opportunities and Challenges* occurring in health promotion work. Participants could freely list and discuss the above.
   b. **Ranking**
   Participants then voted with coloured pens for items on the list according to how important things were to them (red=3 points or most important; green=2 points or moderately important; blue=1 less important; and no tick=not important).
   Note: Totals of votes are the numbers behind the list items in Table 1
   Lists have been divided into common themes identified among the items.
2. **Prioritising (Table 2)**
   Participants then divided into four groups and discussed the priorities. They could combine items or find general themes that they felt were a priority. They were asked to rank the top three priorities.

3. **Strategies for priority areas**
   Participant for each of the four groups then developed strategies to work with the priority areas:
   a. *Build on Strengths*
   b. *Overcome Weaknesses*
   c. *Sieze Opportunities*
   d. *Overcome Challenges*

TABLE 1: BRAINSTORMING			
Strengths	***Weaknesses***	***Opportunities***	***Challenges***
• ***What are we doing well?*** • ***What are the influences that enhance our work?***	• ***What are we not doing well?*** • ***What are the influences that undermine our work?***	• ***What environmental influences can we take advantage of?***	• ***What internal or external factors can derail our efforts?***
Workforce [49] 1. Skilled workforce that is often peer. (24) 2. Adaptability 3. Diversity of workforce experience. (9) 4. Great enthusiastic workforce (7) 5. Committed Hierarchy. 6. Supportive management structures with valuable experience. 7. Committed team with agreed focus. 8. Professional support in the larger Area Health Service. (2) 9. Effective service provided with limited resources available. (7)	***Workforce [33]*** 1. Recruitment/length of time to recruit and staff freezes. (11) 2. Area Health Service Bureaucracy. (8) 3. Distance – Rural 4. Staffing 5. Resources 6. No health promotion officer (3) 7. Burn out experienced by Aboriginal health care workers. (11) 8. Political correctness.	***Workforce [38]*** 1. Very skilled and professional workforce – use it to the best of its advantage. (17) 2. Mobile specialist services – regular road shows in all areas (21) a. Hep C b. HIV c. Health Promotion d. Maybe smaller and bigger teams working together across state	***Workforce [43]*** 1. Remoteness in areas (eg limited staff, transport) (17) 2. Redtape – approvals, fear of letting go of control: - let the deer's have the guns. (11) 3. Staffing – when people resign they are not replaced in a timely manner. 4. Management's personal agendas re providing services. (9) 5. Health Determination vs Allied Health Award (Does the HEO Award reflect the skills of the sector?) (6) 6. Multiple demands
Partnerships [53] 10. Development of partnerships 11. Well established partnerships with internal and external partners assists with a well co-ordinated approach. (10) 12. Great networks and partnerships in some areas. (14) 13. Local and statewide partnerships (29) a. Strong networks within HIV/Sexual Health fields b. Opportunities to meet frequently id state-wide meetings	***Partnerships [17]*** 9. Developing and sustaining partnerships. (4) 10. Multiagency. (3) 11. Not working well enough yet with DET to ensure quality sexual health and blood borne viral education in schools. (10)	***Partnerships [19]*** 3. Un-siloing- working with other services such as AOD and Mental Health. (19)	***Partnerships [15]*** 7. Making sexual health a priority for other services. (3) 8. Constantly 'competing' with clinical priorities. (12)
Priority Populations [23] 14. Sector has made progress towards a priority population approach. (1) 15. Strong understanding of health and culture (refugee, multicultural health) (1) 16. ASHWs have recognised and effective relationships with their communities. (21)	***Priority Populations [30]*** 11. Culture weakness training. (12) 12. Priority populations limiting (7) a. only scratching the surface b. who are we reaching? 13. Not listening to what young people really want – always directed by the documents as to what to give them. (4) 14. Not working with a very at risk population as a priority – people with disability. (7)	***Priority populations [5]*** 4. Increased involvement of our target audiences in our project conversations. (5)	***Priority Populations [1]*** 8. 'Finding priority populations' or getting them to see sexual health as important enough to act on. (1)
Leadership[23] 16. Having strategies that give us a framework – so much is identified in the strategies that can be build on. (23)		***Leadership [14]*** 5. NSW Health is actively seeking to strengthen health promotion & is very supportive of it. (2) 6. Utilisation of STIPU and resources (eg Social Marketing Training at a local level to assist with development of projects). (10) 7. Increased funding to focus on Hep C prevention and treatment (2)	***Leadership [9]*** 9. Funding – poor utilisation now, how better use it? (9) 10. Political agenda.
	Evidence Base/Health Promotion [53] 15. Difficulty in measuring long term health promotion. (5) 16. Health promotion not understood and valued by other health professions. (15) 17. 'Let's do a social marketing campaign!' – What do we mean? (6) 18. Non-evidence based health promotion (17) c. Lack of research	***Evidence Base/Health Promotion [14]*** 8. Research opportunities please. (12) 9. Increased consistent research funding – all share results. 10. Very good disease notification system but what next? (2) a. PLWHIV, Mental health b. Where will they go for services even though they are	***Evidence Base/Health Promotion [40]*** 11. Lack of recognition about what's working well now. 12. Measuring our successes (7) 13. The disease focus approach, how this fits with a population health approach especially when performance indicators are about disease reduction. Health promotion can increase diagnosis so we know there is more. (26)

