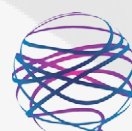




Curtin University

SHBBV PROGRAM PLANNING TOOLKIT

siren.org.au



SIREN
WA Sexual Health and Blood-borne Virus
Applied Research and Evaluation Network

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FOREWORD



The Sexual Health and Blood-Borne Virus Program (SHBBVP) in the WA Department of Health is committed to reducing the incidence and prevalence of sexually transmitted infections and blood-borne viruses and reducing the social and personal impact of these infections within Western Australia. Delivering evidence-based programs which are effective is vital to ensure we are investing public funds appropriately. The sustainability of these programs also needs to be considered to maximise the return on our investments.

The *SHBBV Program Planning Toolkit* was developed in response to consultations facilitated by SiREN, which identified a need for resources to assist in effective program planning and evaluation. It contains information, examples, links and templates that you can work through systematically to build a solid project plan which can be evaluated.

SHBBVP is committed to building the capacity of the SHBBV workforce to develop programs and services which are effective and sustainable. I hope you will be able to use the *SHBBVP Program Planning Toolkit* with great success at all stages in the planning, implementation and evaluation of your programs and services.

Lisa Bastian, Manager, SHBBVP
WA Department of Health



I am delighted to introduce the *SHBBV Program Planning Toolkit*, a new resource available to managers, service providers, clinicians and project officers in the SHBBV sector.

The SiREN team at the WA Centre for Health Promotion Research at Curtin University developed the SHBBV Program Planning Toolkit. The guidance and input of the SiREN Resources Reference Group, comprising staff working in policy, practice and research organisations within the Western Australian SHBBV sector, was critical in determining the content and learning strategies used in this resource.

The *SHBBV Program Planning Toolkit* emphasises the importance of a systematic approach to planning and evaluating projects. The toolkit uses the standard project planning lifecycle (Plan-Do-Check-Adjust) and explains the steps involved at each stage to deliver a project plan with specific, measurable, achievable, relevant and time-bound (SMART) objectives and outcomes that can be evaluated and that facilitate research activity. There are examples and links to additional suggested resources throughout.

I invite you to explore the toolkit and I hope this resource will assist you to deliver high quality evidence-based programs and services, which really make a difference.

Maryanne Doherty, Co-Director, WACHPR
Curtin University

ACKNOWLEDGEMENTS

The following people are gratefully acknowledged for their guidance and feedback in the design, development and implementation of the SHBBV Program Planning Toolkit:

Sean Brennan

WA Department of Health, Sexual Health and Blood-borne Virus Program (SHBBVP)

Jude Comfort

WA Centre for Health Promotion Research, Curtin University

Gemma Crawford

WA Centre for Health Promotion Research, Curtin University

Maryanne Doherty

WA Centre for Health Promotion Research, Curtin University

Jonathan Hallett

WA Centre for Health Promotion Research, Curtin University

Andrea Jones

Curtin University Marketing

Olivia Knowles

Youth Affairs Council of WA

Stephen Plecas

FPWA Sexual Health Services

Meagan Roberts

WA Centre for Health Promotion Research, Curtin University

Anne Sorenson

Metropolitan Migrant Resource Centre

P.J. Matt Tilley

Department of Sexology, Curtin University

Rochelle Tobin

WA Centre for Health Promotion Research, Curtin University

Simon Yam

WA AIDS Council

Thank you also to the following staff from the WA AIDS Council who participated in testing the SHBBV Program Planning Toolkit:

Tony Bober

Steve Fragomeni

Rebecca Hall

Bethwyn Hodge

Sally Rowell

Gavin Tsai

Simon Yam

Suggested citation

WA Centre for Health Promotion Research. (2013). *SHBBV Program Planning Toolkit*. Perth, WA: Curtin University.

The background of the entire page is a complex, abstract pattern of overlapping, curved, and angular shapes in various shades of blue, ranging from light sky blue to deep navy blue. The pattern creates a sense of depth and movement, resembling a stylized, layered landscape or a network of paths.

ABOUT THIS TOOLKIT

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The **SHBBV Program Planning Toolkit** is for managers, service providers, clinicians and project officers in the sexual health and blood-borne virus (SHBBV) sector.

The **SHBBV Program Planning Toolkit** is for managers, service providers, clinicians and project officers in the sexual health and blood-borne virus (SHBBV) sector. The toolkit contains information, tools and quick links to assist practitioners in planning, implementing and evaluating health interventions that aim to reduce the transmission of sexually transmitted infections (STIs) and blood-borne viruses (BBVs) in priority population groups shown in Box 1.

Box 1: Priority population groups for the SHBBV sector

Priority population groups

The STI, Hepatitis B, Hepatitis C and HIV national strategies (2010-2013) and the WA Models of Care implementation plans for 2010-2014 have specified the following priority populations within the SHBBV sector:

- Gay men and other men who have sex with men
- Injecting drug users
- Young people
- Aboriginal population
- Sex workers
- People living with HIV and/or other BBVs
- People within custodial settings
- Priority culturally and linguistically diverse populations
- Migrants and new refugees
- Travelers to and from high prevalence regions
- Health professionals

In this Toolkit, we will refer to both **projects** and **programs**. *What is the difference?*

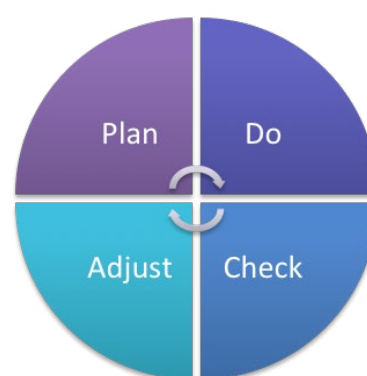
Project

A discrete piece of work addressing a single population group or health determinant, which is implemented and completed usually within a set time period and budget.

Program

A group of activities that are implemented together to achieve a set of objectives. Successful projects may become ongoing programs. A program may also consist of a number of related projects.

Figure 2.1: Program planning and evaluation cycle



This toolkit is based on the program planning and evaluation cycle shown in Figure 1. The cycle has four stages: **Plan, Do, Check, Adjust**.

The program planning and evaluation cycle is an **ongoing process** that leads to **continuous improvement**, **increased health gains** and the development of **effective** and **sustainable** programs.

Who developed this toolkit and why?

SiREN – the Western Australian Sexual Health and Blood-borne Virus Applied Research and Evaluation Network – developed the **SHBBV Program Planning Toolkit**. The overall aim of SiREN is to strengthen existing, and create new partnerships by promoting and facilitating Western Australian applied research and evaluation relating to the prevention and control of STIs and BBVs. SiREN is coordinated by the Western Australian Centre for Health Promotion Research (WACHPR) at Curtin University and funded by the WA Health Sexual Health and Blood-borne Virus Program (SHBBVP).

This toolkit was developed in response to the findings of a needs assessment survey conducted by SiREN for the WA SHBBV sector. The survey results indicated that practitioners in the SHBBV sector in WA identified a need for training and toolkit resources to assist with SHBBV program planning and evaluation. This **SHBBV Program Planning Toolkit** will be useful to all health professionals

involved in planning and evaluating SHBBV programs which aim to reduce the transmission of STIs and BBVs.

What's in this toolkit?

The **SHBBV Program Planning Toolkit** provides information, tools and templates that you can use to follow the planning and evaluation cycle shown in Figure 1.

This toolkit contains six sections:

1. Who is your program for and why is it needed? (**Plan**)
2. What does your program expect to change? (**Plan**)
3. How do you know your program will work? (**Do**)
4. What will your program include? (**Do**)
5. Did your program work? (**Check and Adjust**)
6. Tools (**blank templates** for you to use during planning and evaluation).

How do I use this toolkit?

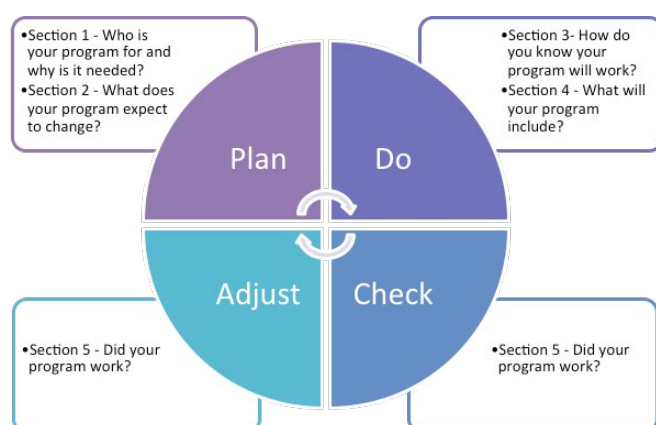
The complete **SHBBV Program Planning Toolkit** and the separate toolkit sections are available for free download from the SiREN website www.siren.org.au and may be used for educational, planning and/or evaluation purposes.

Work through each section of this toolkit systematically and use the templates in section 6 to create a complete project and evaluation plan.

When should I use this toolkit?

The **SHBBV Program Planning Toolkit** can be used throughout the planning and evaluation cycle (see Figure 2).

Figure 2.2: When do I use this toolkit?



PLAN	Before implementing a program This toolkit should ideally be used at the start of program planning to ensure that all stages of planning and evaluation are undertaken effectively. Work through Section 1 and Section 2 to create a strong program rationale and write clear program objectives based on evidence and identified needs.
DO	During program planning and implementation Section 3 and Section 4 guide you to choose appropriate strategies that will achieve the intended program outcomes. The use of behaviour change theories will help you understand human behaviour and what factors can help motivate and support healthy behaviour choices within priority groups.
CHECK	Evaluation is a crucial element for determining the outcome of your program strategies and for identifying opportunities for future improvement. Section 5 will help you understand different types of evaluation and the range of methods you can use to evaluate your program.
ADJUST	After a program is finished Once a program has been implemented, it is useful to review the planning and implementation methods that were used to identify any areas for improvement. You need to assess the effectiveness of completed programs to identify if the program could achieve even greater outcomes and what refinements would be needed to enable this.

Why should I use this toolkit?

We need to find out what works (what does not work) and why

Practitioners (that's you!) are under increasing pressure to develop programs that are effective

and sustainable. With increasing rates of STIs and BBVs, we need to be able to identify what works (and what is not working) and why. We also need to investigate new trends seen in the behaviours of priority populations and the factors influencing risk-taking behaviours. Our multicultural and geographical diversity in Western Australia presents further challenges. A 'one size fits all' is unlikely to work when it comes to SHBBV health interventions.

Advances in technology and community-based healthcare strategies do provide new opportunities for engaging hard-to-reach populations but we need to collect evidence about what strategies deliver the best health outcomes in order to make well-informed decisions about where future resources should be allocated.

Using the guidelines in the **SHBBV Program Planning Toolkit** will assist you in many ways. You will learn:

- How to research and explore new trends you have seen
- How to investigate the factors influencing risk-taking behaviour
- How to write research questions
- How to monitor and evaluate your program – is it reaching the intended participants, is the program acceptable to staff and participants, what is working well, what needs to be adjusted?