	d. No opportunities offered for research 19. Where is the focus on social determinants? (10)	diagnosed? c. Notifications are an opportunity to design new programs? 11. What environmental changes can we do easily because it's easier to do this than change behaviour (eg make condoms available – normalise everywhere.)	14. A combination of evidence based health promotion and community based health promotion. (7) 15. Health promotion to form evidence – informed. 16. Health promotion for effective health promotion interventions.
		Technology [36] 12. Access to relevant online programs (eg Facebook, Twitter, etc) to promote social services, increase communication and pleasurable interactions. 13. New technologies which we can utilised. (36)	***Technology [21]*** 17. Inability to access new media technology to reach all priority populations. (21)

TABLE 2: PRIORITISING	
• ***Of the issues that you have been identified what are the top three that can have the greatest impact on our work?***	
Strengths 1. Local and statewide partnerships. 2. Skilled workforce. 3. Strategies that give us a framework.	***Weaknesses*** 1. Workforce issues. 2. Priority Populations 3. Partnerships with other govt/NGO organisations.
Opportunities 1. Technology. 2. Mobile specialist services. 3. Research.	***Challenges*** 1. Recognition of the difficulties of measuring the success of health promotion. 2. Achieving effective and sustainable health promotion in a constantly changing yet stagnant bureaucratic system.. 1. Adequate staffing to respond to needs of: a. Communities b. Priority populations c. Services d. Individual workers.

TABLE 3: STRATEGIES FOR PRIORITY AREAS

Building on strengths	***Overcoming weaknesses***	***Seizing opportunities***	***Planning to minimise the challenges***
• ***What are we doing well?*** • ***What are the influences that enhance our work?***	• ***What are we not doing well?*** • ***What are the influences that undermine our work?***	• ***What environmental influences can we take advantage of?***	• ***What internal or external factors can derail our efforts?***

1. Local and statewide partnerships.
• Keeping partnerships vibrant and relevant.
• Know when committees have reached a natural end and refocus.
• Provide an effective means of communication.
• Accountability/transparency/evaluation of partnership approaches.
• Application to high level committees as well as local.
	1. Workforce issues
	• Orientation and support for new workers including cultural competency as part of the orientation.
	• Make job more attractive (eg make people want the job and want to stay)
	• What's the carrot for going rural?
	  o Allowances
	  o Additional leave/incentives
	  o Moving costs
	  o Family moving etc.
	• Accessing teleconferencing & video conferencing for support networks.
	• Peer support/mentors for new staff.
		1. Technology
		• Professional development – How to use and how best to use.
		• Need policies, guidelines, procedures.
		• Need leadership through AIDB and advocacy.
		• Need evidence (eg STIPU pilot project, CDC models)
		• Partnership with NGO/private sector who are able to utilise technologies.
		• How to ensure a two – way conversation/relationships through technology?
		• Consistency of access.
			1. Recognition of the difficulties of measuring the success of health promotion.
			• Changing performance indicators.
			• Building in impact measures at state level.
			• Revising the Sexual Health Promotion Guidelines to incorporate more on priority populations and placed online for other HCWs to access also.
			• Development of a new Evaluation Guidelines Document from NSW Health.
			• Showcasing of Health Promotion at any opportunity:
			  o ASHM, Sexual Health Conference, etc.
			  o 'Shameless self promotion'
			  o Other health care workers
			  o Area Health Services especially media at an area health service level.
			  o Into the Department as well.
			  o STIPUS Activities Register used for HPOs to place work on not just innovative but all such as SHW.
			• Commitment from HP staff to have our work be evidence informed.