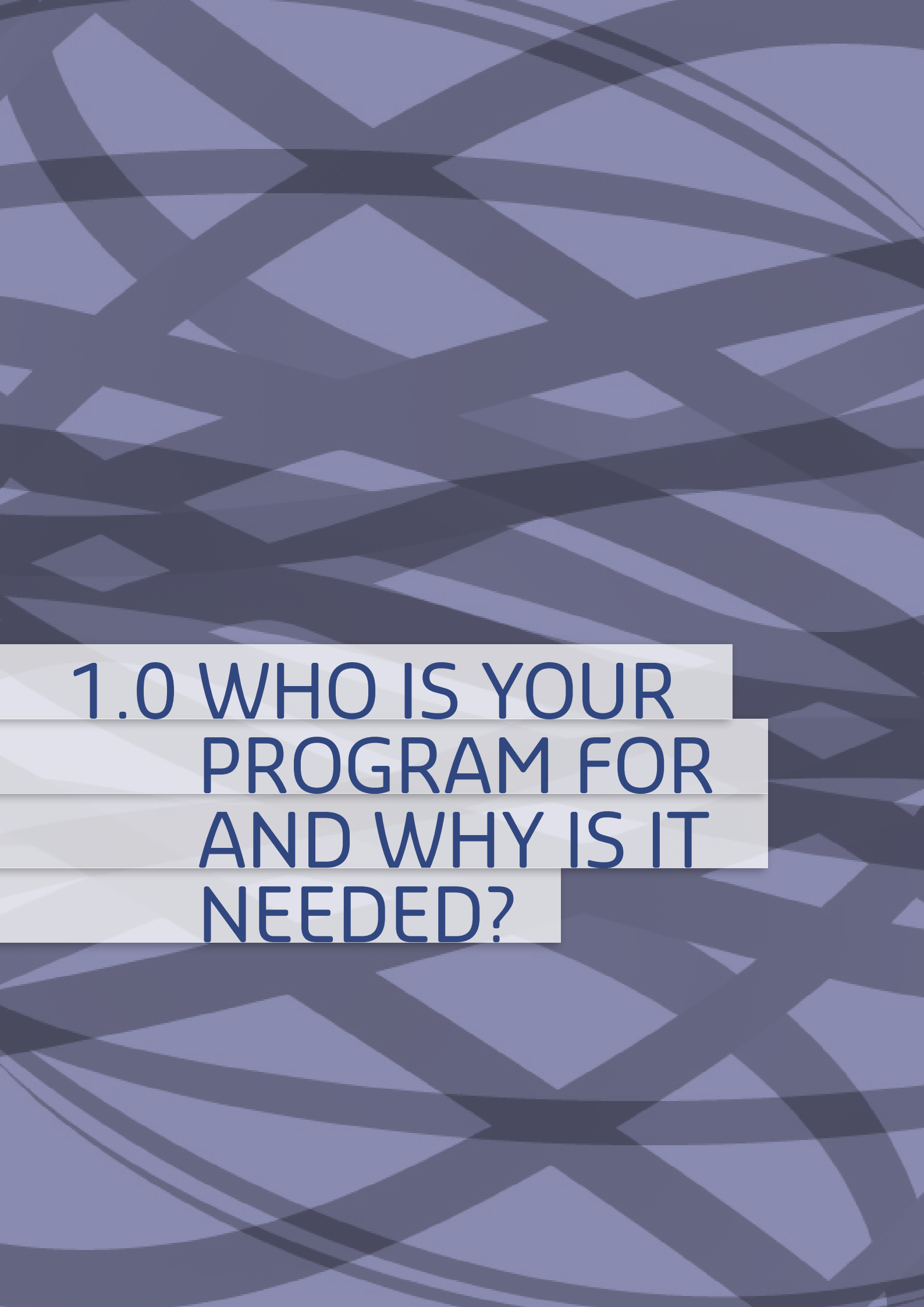
I'm stuck! Where can I get more information?

SiREN provides one-to-one mentoring and support for practitioners during program planning and evaluation. Support available from SiREN includes understanding the health issue and scoping out the program, assistance with the ethics approval process, identifying funding opportunities and providing assistance with grant applications, providing feedback on the development of conference abstracts and presentations, skills-building workshops, and facilitating linkages between researchers and practitioners.

For further information about SiREN and the support available please visit the SiREN website www.siren.org.au or email siren@curtin.edu.au.

Got a question or comment?

SiREN welcomes your feedback on the **SHBBV Program Planning Toolkit**. Please contact us at siren@curtin.edu.au if you have any comments or questions or if you have suggestions for other resources you would like to see included in this toolkit.



1.0 WHO IS YOUR PROGRAM FOR AND WHY IS IT NEEDED?

1.0 WHO IS YOUR PROGRAM FOR AND WHY IS IT NEEDED?

In this section of the toolkit we consider the program rationale - who is the program for and why is it needed? Before we can develop an effective program or service we need to be able to answer these questions.

In this section:

- Target group
- Stakeholders
- What are needs?
- Needs assessment process
- Collecting data for your needs assessment
- Steps in needs assessment
- Results of needs assessment

STI and BBV national strategies

These national strategies will help you ensure that your program is appropriate

It is important to ensure that all elements of your program align with one of the five national strategies for blood-borne viruses and

sexually transmissible infections. These strategies should guide the development STI and BBV prevention, testing and treatment programs. These documents can be found at the link below.

www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010

The more specific we can be about the nature of the health issue, the beneficiaries of the health intervention, and the needs of these beneficiaries in relation to the health issue, the more likely it is that we will be able to develop an effective program.

Unfortunately, needs assessment is often skipped completely in the planning process or lacks the detailed information required to inform good planning decisions. Some reasons for this may include understanding the reason for needs assessment and how to use it to build the rationale and intent of the program/project, resource or time constraints, difficulties accessing data, or lack of skills and knowledge to undertake needs assessment effectively.

This section of the toolkit provides step-by-step guidelines for conducting a needs assessment to develop a strong program rationale. First you need to define your target group and who your stakeholders will be.

1.1 Target group – who are you aiming to reach?

The target group is whom your program is designed for. It should be clearly described and defined.

The nature of the target group – size, demographic, age, gender, ethnicity, location, etc – will obviously influence the style of intervention. You may need to re-define your target group as you progress through the planning process e.g. different program strategies may be needed for different sub-groups within the target group.

1.2 Stakeholders

Stakeholders are groups or individuals who will be affected directly (e.g. program recipients) or indirectly (e.g. health workers) by the program. You will need to consult and participate with your stakeholders throughout the project to assess the needs your program will address and to ensure the program continues to meet stakeholder expectations.

There may be a **diverse range of stakeholder groups**, communities, organisations and individuals that are important to your project. You need to identify the **range of expectations** these stakeholders may have of the project early on and continue to monitor how well the project is meeting expectations during implementation.

You will also need to **revisit your list of stakeholders** as you implement the project to reflect changes in the stakeholder organisations or other external changes that could affect the success of your project.

1.3 What are needs?

Bradshaw (1972) suggests there are four different types of needs³. We need to consider these different types of needs to fully understand how to address the health issues in a community.

Normative need

what expert opinion based on research defines as a need

Expressed need

what can be inferred by observation of a community's usage of health services

Comparative need

examining the services available in one region to determine the services needed in a different region with a similar population

Felt need

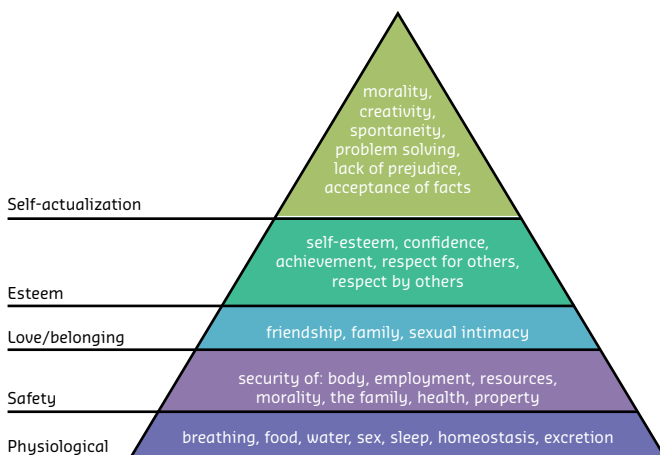
what people in the community say they want or feel they need

Information collected during needs assessment can be used to plan a program so that it best meets local conditions and addresses priority issues. A judgment has to be made about all the information collected in order to select a health issue, target group, setting or focus for a program.

A needs assessment will answer the following questions:

1. What does the community REALLY need?
2. Is there an indication that needs are not being met or change in service delivery is required?
3. Is the need for directional change indicated (e.g. we want to decrease STIs)?
4. How much time, money and other resources are required?
5. What are the most relevant issues?

Click on this [link](#) for further information about assessing different types of needs.

Maslow's hierarchy of needs⁴

Maslow's hierarchy of needs (1943) is a theory of human motivation. The model proposes that the most basic physiological needs must be satisfied before other needs are addressed. Higher level needs (esteem, self-actualization) will be pushed into the background or become non-existent until lower level needs (physiological, safety, love/belonging) are adequately satisfied.

1.4 Needs assessment process

A needs assessment is an important process to:

- Identify as much relevant information as possible to guide the development of best practice programs and activities
- Ensure that programs and activities are planned, are as effective as possible and are most likely to achieve their goals and objectives
- Ensure that communities are engaged in identifying their needs.

1.5 Collecting data for your needs assessment

Make sure that you collect as much data as you can. This will help you in the long run.

Different groups of people consider needs differently. Gathering information from a wide range of sources will enable you to build a

complete picture. Remember we are usually dealing with a community or population that is complex so it is unlikely you will find out what are considered the needs from just one place.

Collect as much health and demographic data on your community of interest as possible to get an idea of the scope of the issue. Check out the following sources of data:

- Australian Bureau of Statistics www.abs.gov.au including their census data.
- Australian Institute of Health and Welfare publications such as the Australia's Health reports available at www.aihw.gov.au.
- Local government websites.
- Epidemiology Branch of WA Health for SHBBV surveillance reports, testing data and notifications data. For more information about epidemiological data available or to make a request for data contact epi@health.wa.gov.au.
- Data from your own organisation e.g. clinical statistics may provide valuable information.
- Information from journals, the Internet, other publications and organisational reports. Use only reputable sources for your information for example research organisations and institutions, peer-reviewed publications.
- Information from consumers/community members and other people affected by the health issue. You might hold a community forum, run a focus group, and/or speak to key players such as community leaders or the head of an organisation.
- Experts in the field - either experts in the health topic or people who know the community of interest. Contact SiREN at siren@curtin.edu.au if you are unsure where to find an expert.

1.6 The steps in needs assessment

The steps in needs assessment are shown in the flowcharts in **Figure 1.1 – Identify the health problem** and **Figure 1.2 – Analyse the health problem**.

Figure 3.1: Identify the health problem



Figure 1.2: Analyse the health problem



The factors influencing a health problem can be identified at different levels:

- **Individual level** (e.g. age, gender, perceived risk)
- **Community level** (e.g. community norms, acceptability of services)
- **Systems or policy level** (e.g. availability of services)

A note about cultural sensitivity

Collecting data for a needs assessment should take into account preferences for data collection methods and characteristics of the target group which may influence the cultural acceptability of different methods. For example, in the Aboriginal culture, it is shameful and embarrassing to discuss sexual health issues. The following resources may be useful when planning a culturally sensitive needs assessment process:

Cultural respect and communication guide: a resource to assist sexual health delivery to Aboriginal communities

www.healthinfonet.ecu.edu.au/uploads/resources/19163_19163.pdf

Djiyadi: Can we talk? A resource manual for sexual health workers who work with Aboriginal and Torres Strait Islander youth

www.ashm.org.au/images/publications/djiyadi_can_we_talk.pdf

Straight Talking: a best practice guide in HIV and sexual health promotion for workers in Aboriginal and Torres Strait Islander health

www.straighttalking.org.au/cultural_sensitivity.html

1.7 Results of needs assessment

At the end of the needs assessment you should have:

- A health problem of agreed priority
- Characteristics of the target group (age, gender, ethnicity, etc.)
- An indication of the magnitude of the health problem (size of target group, prevalence data, location of target group, etc.)
- Factors influencing the health problem identified (individual, community, system or policy level factors)
- An indication of community resources to be involved in the health planning process (human resources, financial resources, materials, venues, etc.)
- Commitment from a range of groups and parties to bring about change
- Key people (allies, stakeholders, community members etc.) identified and involved in program planning.

1.8 I'm stuck! Where can I get more information?

Please contact SiREN at siren@curtin.edu.au if you have any questions or need more information about needs assessment and collecting data to develop a strong program rationale for why your proposed program is needed.

Health Needs Assessment Workbook

www.nice.org.uk/niceMedia/documents/hna.pdf

SWOT (Strengths, Weaknesses, Opportunities, Threats)

See Community Toolbox ctb.ku.edu/en/tablecontents/sub_section_main_1049.aspx



2.0 WHAT DOES
YOUR PROGRAM
EXPECT TO
CHANGE?

2.0 WHAT DOES YOUR PROGRAM EXPECT TO CHANGE?

This section of the toolkit will consider the question “What will change as a result of the program?” It is important to answer this question during the project planning stages in order to develop effective strategies that have **measurable** outcomes that can be evaluated.

In this section:

How will your program succeed?
Writing SMART goals and objectives
Linking objectives to program strategies
Short term and long term changes
Project planning tools and templates
Useful links

Invest adequate time for project planning

It is very tempting to move directly into developing the program strategies (the ‘doing’ stage) without clearly defining what changes we expect to see as a result of the program. Taking time to collect evidence about which strategies have been shown to be effective previously or developing a theory-based rationale for why a new strategy might work can improve the likelihood that precious resources are wisely invested. Begin planning with a **needs assessment**. For more information on needs assessment, refer to **Section 1 – Who is the program for and why is it needed?**

Set realistic and achievable targets

The next step is to determine the desired changes as a result of the program. Setting targets for the types of change and realistic levels of change is important. We want to be able to assess whether the program made a difference. Many sources of data are available to assist you in setting benchmark measurements for developing program goals and objectives (see **Section 1**). Where data does not exist, talk to your colleagues and experts in the field and agree on a realistic target. Don’t be too ambitious when setting targets – failing to hit a target can be demoralising while meeting or exceeding a target can be very motivating!

2.1 Risk factors (and protective factors)

A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury (World Health Organisation 2013).

A person’s health and wellbeing can be affected by many factors associated with ill health, disability, disease or death. Risk factors rarely operate in isolation; they will often coexist and interact with each other and may **predispose** an individual to behave in a certain way, **contribute** to or **reinforce** a health issue.

EXAMPLE: TEENAGE PREGNANCY

- Risk factor: Having unprotected sex
- Contributing risk factors
 - > *Predisposing*
 - + attitudes to contraception
 - + knowledge about contraception
 - > *Enabling*
 - + high cost of contraception
 - + barriers to purchase of contraception
 - > *Reinforcing*
 - + value/belief that it is OK to be pregnant/a teenage mother
 - + financial support for single mothers
 - + baby bonus

Protective factors are the opposite of risk factors. Protective factors explain why some individuals in a community will have better health outcomes than others when faced with the same health issue. For example, people diagnosed with HIV who have access to good social support networks may have better health outcomes than those who feel marginalised or isolated following a positive diagnosis. Social support is an example of a protective factor.

When writing objectives, you may want to focus on reducing the risk factors or the harms associated with risk factors that contribute to a health issue. In addition, you may wish to consider increasing the protective factors which contribute to or reinforce positive health outcomes and that could mitigate the effects of risk factors.

There are five different types of risk factors (or protective factors), each is described below.

BEHAVIOURAL
Factors associated with lifestyle changes, e.g. reducing the number of sexual partners, condom use
BIOMEDICAL
Factors influenced by a combination of lifestyle factors, e.g. uptake of hepatitis B and HPV vaccines, uptake of treatment for curable STIs
ENVIRONMENTAL
Social, economic, cultural and political factors e.g. steroid use for enhancing body image, stigma/shame
Physical, chemical and biological factors, e.g. access to needle exchange programs, high prevalence of STIs
GENETIC
Factors influenced by an individual's genetic make-up, e.g. race and family history can make some women more susceptible to HPV infection
DEMOGRAPHIC
Age, sex, and population subgroups, e.g. young people are more likely to experiment and engage in risky sexual behaviours, Indigenous Australians have higher rates of STIs than non-Indigenous Australians.

A note about the social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries (World Health Organisation 2013).

Wilkinson & Marmot² defined 10 social determinants of health:

- The social gradient
- Unemployment
- Social support
- Addiction
- Food
- Transport
- Stress
- Early life
- Social exclusion
- Work

While these factors are not easily modifiable, your program may be able to partially address these factors to improve health outcomes for a group.

2.2 Writing SMART goals and objectives

Writing **SMART** or **Specific, Measurable, Achievable, Relevant** and **Time specific** goals and objectives is one of the first and most important steps in effective program planning and evaluation. A **Goal** is a statement about long term outcomes or changes that the program seeks to influence or change. Goals can also be referred to as aims.

An **Objective** is a statement of change designed to achieve the program goal that measures short-term outcomes. Objectives are more direct and specific than the goal. A program can include both objectives and sub-objectives that show program implementation at different stages and levels.

GOALS | Correspond to the health problem
e.g. Chlamydia

OBJECTIVES | Correspond to the risk factors that influence the health problem
e.g. unprotected sex

What are SMART goals and objectives?

The acronym SMART stands for:

Specific	Who? What? Where?
Measurable	By how much? Is this number realistic?
Achievable	Will the time-frame allow the program to succeed?
Relevant	Which objectives provide a good indication of the program's effects?
Time Specific	By when?

Think about what the program will change at the start of planning

Evaluation may seem like one of the last steps in program implementation but in reality it is much easier to consider evaluation at the start of the planning process. Many projects have failed simply because the project had no specific goals or objectives. The evaluation therefore could not determine if the goals or objectives had been achieved.

An example of a SMART goal:

"To reduce by 30% the incidence of sexually transmitted infections among adolescents aged between 15-18 years, attending government secondary schools in the Perth metropolitan area, by the end of 2015".

An example of a SMART objective:

"To increase by 30% the number of sexually active adolescents aged between 15-18 years, attending government secondary schools in the Perth metropolitan area who have had an STI test in the last 12 months, by the end of 2015".

Use the SMART approach to write your own goal and objectives.

Let's have a look at why these example goals and objectives are SMART.

Specific:

Who? Adolescents aged between 15-18 years, attending government secondary schools.
What? Incidence of sexually transmitted infections
Where? Perth metropolitan area

Measurable:

By how much? To reduce by 30%. To increase by 30%.

Achievable:

To reduce by 30% by the end of 2015. The timeframe is sufficient for the goal to be achieved.

Relevant:

STI transmission is a problem among adolescents and therefore having an STI test is relevant to the target group and a suitable indicator of change. 30% is a realistic measure as it allows room for further growth. The goal is primarily based on behaviour change and therefore a lower percentage decrease is more realistic to aim for as behaviour change takes time.

Time Specific:

By when? By the end of 2015. This is a more specific target than "by 2015" or "When the program has ended". It is important to set a precise time frame.

Now compare the following two objectives:

Avoid vague or 'fuzzy' objectives

1. To increase the confidence of youth workers to deliver sexual health programs to young people

Look for measurable indicators of change

2. To increase by 30% the number of sexual health programs for young people available in youth centers within two years.

The first objective is not very specific or measurable. How will you measure increased confidence of youth workers?

2.3 What activities will achieve your objectives?

Program objectives are also used to decide on **program strategies** (or activities) i.e. what you are actually going to do. The objectives correspond to the **risk factors** influencing the health problem and are used to shape the strategies required to meet the goal.

Good project planning seeks to identify **modifiable** risk factors (or protective factors) and program goals and objectives **before** choosing strategies.

GOAL
What you want to achieve overall
OBJECTIVE
The change expected from your strategies
STRATEGIES
What your program is going to do

Table 2.1 illustrates the relationship between goals, objectives, risk factors and strategies.

Table 2.1: Understanding goals, objectives, risk factors and strategies

Health Problem Sexually transmitted infections among adolescents		
Goal “To reduce by 30% the incidence of sexually transmitted infections among adolescents aged between 15-18 years, attending government secondary schools in the Perth metropolitan area, by the end of 2015”.		
Risk factors 1. Limited sexual health knowledge	Objectives 1. To increase by 30% the number of sexually active adolescents aged between 15-18 years, attending government secondary schools in the Perth metropolitan area who have had an STI test in the last 12 months, by the end of 2015	Strategies 1. Policy change for mandatory sex education in all secondary schools

2.4 Short term and long term changes

When developing goals and objectives for your program, it is important to differentiate between short term and long term changes.

SHORT TERM CHANGES

Short term changes include an increase in knowledge and skills of the target group.

E.g. increasing knowledge of where to go for an STI test, or increasing skills related to correctly putting on a condom.

LONG TERM CHANGES

Long term changes include outcomes such as behavior modification or a change in legislation or policy.

E.g. changing behaviors to ensure that condoms are used every time a person has sex, or changing policy in terms of making sex education mandatory in all secondary schools.

When setting goals, the time frame needed to achieve the desired outcome needs to be considered carefully. Outcomes such as achieving a change in policy will generally take a lot longer to accomplish than increasing somebody's knowledge on a particular topic.

The timing of evaluation and measuring program effects or changes should take into account whether changes are short term or long term. Evaluating too early may not allow sufficient time for changes to be seen.

2.5 Program planning tools and templates

All of the tools that can be used when planning a health intervention. This section outlines five commonly used planning tools:

1. PABCAR model
2. PRECEDE-PROCEED model
3. Logic model
4. Planning and Evaluation Wizard (PEW)
5. Quality Improvement Program Planning System (QIPPS)

The choice of planning tool is based on your personal preferences

All of the planning tools involve working through a series of steps in a logical way, whilst still providing

room for modifications throughout the process. The planning tools may need to be adapted to suit your program. Using a planning tool or model will assist in identifying key factors of your intervention that will shape your goal, objectives and strategies. Some people prefer online tools or flow charts while other people prefer tables.

The first three planning tools discussed below (PABCAR, PRECEDE-PROCEED and Logic Model) provide an example of how to apply the tool to a current health issue. The example health issue for all three examples is the same to allow you to easily determine which template would best suit your program.

2.5.1 PABCAR model

The PABCAR model⁵ is a decision-making tool for health program planning. This practical tool for planning a program uses five key steps (see Figure 2.1).

Figure 2.1: PABCAR model

1. **P**roblem (*significance to community, cost, epidemiology*)
2. **A**menable to change (*can you fix it? How do you know?*)
3. Intervention **B**enefits are greater than **C**osts (*social, ethical, economic, efficacy*)
4. **A**cceptance for the interventions (*is the target group, community, and industry etc. going to accept the intervention?*)
5. Actions **R**ecommended and monitoring.