2. Skilled workforce.
• Recruitment
• Opportunities for workforce development.
• Dedicate funds to support skilling up and report on this. NSW Health allocate funds – provide evidence that this is available to the workforce.
	2. Priority populations
	• Review and development of policies to be more inclusive of all.
		2. Mobile specialist services
		• Regular road shows
		• Utilise Statewide Services
		  o STIPU (ie specialist centralised) services better esp. for rural areas.
		  o ASM Workforce Development Program
		• Develop a centralised model.
		• Collaborative approach
			2. Achieving effective and sustainable health promotion in a constantly changing yet stagnant bureaucratic system.
			• Advocacy – us and higher up (AIDB) particularly in IT Area.
			• HPOs better supporting each other eg forums, activities register.
			• Core competencies (AHPA)
			• Standard operating framework for HP which allows for individuality.

3. Strategies that give us a framework. • Sexual Health Week becomes statewide. • Involvement in evaluation process. • Improve key deliverables and make more realistic. • Action Plans are very useful but need consistency across all strategies and Aboriginal Implementation Plan.	***3. Partnerships with other Government and non-Government organisations*** • Formalise partnership agreements, implementation tools and regularly review. • Manager to manager, CEO to CEO service mediations when partnerships go bad. • Client must be the focus and priority • Have a purpose for the partnership	***3. Research*** • Centralised research to pool funding/resources. • Evaluation framework. • Create partnership/links with research bodies & universities.	***3. Adequate staffing to respond to needs of:*** ***a. Communities*** ***b. Priority populations*** ***c. Services*** ***d. Individual workers*** • Core competencies (AHPA) • Standard operating framework for HP which allows for individuality.

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List of workshop participants:

Last Name	First Name	Organization
Asprey	Julie	Northern Sydney Central Coast Health
Crowley	Margaret	Greater West Area Health Service
Dabbhadatta	Jeffrey	HARP Unit - South Eastern Sydney & Illawarra Area Health Service
Duck	Timothy	Sydney South West Area Health Service
Elkaim	Jessica	South Eastern Sydney & Illawarra Area Health Service-HARP
Grant	Kim	Greater Western Area Health
Green	Bernard	Hunter New England - Population Health
Haque	Ahm Azizul	Sydney South West Area Health Service
Holt	Naomi	HARP Unit - South Eastern Sydney & Ilawarra Area Health Service
Holtmann	Madeleine	North Coast Area Health Service
Kaan	Iain	Northern Sydney Central Coast Area Health Service - HARP Health Promotion
Knox	Douglas	HARP South Eastern Sydney & Illawarra Area Health Service
Leece	Bronwyn	Sydney West Area Health Service
Lenton	Jo	Greater Western Area Health Service
Little-Richter	Christine	Greater Western Area Health Authority
Longbottom	Renea	South Eastern Sydney & Illawarra Area Health Service
Lynch	Tim	Sexual Health Greater Western Area Health Service
Mackenzie	Ailsa	Hunter New England Population Health
Maddedu	Daniel	AIDS Infectious Diseases Branch, NSW Health
Maher	Louise	Sydney West Area Health Service
Maidment	Christine	Sydney South West Area Health Service
McGowan	Lidya	HARP Health Promotion Team
Menzies	Kevin	Greater Western Area Health Service
Mlambo	Elizabeth S.	Sydney West Area Health Services
Orchard	Michael	Sydney West Area Health Service
Paljor	Sonam	Multicultural HIV/AIDS & Hepatitis C Service
Prihaswan	Priyadi	South Eastern Sydney & Illawarra Area Health Service - HARP Unit
Rutter	Scott	NSW Health Department AIDS/Infectious Diseases Branch
Story	Liz	NSW STI Programs Unit
Turner	Ronnie	WDP/ASHM
Tyson	Beverley	Greater West Area Health Service