The example in Table 2.2 demonstrates how the PABCAR model can be used to guide an intervention focusing on a sexual health program aimed at culturally and linguistically diverse (CaLD) youth. A series of questions are asked during the PABCAR planning process. The answers to these questions will help to shape the program objectives and strategies.

Table 2.2: PABCAR example – Sexual health program for CaLD youth

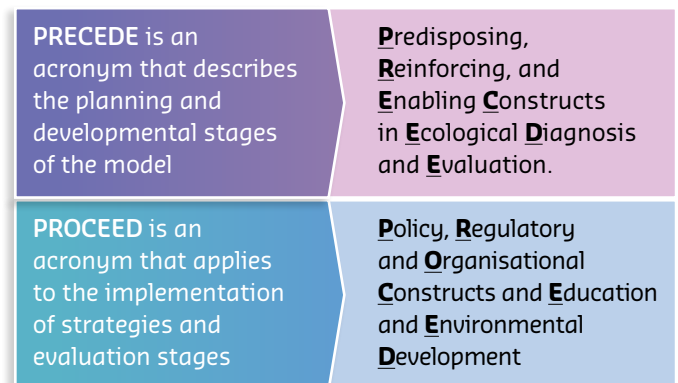
1. What is the problem and is it significant?
<i>The problem:</i> High risk of STI transmission among young Culturally and Linguistically diverse people in Perth. <i>Significance:</i> The transmission rate of STIs within CaLD communities is a serious issue for young people. Many STIs go unnoticed and untreated which may result in serious future health consequences. CaLD youth are less likely to seek assistance due to cultural barriers making them a vulnerable group.
2. Is the problem amenable to change?
Evidence indicates that the transmission rate of STIs would be reduced with the introduction of sexual health programs within CaLD communities to increase knowledge, awareness and skills.
3. Are intervention benefits greater than the costs?
With the introduction of a sexual health program, young CaLD people and their communities would benefit at a social, ethical and financial level, e.g. medical treatment costs are reduced.
4. Is there acceptance for interventions?
There is strong community and political support for this program and there is acceptance for the program among local CaLD communities.
5. What actions are recommended?
The implementation and monitoring of an ongoing sexual health program within the Perth metropolitan area.

2.5.2 PRECEDE-PROCEED model

The PRECEDE-PROCEED model is one of the more comprehensive models used for health promotion program planning. It provides a useful format for assessing priority health issues and identifying factors that should be focused on during an intervention.

The PRECEDE-PROCEED model emphasises that: **“The determinants of health must be diagnosed before the intervention is designed; if they are not, the intervention will be based on guesswork and will run a greater risk of being misdirected and ineffective.”⁶**

Figure 2.2: PRECEDE-PROCEED model



The PRECEDE-PROCEED model can be broken down into five planning questions that relate to a program. An example of these questions is shown in Table 2.3 below.

Table 2.3: Research questions related to the PRECEDE-PROCEED model

Health Issue: High rates of STI transmission among young culturally and linguistically diverse (CaLD) communities in Perth.	
Planning Questions	Answers
How serious is the health problem?	The transmission rates of STIs within CaLD communities are a serious issue for young people. Many STIs go unnoticed and untreated which may result in more serious health consequences. CaLD people are less likely to seek assistance due to cultural barriers.
What health related behavioral and environmental factors are involved?	Language barriers, fear of shame and stigma, limited understanding of the health care system, and a lack of access to culturally appropriate services are factors involved in this health issue.

Health Issue: High rates of STI transmission among young culturally and linguistically diverse (CaLD) communities in Perth.

Planning Questions	Answers
What are the determinants of those behavioral or environmental factors?	Social determinants such as social exclusion in society, stress and limited social support.
Which combination of health promotion interventions might change these determinants and factors?	Provision and advertisement of culturally appropriate health services available. Development of culturally appropriate sexual health education sessions and resources to distribute among community members. Use of creative techniques such as art, drama and music to educate communities as it may reduce shame and stigma surrounding the topic of sexual health.
How can those interventions be implemented?	Partner with local agencies such as WA AIDS Council (WAAC) and FPWA to develop appropriate resources to distribute. Contact multicultural and settlement organisations to use champions or community leaders to educate others.

Further information is available at the link below:
Using PRECEDE-PROCEED: A resource for instructors, students, health practitioners and researchers
www.lgreen.net

2.5.3 Logic model

The logic model is used during the developmental stages of program planning to demonstrate the logical flow of program elements. It provides a one page visual map of the activities and outputs of a health based program.

The model is used in a way that paints a picture of the theories and ideas that underpin a program. It illustrates a system of cause-and-effect relationships that create a path for the desired result. The logic model links the problem (**situation**) to the intervention (**inputs and outputs**) and the impact (**the outcome**).

Figure 2.3 illustrates the elements of the logic model.

The logic model elements are defined below:

- **Inputs:** the resources, contributions and investments that go into the program.
- **Outputs:** the activities, services, events and products that reach the target audience.
- **Outcomes:** the results or changes for individuals, groups, communities, organisations or systems.
- **Assumptions:** the beliefs we have about the program, the people involved, the context and the way we think the program will work.
- **External Factors:** the environment in which the program exists that includes a variety of external factors that interact with and influence the program.

Further information is available at the link below:
The logic model for program planning and evaluation
www.uiweb.uidaho.edu/extension/LogicModel.pdf

Use the Logic Model to create a clear visual image that outlines the important elements of your project.

An example of the logic model is shown below in Figure 2.4. This model has been applied to a program that uses drama and theatre based strategies to educate migrant youth on sexual health.

Figure 2.3: Elements of the logic model⁷

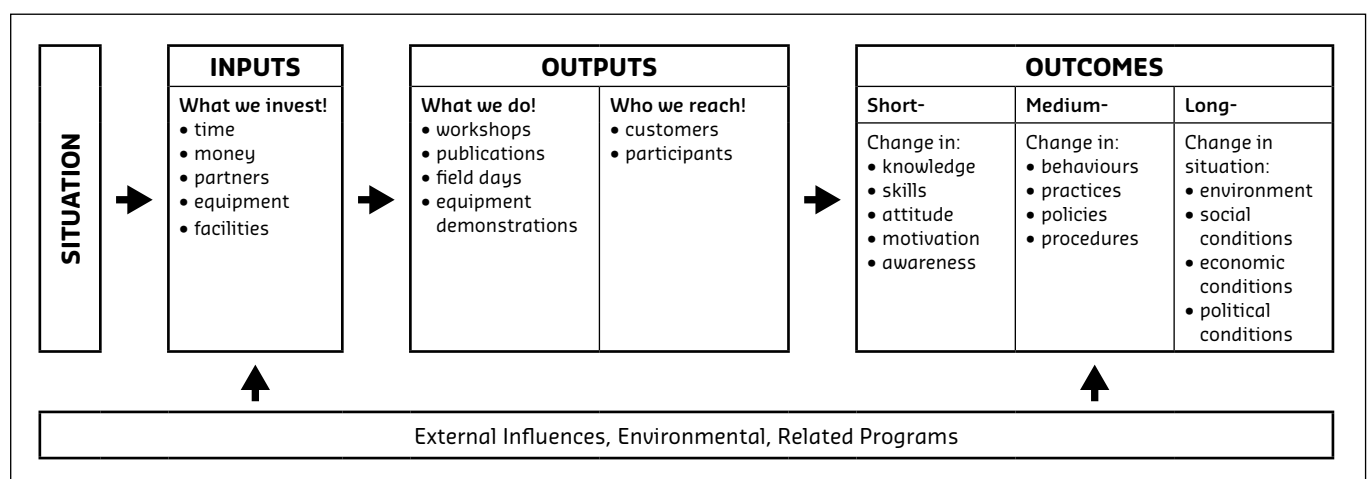
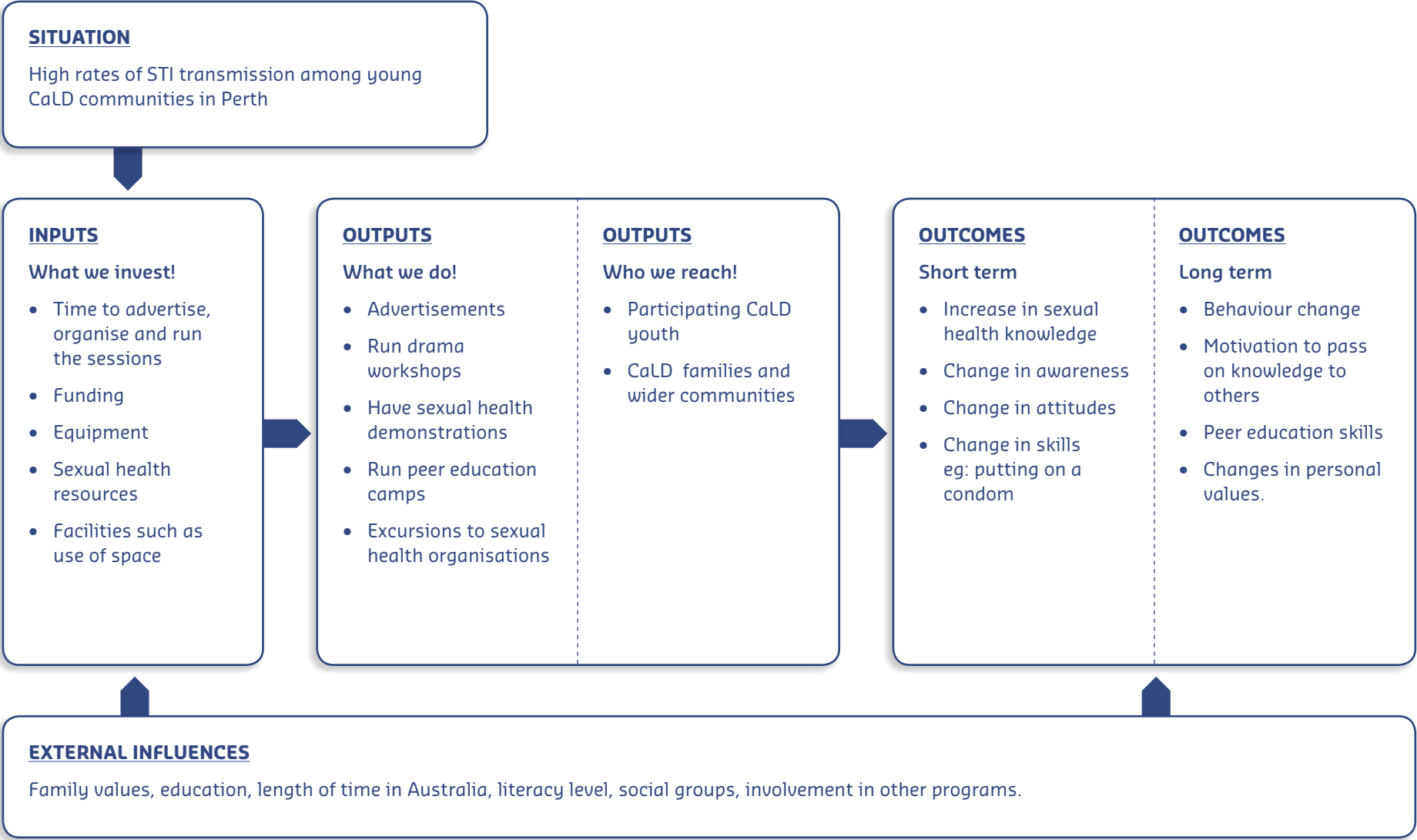


Figure 2.4: Example of the logic model

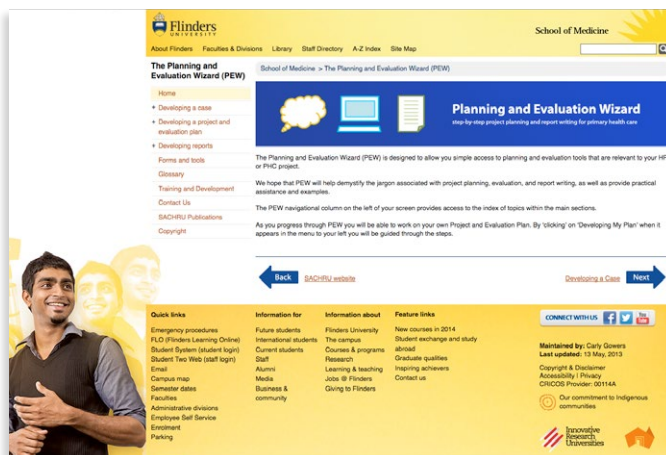


2.5.4 Planning and Evaluation Wizard (PEW)

The Planning and Evaluation Wizard (PEW) is an online planning and evaluation tool that can be accessed by clicking on the link below. PEW was developed by the South Australian Community Health Research Unit at Flinders University in Adelaide. PEW provides an easily accessible tool for practitioners with both practical assistance and examples.

The PEW website is divided into sections that provide information, blank templates and examples of previous case studies and programs.

The Planning and Evaluation Wizard (PEW) can be accessed at the link below: www.flinders.edu.au/medicine/sites/pew/pew_home.cfm



2.5.5 Quality Improvement Program Planning System (QIPPS)

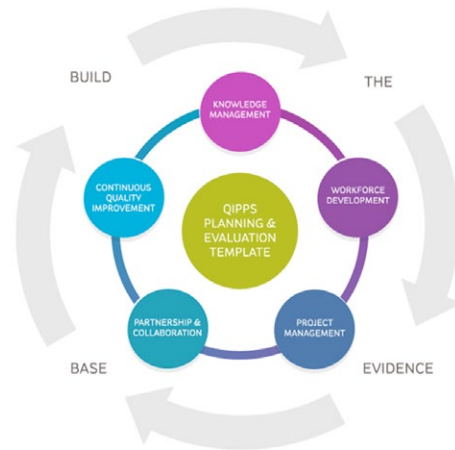
The Quality Improvement Program Planning System (QIPPS) is an online tool that has been designed to assist in planning and evaluating a variety of projects. QIPPS was originally developed by Mitchell Community Health Service (Victoria). Ownership of QIPPS was then transferred to the Victorian Community Health Association where it underwent huge transformations.

QIPPS has evolved into a tool that provides collaboration and searching of the growing body of community based projects throughout both Australian and New Zealand.



QIPPS is a dynamic tool that enables a consistent and structured approach to managing a program. It provides opportunities to facilitate partnerships, develop skills in writing a project plan, track project process, and support capacity building.

Figure 2.5: The QIPPS planning and evaluation template



This image and further information on the tool can be found on the QIPPS website below: www.qipps.com

2.6 I'm stuck! Where can I get more information?

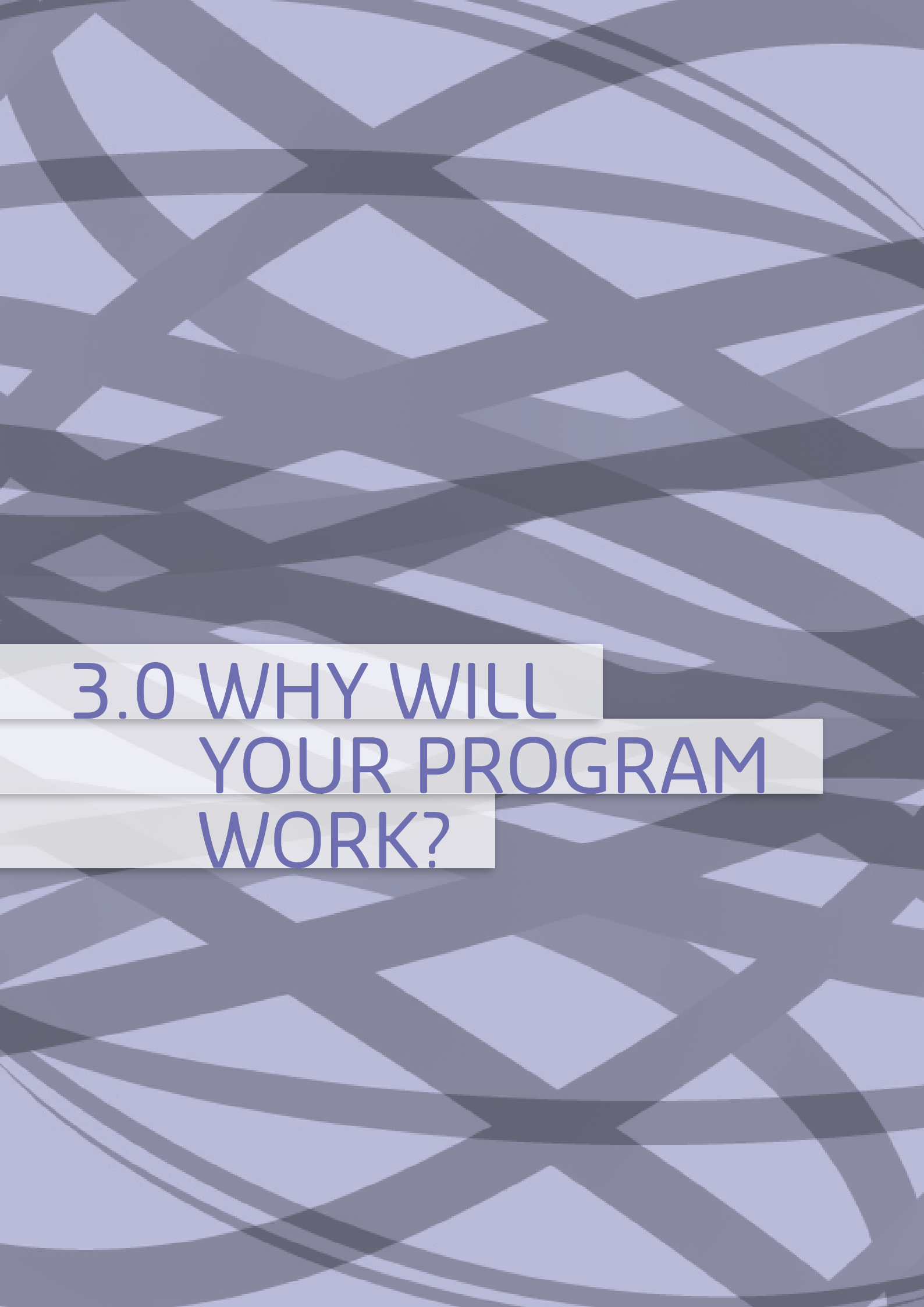
For further information about program planning, please see the links below.

SiREN website
www.siren.org.au

Health needs assessment workbook
www.nice.org.uk/niceMedia/documents/hna.pdf

Healthway website – provides good examples of case studies for health promotion projects.
www.healthway.wa.gov.au/profile/publications/case-studies-for-health-promotion-projects

Introduction to health promotion program planning
www.thcu.ca/infoandresources/publications/planning.wkbk.content.apr01.format.oct06.pdf



3.0 WHY WILL YOUR PROGRAM WORK?

3.0 WHY WILL YOUR PROGRAM WORK?

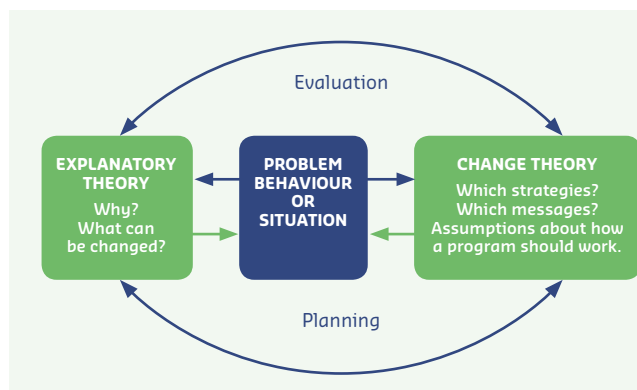
Understanding the health behaviours of a specific target group – what people do and why – can be very difficult. We need to understand what motivates certain human behaviours, especially risk-taking behaviour, in order to influence and change behaviour. Successful health interventions assist people to maintain and improve their health.

In this section:

Why use theories?
Stages of Change Model
Health Belief Model

Behaviour change theories are tools for practitioners to develop and evaluate health interventions that are based upon a systematic understanding of the dynamics of health behaviour and the external influences that affect them (see Figure 3.1).

Figure 3.1: Using explanatory theory and change theory⁸



3.1 Why use theories?

Not all programs will demonstrate positive results and achieve their program goal.

Programs that are more likely to succeed in achieving their desired results are those that are based upon a solid understanding of the health behaviours of the target group, and the context or setting in which they occur.

Theories can be applied to a range of different situations, settings and target groups. They provide guidance and offer insight on how to create a successful and strong program with sustainable behaviour changes.

What is a theory?

Theories generally consist of a set of definitions and concepts that will describe or predict actions, events or circumstances by demonstrating a relationship between the factors (or determinants) which influence change.

You can influence behaviour change at three levels:

INDIVIDUAL
Changing an individual's behaviour
INTERPERSONAL
Changing the behaviour of a small group of people
COMMUNITY
Changing the behaviour of a whole community

There are a variety of theories and models available (see Table 3.1 for examples).

Table 3.1: Examples of behaviour change theories and models

Individual level	Interpersonal level	Community level
Health Belief Model	Social Cognitive Theory	Communication Theory
Stages of Change Model		Diffusion of Innovation
Theory of Planned Behaviour		Community Organisation Theory

Further links:

Theory at a glance

www.cancer.gov/cancertopics/cancerlibrary/theory.pdf

Theory in a Nutshell (3rd Edition) (2010) by Donald Nutbeam, Elizabeth Harris, and Marilyn Wise. Published by McGraw-Hill: Australia

This book provides a more in-depth look at different types of behaviour theories and models.

We will now illustrate how two commonly used behaviour change theories can be applied to planning a health intervention to change an individual's behaviour:

- Stages of Change (or Transtheoretical) Model
- Health Belief Model.

Theories give planners tools for health promotion that are based on an understanding of health behaviour.

3.2 Stages of Change Model

The Stages of Change (or Transtheoretical) model was developed by Prochaska and DiClemente⁹. The model defines a person's individual motivation and readiness to change their behaviour.

Figure 3.2: Stages of Change model

The Stages of Change model has 5 stages:

- 1. Pre-contemplation stage**
Individual is not concerned with or aware there is a health problem
- 2. Contemplation stage**
Individual is aware of the health problem and considering what to do about it (if anything)
- 3. Preparation stage**
Individual has decided to take action and begins to research options
- 4. Action stage**
Individual decides on a plan of action and implements it
- 5. Maintenance stage**
Individual continues to implement their action plan

The Stages of Change model recognises that behaviour change is a **process not an event**.

The Stages of Change model allows for relapse and movement between the stages. It also illustrates how within a population, different

individuals may be at different stages and will require different strategies to move them to the next stage. A range of health interventions may therefore be appropriate when trying to change the behaviour of more than one individual.

Figure 3.3 shows how the Stages of Change model can be applied to understanding an individual's behaviour in relation to accessing sexual health testing and what strategies or activities may be suitable to move the individual to the next stage.

Figure 3.3: Example – Application of the Stages of Change model to sexual health testing

- 1. Pre-contemplation**
The individual is not even aware of or concerned about sexual health testing
Suggested strategies: awareness raising e.g. posters, radio ads, pamphlets
- 2. Contemplation**
The individual has heard or read about screening services and is wondering whether this is something they should do and what testing might involve
Suggested strategies: information/education sessions, website information
- 3. Preparation**
The individual decides they will have a sexual health test and starts to find out more about screening services available in their area including opening hours, costs, getting there, what the tests involve
Suggested strategies: removing barriers e.g. costs, location, access, eligibility
- 4. Action**
The individual makes an appointment and goes to a sexual health testing service
Suggested strategies: appointments are available, testing experience is acceptable and culturally appropriate, feedback collected on individual's testing experiences, and any issues addressed
- 5. Maintenance**
The individual goes for regular screening
Suggested strategies: reinforcing the importance of testing at each appointment, continued efforts to normalise screening in the community

Further information is available at the following link:

Transtheoretical Model

www.uri.edu/research/cprc/TTM/detailedoverview.htm

3.3 Health Belief Model

This model is one of the **most popular theories used in behaviour change**.

The second model we will illustrate is the **Health Belief Model** (or HBM) first developed by Rosenstock (1966) and further developed

by Becker in the 1980s¹⁰. The HBM **predicts the actions of an individual** based on the individual's **perceptions of risk** related to a health problem (**perceived susceptibility** and **perceived severity**). It also addresses the **perceived benefits** to avoiding the threat and factors that can influence their decisions to act.

If an individual perceives the risk of a health issue to be low and/or the benefits associated with taking any action to be less than the associated inconvenience or costs, they may not take any action and may not change their behaviour.

Figure 3.4 illustrates application of the Health Belief Model for a young male and their likely use of condoms based on their health beliefs.

Further information is available at the following link:

Health Belief Model

http://www.jblearning.com/samples/0763743836/chapter_4.pdf

This document discusses the Health Belief Model in more detail.

3.4 I'm stuck! Where can I get more information?

For further information and resources about using theories to inform program planning, the following links and references may be useful.

SiREN website

www.siren.org.au

E-Book: Theory at a glance

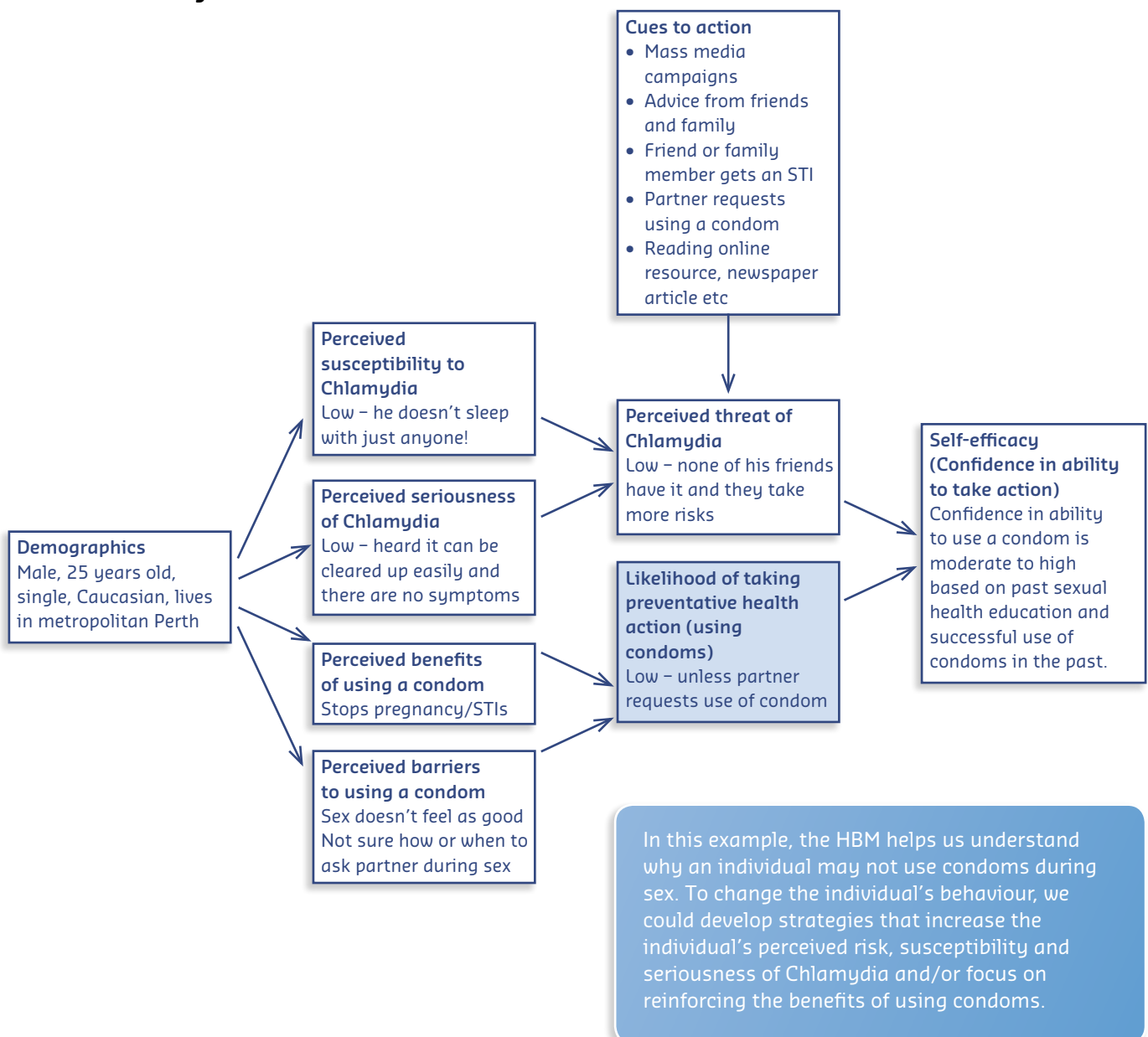
www.cancer.gov/cancertopics/cancerlibrary/theory.pdf

Book: Theory in a Nutshell 3rd Edition (2010)

By Donald Nutbeam, Elizabeth Harris, and Marilyn Wise.

Published by McGraw-Hill: Australia

Figure 3.4: Application of the Health Belief Model to likelihood of using condoms





4.0 WHAT WILL YOUR PROGRAM INCLUDE?

4.0 WHAT WILL YOUR PROGRAM INCLUDE?

In this section:

Deciding on strategies for achieving your goals
Influencing change at different levels
Using a settings approach

Many factors may contribute to the increases seen in sexually transmitted infections and blood-borne viruses. These include individual factors, social/community factors, environmental factors and legislative, policy or organisational factors. This section of the toolkit will consider the strengths and limitations of different methods (or strategies) that can be used to address these factors. The decision-making processes used to select the most appropriate strategy or combination of strategies will also be discussed.

4.1 Deciding on strategies for achieving your goals

Which methods will be most effective?

So where do you begin when deciding on which strategies you are going to use to deliver the greatest health outcomes? This section provides information on the most common approaches to deciding on and implementing health strategies, with specific examples applied to the sexual health and blood-borne virus field.

It is important to consider the planning stages that have been covered in the previous sections of this toolkit: needs assessment (Section 1), creating your goal and objectives (Section 2) and using behaviour change theories (Section 3). Understanding the target group clearly will help to ensure you are on the right track to choosing appropriate strategies for achieving your program goals and objectives.

Consider the points in Figure 4.1 when choosing strategies.

Figure 4.1: Considerations when choosing strategies

1. Evidence

Collect evidence from journals, reports and websites about strategies that have worked previously and how challenges and barriers could be addressed.

2. Timing

Consider the timing of your intervention including other programs that may be implemented at the same time for your target group.

3. Social Impact

Consider the impact of your proposed strategies on the target group. Is it fair and reasonable?

4. Ethical Considerations

Ensure your program is implemented within an ethical framework. Consider the following questions:
"Are you using somebody else's material without permission?"
"Are your strategies culturally sensitive?"
"Are you rewarding some people for participating but not others?"

5. Economic Costs

Complete a budget that will cover all stages of your project. Your strategies may need to be redesigned if costs exceed available budget and resources.

6. Acceptability

How acceptable is the program? Will people happily participate in your program? Unwillingness to participate may indicate further research about the target group is needed to understand the barriers to participation.

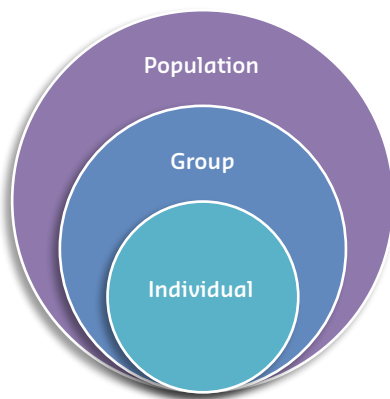
6. Evaluation

Ensure the strategies you select can be evaluated. You want to be able to easily measure how successful each strategy has been so that you can provide this information to your funders, target group and community.

4.2 Influencing change at different levels

Program strategies can be implemented at three different levels: **individual**, **group** or **population** (see Figure 4.2). The level or levels you choose will depend on the focus of the intervention, the funding available and the size and participation of the target group. Most programs require a multi-faceted approach that addresses a variety of factors throughout the intervention to achieve the intended outcomes.

Figure 4.2: Influencing change at different levels



4.2.1 Individual Strategies

Good training and interpersonal skills are needed by the person delivering individual strategies

Individual strategies focus solely on the individual and may include brief interventions delivered by clinical practitioners, preventative health

checks and advice, and one-on-one education sessions for personal information gain or self-management of ongoing conditions such as HIV.

Individual strategies will often be tailored to the individual to respond to their needs and concerns. This allows for positive responses among those who are considering changing their behaviour as they will feel more comfortable in a personal setting, and are able to confidentially voice their concerns.

EXAMPLES OF INDIVIDUAL STRATEGIES

- The WA AIDS Council has a peer outreach program that provides one-to-one support and counselling to people living with HIV/AIDS. Further information can be found at the following link: www.waaims.com/Positive-Services/support.html
- The Department of Health have developed the website, "Could I have it" which provides information on Chlamydia and a free chlamydia test for use at home. An online Pathwest laboratory request form can be downloaded and then taken to a Pathwest lab location. www.couldihaveit.com.au/index.asp
- Hepatitis WA offers services for people affected with Hepatitis that includes confidential peer support, referral, disease management information and one-to-one sessions. www.hepatitiswa.com.au/support/support-services-for-people-affected-by-hepatitis.html

4.2.2 Group Strategies

In group settings participants can learn from and support each other to make positive changes

Working with a group provides a good setting to implement a health strategy. Participants are able to learn from and share with one another

on a similar and relevant issue, which can be a very powerful tool for behaviour change.

Group strategies can either be **didactic** (a one way provision of information) or **experiential** (the group becomes involved in the activities). Each method can be successful depending on the group size, age, culture and the complexity of the issue. When delivering a group-based strategy, health practitioners can either establish a new group or use an existing group structure such as a school, worksite, social or sporting club.

Working with a group requires good facilitation skills and a strong understanding of the goal or aim of the session. Careful attention is required when recruiting participants in regards to how appropriate the content is for the audience. For example: discussing sexual health with adolescents is less likely to be successful in a group of mixed gender and ages. Group strategies provide the opportunity for train-the-trainer workshops so that skills can be transferred to others, and programs can then be further implemented across a wider setting.

EXAMPLES OF GROUP STRATEGIES

- FPWA offers a range of sexual and reproductive health education and training courses for teachers, doctors, nurses and other health professionals. The aim of these courses is to develop and update skills and knowledge in the area of sexual health, for a specific group of people. www.fpwa.org.au/educationtraining/
- The Freedom Centre is a peer support service for young people who are gay, lesbian, bisexual, transgender, intersex or questioning. It is a safe social space for people to meet and talk to others with similar experiences. www.freedom.org.au/

4.2.3 Population Strategies

Population health strategies include:

A: Social marketing approaches

B: Community-based approaches

C: Environmental approaches

A: Social marketing approaches

Social marketing is the application of the principles and methods of marketing to the achievement of socially desirable goals¹

Use social marketing to get messages to a large audience

it is the use of marketing principles to influence behaviour change. Social marketers may try to maintain existing behaviours, change unhealthy behaviours or encourage new behaviours.

Social marketing is a strategy that will be more successful when used in conjunction with other supporting strategies. Using social marketing strategies can be expensive. Extensive research is generally carried out to make sure that disseminating a health message through a certain outlet will be successful.

The use of **mass media** such as television, newspapers, magazines, and the radio can also be components of a social marketing strategy. The choice of media used to implement your strategy can help ensure messages reach the intended audience. For example: television advertisements chosen to air during a certain television program that has a known viewing demographic, or print advertisements in magazines with specific readership.

Social marketing and social media approaches.

What is the difference?

Social media include free social networking sites such as Facebook® and Twitter®. Using these sites to access social networks is becoming increasingly popular to distribute messages to a large audience. Facebook® and Twitter® often feature as components of contemporary social marketing strategies.

EXAMPLES OF MASS MEDIA STRATEGIES

- The Western Australian AIDS Council (WAAC) in conjunction with the WA Department of Health and Family Planning WA launched the "Safe Sex No Regrets" (SSNR) mass media campaign across WA in response to rising rates of HIV and STIs. www.safesexnoregrets.com.au
- The WA Department of Health developed a mass media campaign involving radio advertisements, posters, press and a website offering free chlamydia testing. www.couldihaveit.com.au
- The Australian Government developed radio ads as a part of a sexual health campaign which were aired to raise awareness on STIs www.sti.health.gov.au/internet/sti/publishing.nsf/content/campaign5

For further information about using **social marketing approaches**, check out the following:

Principles and Practice of Social Marketing: An International Perspective (2010) by Rob Donovan published by Cambridge University Press¹¹.

B: Community-based approaches

Community-based approaches can empower a group to change their health behaviour

Community-based approaches are also effective for targeting a large number of people. These approaches aim to empower a subgroup of a population to make decisions about their health. Successful community strategies should involve a working relationship with the target population to ensure that they are involved in all stages of the intervention. Encouraging community participation will increase the likelihood of the intervention succeeding.

EXAMPLES OF COMMUNITY-BASED STRATEGIES

Australia's community-based national response to managing STIs and BBVs. The STI Strategy recommends voluntary, patient-initiated STI and HIV testing, people with STIs or HIV have a right to participate in the community without stigma or discrimination, harm reduction principles (including through provision of needle exchange programs) and active participation of affected communities increases their influence over their health. [www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-sti/\\$File/sti.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-national-strategies-2010-sti/$File/sti.pdf)

C: Environmental approaches

Changes to the environment which help to make the healthy choice the easier choice¹² may include adaptations not only to the physical environment but also to the economic, social, cultural, service and political environment such as:

- **Physical modifications to the environment** – may be thought of as changes around individuals, for example installing condom vending machines.
- **Regulation, Legislation/Policy and Advocacy** – regulation, legislation and policy interventions may be thought of as strategies that are mandated or making the healthy choice the only or default choice/decision of individuals. Advocacy is a combination of actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program¹³.
- **Technology** – the use of point of care testing, condoms or new developments in the delivery of vaccinations harnessing innovations to advance health. These can be cost effective when distributed en masse, especially in resource poor settings. Because technological interventions do not rely only on the behaviour of an individual, they may protect the health of vulnerable or marginalised groups.
- **Incentives and Disincentives ('the carrot and the stick')** – this strategy may focus on *rewards* (incentives which may be financial such as rebates, membership fees, gift certificates) or non-financial such as recognition, social support or *negative consequences* (disincentives such as penalties which should be considered with caution)

- **Sponsorship** – such interventions may provide financial and non-financial supports for racing, sports and arts organisations in return for the promotion of healthy messages (and the ending of unhealthy messages in the case of replacing alcohol sponsorship with fruit and vegetables or physical activity messages) and the introduction of policies to support healthy environments.
- **Organisational interventions (or settings based approaches)** – A *settings approach* means that you operate within a specific setting that provides access to your target audience or group that could assist in achieving your program goal. Each setting will have its own benefits and challenges relating to the implementation of a single strategy or multiple strategies.

When choosing an appropriate setting for your intervention, consider:

- Do you already have strong connections with an existing setting?
- Are you familiar with an existing setting?
- Will this setting be credible for your audience, funders and partners?
- What is the evidence regarding successful and unsuccessful interventions that have occurred in this setting in the past?

EXAMPLES OF ENVIRONMENTAL STRATEGIES

- Some examples of physical modifications to the environment include: creating easy access sexual health clinics, installing interactive risk assessment kiosks, installing safe disposal units.
- An example of a sponsorship strategy may be providing a safer sex message to a local drama production such as YOHfest (Youth on Health Festival) www.yohfest.com.au
- Examples of regulation and legislation strategies include: requiring condom manufacturers to comply with Australian standards, changing the age of consent, changes to sex work laws or regulation of the industry.
- Some examples of policy and advocacy strategies include: the national HIV/STI/hepatitis strategies, required organisational cultural security training, advocacy for mandatory sexual health education to be in all secondary schools, advocacy for reform of sex work laws.

Some commonly used settings for health-based interventions, and an example for each, are listed below in Table 4.1.

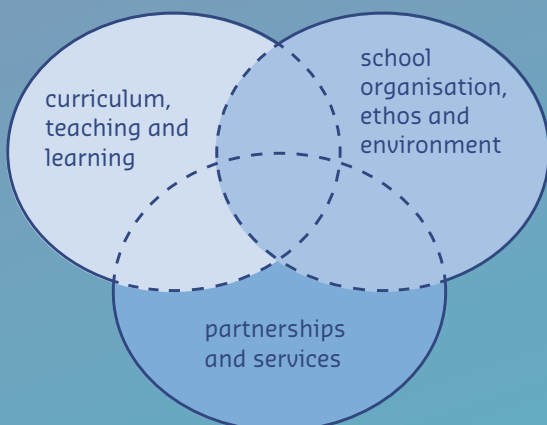
Table 4.1: Settings for health-based interventions

Setting	Example
Hospitals	Safety protocol training to prevent the spread of BBVs in a clinical setting.
Schools	Comprehensive sexual health education in secondary schools
Workplaces	HIV community awareness training to reduce stigma and increase knowledge.
Universities	Using the local university radio to transmit positive sexual health messages.
Social/sporting organisations	Implementing the blood rule for contact sports to prevent BBV transmission
Local Government	Condom dispensers in public toilets.
Prisons	Needle syringe exchange program (NSEP)

EXAMPLE OF A SETTINGS BASED APPROACH

WA Health Promoting Schools Framework
www.wahpsa.org.au

The three components of school communities interact and are inter-connected to create a health promoting school. By addressing each of these aspects of school life, it assists to make your planning and direction for change easier. If you have considered each of the components of the framework and made changes to promote a healthy school in each of the areas then your school will be on its way to providing a healthy and productive life at school.



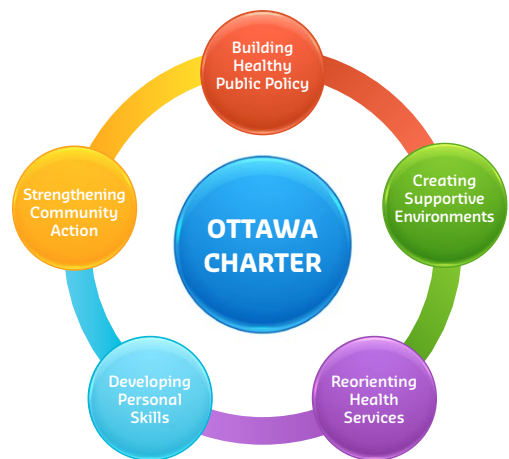
4.3 Using the Ottawa Charter for selecting strategies

Health promotion is the process of enabling people to increase control over, and to improve, their health.

The Ottawa Charter for Health Promotion¹², developed in 1986, is the predominant framework used for health promotion practice. Using the Ottawa

Charter ensures that health promotion interventions operate broadly across different levels and are more likely to lead to behaviour change than a narrow approach.

The five action areas of the Ottawa Charter give you some clues on areas to develop strategies (see Table 4.2).

Figure 4.3: Ottawa Charter for Health Promotion¹²

The Ottawa Charter for Health Promotion encourages us to think about the broader context in which we implement our health programs and how different strategies can be used to influence behaviour change, not just strategies that are focused on the individual.

Table 4.2: Ottawa Charter Strategic Direction

Ottawa Charter Areas of Action	Examples of Appropriate Strategies
Build Healthy Public Policy	Advocating for legislative and policy change that will support healthy choices
Strengthen Community Action	Active involvement and participation of community members to prioritise health issues and advocate for change
Create a Supportive Environment	The interactions between individuals and their environments can support or inhibit healthy choices. Supportive environments reinforce positive behaviour changes.
Develop Personal Skills	Providing information, education for health, and enhancing life skills. This development assists people to exercise more control over their own health and environments, and to make choices for better health.

Remember:

- Start with your health issue and target group needs – this encourages you to think more broadly about which strategies could be effective
- BE CREATIVE AND INNOVATIVE! Changing behaviour in a way that is sustainable often requires more than simply education

different strategies that can be used to change behaviour. The combination and number of strategies available to us is limited only by our creativity, funding (of course!), and the partnerships we can establish to support our ideas.

The Behaviour Change Mind Map shown in Figure 4.4 was developed by live-the-solution.com and illustrates some of the

Table 4.3 provides a list of potential strategies to help you start thinking about the wide range of specific actions you can take for your intervention. The strategies provide examples of influencing behaviour change at the individual, group and population levels and using strategies determined by the Ottawa Charter, e.g. advocacy and policy change. The table also lists some of the advantages and disadvantages of each strategy and an example of where it has been applied so that you can choose a combination of methods that are best suited to your program.

[illegible]

Table 4.3: Health based strategies

Strategy	Advantages	Disadvantages	Example	Level
Advocacy	<ul style="list-style-type: none"> Great for gaining community support about topical issues Way of proposing positive and sustainable change 	<ul style="list-style-type: none"> Advocacy is usually a long term strategy It needs passionate campaigners 	<p>YACWA is advocating for sexual health education to be mandatory in all secondary schools www.change.org/en-AU/petitions/sex-education-should-be-mandatory-in-all-wa-high-schools</p> <p>PHAA advocacy to include a needle and syringe exchange program in prisons for effective management of BBVs www.phaa.net.au/documents/Sept12.pdf</p>	Population
Campaigns	<ul style="list-style-type: none"> Interactive Action-oriented (not just educational) Community members can make a difference to a health issue of concern 	<ul style="list-style-type: none"> Campaign development may be costly Visual appeal of campaign is important therefore allow funds for graphic design 	<p>Hepatitis WA “Play the blood rule” campaign http://playthebloodrule.com/index.html</p>	Group Population
Community education	<ul style="list-style-type: none"> A good way of engaging a specific community at a personal and population level 	<ul style="list-style-type: none"> It often takes time and funding to develop good resources for the sessions May take time to find and train good facilitators 	<p>WA AIDS Council runs community awareness events and workshops www.waids.com/Education/community-events.html</p>	Group Population
Demonstrations	<ul style="list-style-type: none"> Provides a hands on approach for the target audience Provides opportunity for partnership building 	<ul style="list-style-type: none"> Requires well-trained staff Need a good budget for resources Can be hard sometimes to find the right time and location 	<p>Condom demonstrations at secondary schools during health class</p>	Group Individual
Environment	<ul style="list-style-type: none"> Reinforces the effects of other health promoting strategies Facilitates behaviour change indirectly 	<ul style="list-style-type: none"> Visible changes to the environment may be considered too explicit or capable of having unintended effects e.g. promoting sexual promiscuity 	<p>Condom vending machines in public toilets and schools</p> <p>‘Sex positive’ youth centres which display posters and provide information about sexual health and relationships encourage young people to feel comfortable to ask questions about any sexual health issues</p>	Population

Strategy	Advantages	Disadvantages	Example	Level
Group sessions	<ul style="list-style-type: none"> • A more personal approach • Can be sustainable if the community take ownership of it 	<ul style="list-style-type: none"> • Can be hard to get participants to attend and commit to the sessions • Finding the right time and location can be difficult 	8 week HIV community educator training facilitated by the WA AIDS council.	Group
Incentives	<ul style="list-style-type: none"> • Can increase engagement in a health promotion strategy • Respects and values the time/input of participants 	<ul style="list-style-type: none"> • Finding an appropriate incentive to avoid 'bribing' participation • May be difficult to sustain longer term without funding 	<p>Can be financial, products obtained from relevant sponsors, or related to personal development e.g. work experience for CV</p> <p>Opportunity to enter a prize draw for participating in a project/survey</p>	Individual Group Population
Interactive internet websites	<ul style="list-style-type: none"> • Reaches a wide audience • Usually cost effective • Easy to update and edit information 	<ul style="list-style-type: none"> • Only useful if target group are comfortable using the internet • Need technical assistance in the design and development phase 	<p>WA Department of Health "Get the Facts" website www.getthefacts.health.wa.gov.au</p> <p>Sydney Sexual Health Centre interactive website www.sshc.org.au/Risk_Start.aspx</p>	Individual
Mass media print	<ul style="list-style-type: none"> • Wide reach • Has a longer lasting time than TV ads • Local papers like local stories 	<ul style="list-style-type: none"> • Paid print media can be expensive 	<p>Article in The Sydney Morning Herald on STIs www.smh.com.au/lifestyle/diet-and-fitness/sexually-transmitted-disease-rates-skyrocketing-20100528-wip5.html</p>	Population
Mass media television	<ul style="list-style-type: none"> • Reaches a wide audience • Brand awareness is created 	<ul style="list-style-type: none"> • Can be expensive • Need to keep messages simple • The effect is short-lived 	<p>Safe Sex No Regrets TV commercial www.youtube.com/watch?v=NnEfukGtVFw</p>	Population
Outreach	<ul style="list-style-type: none"> • Reduces barriers to accessing health services (e.g. time, transport, cost, opening hours) by taking the health service to the consumer 	<ul style="list-style-type: none"> • Can be expensive • May operate outside normal 'working hours' 	<p>Stamp Out Chlamydia 2 Project – raises awareness of chlamydia and brings on the spot, free chlamydia testing to young people in public venues including music festivals and sporting clubs http://socproject.net/index.php/about-us</p>	Individual Group Population
Peer-led interventions	<ul style="list-style-type: none"> • Good way to target hard to reach groups 	<ul style="list-style-type: none"> • Need to have appropriate peer leaders • Peer leaders will require support as well 	<p>The Youth Educating Peers (YEP) project www.yacwa.org.au/projects/the-yep-project.html</p> <p>M Clinic – free STI/HIV screening clinic for men who have sex with men www.mclinic.org.au</p>	Individual Group Population

Strategy	Advantages	Disadvantages	Example	Level
Policy/ legislative change	<ul style="list-style-type: none"> Long lasting change is achieved Uses a good evidence base There is generally positive compliance with the change 	<ul style="list-style-type: none"> Time consuming – can take years to implement Need to ensure that the policy is enforced Need committed campaigners and politicians 	Decriminalisation of sex work industry in WA www.scarlettalliance.org.au/library/sub_2011	Population
Posters	<ul style="list-style-type: none"> Cheap Easy way of providing factual information. Easy to distribute 	<ul style="list-style-type: none"> Needs simple, short messages Need to test readability e.g. using SMOG test (simplified measure of gobbledygook) Short term response Needs to be used in conjunction with other strategies 	WAAC “Safe sex no regrets” posters www.safesexnoregrets.com.au	Population
Printed resources (brochures and pamphlets)	<ul style="list-style-type: none"> Cheap Easy way of stating factual information 	<ul style="list-style-type: none"> Assumes good literacy levels Need to SMOG test for readability Short term response Generally unattractive to target audience Might end up in the bin 	<p>WA Department of Health fact sheets and brochures on sexual health for Aboriginal people and multicultural groups www.public.health.wa.gov.au/3/565/2/aboriginal_sexual_health_facts_sheets.pm</p> <p>WA Department of Health “Talk Soon Talk Often: A guide for parents talking to their kids about sex” www.public.health.wa.gov.au/cproot/4011/2/TSTO_V2.pdf</p> <p>“Blood Rules OK in Sport” pamphlet produced by Sports Medicine Australia http://sma.org.au/wp-content/uploads/2009/10/Blood_rulesOK-pamphlet.pdf</p>	Group Population
Technology	<ul style="list-style-type: none"> Innovative May increase engagement Reduces barriers to accessing health care 	<ul style="list-style-type: none"> May be costly to develop and implement Requires specialist skills There may be legislative and policy requirements to address 	Rapid HIV (Point-of-Care) testing for high risk population groups to engage users in screening and reduce barriers associated with waiting for test results http://theconversation.com/quick-and-easy-how-rapid-hiv-tests-can-help-reduce-transmission-1447	Individual Population

Strategy	Advantages	Disadvantages	Example	Level
Training and capacity building	<ul style="list-style-type: none"> Provides a reference tool for trainers and health professionals Increases skills in cultural sensitivity and competency in working with people from other cultures 	<ul style="list-style-type: none"> Time consuming to develop Can become out-dated quite quickly May not be used 	<p>“Talking Sexual Health” a teaching resource for secondary school teachers www.latrobe.edu.au/arcs/shs/downloads/arcs/shs-research-publications/TSH_full_teacher_resource.pdf</p> <p>Diverse sex and gender training workshops run by Freedom Centre www.freedom.org.au/index.php?option=com_content&view=article&id=169&Itemid=118</p> <p>Aboriginal cultural competency training www.healthinfor.net.ecu.edu.au/cultural-ways-home/cultural-ways-workforce/training</p>	Group
Twitter, Facebook etc.	<ul style="list-style-type: none"> Affordable and current Engaging Great way to reach certain demographics such as young people 	<ul style="list-style-type: none"> Does not address people who are not familiar with this technology outlet or who do not have access 	<p>The World Association for Sexual Health has a Facebook page. www.facebook.com/WAS.org</p>	Individual
Web-based information	<ul style="list-style-type: none"> Broad audience Easy to update Can include a large amount of information 	<ul style="list-style-type: none"> Hard to know how the information is being interpreted Web design can take time and is costly Need to keep material current and credible 	<p>Quarry Health Centre for Under 25s www.quarryhealthcentre.org.au</p> <p>WA Department of Health “Growing and developing healthy relationships” www.gdhr.wa.gov.au</p>	Individual Population

4.4 I’m stuck! Where can I get more information?

For further information about choosing effective strategies, please see the links below.


SiREN website
www.siren.org.au

Introduction to Health Promotion Program Planning
www.thcu.ca/infoandresources/publications/planning_wkbk.content.apr01.format.oct06.pdf

Healthway Website - Provides good examples of case studies for health promotion projects.
www.healthway.wa.gov.au/profile/publications/case-studies-for-health-promotion-projects

Health Promotion Strategies and Methods, Third Edition, (2013) by Garry Egger published by McGraw-Hill Education, NSW.

Promotion of Sexual Health Recommendations for Action www1.paho.org/english/hcp/hca/promotionsexualhealth.pdf

The background of the slide is a complex, abstract pattern composed of various shades of green. The pattern consists of overlapping, curved, and angular shapes that create a sense of depth and movement, resembling a stylized, low-poly landscape or a series of interlocking geometric forms.

5.0 DID YOUR PROGRAM WORK?

5.0 DID YOUR PROGRAM WORK?

Evaluation is the process of judging the **value** of something. It is a crucial component for assessing whether or not an intervention has achieved its desired goal and objectives.

In this section:

Why evaluate?
Types of evaluation
Evaluation methods
Improving data reliability and validity
Analysing data
Using the results of an evaluation

5.1 Why evaluate?

Evaluation enables health practitioners to **document**, **promote** and **disseminate effective practice**. Others can learn from what you have done and can identify program strengths and areas for future program improvement.

Furthermore, we need to evaluate our programs and services to ensure we do no harm to our intended target groups and to **justify expenditure** of public funds.

Evaluation can answer many questions, for example:

1. Has the intervention been implemented as planned?
2. Have there been any changes to the cause of the problem?
3. Are we reaching the right people?
4. Has the health issue improved as a result of the program?
5. Did the program achieve its goal and objectives?
6. What worked well? What could be improved?

It is important to think about evaluation in the early planning stages

Although some evaluation will not be conducted until after a program concludes, evaluation strategies should

be considered early in the planning process to ensure that opportunities to collect data are not missed. For example, undertaking a pre-test to determine baseline measures for your target group cannot be done after the intervention.

5.2 Types of evaluation

A comprehensive program evaluation is likely to include three different types of evaluation. These are:

1. PROCESS EVALUATION

2. IMPACT EVALUATION

3. OUTCOME EVALUATION

Each type of evaluation is related to the stages of program planning (see Table 5.1) and is described in more detail below.

Table 5.1: Evaluation linked to program planning

Strategies	measured by	Process evaluation
Objectives	measured by	Impact evaluation
Goal	measured by	Outcome evaluation

5.2.1 Process Evaluation

Process evaluation is used to measure **program development**, **delivery** and **progress**. It assesses factors such as the program's quality, availability, appropriateness, target group reach and how well the strategies were received by the intended audience.

Process evaluation can be implemented throughout the entire duration of the program, from the early planning stages to completion. Questions could include:

- Did we reach the intended participants?
- Was the program liked/accepted?
- Was the program cost effective?
- What worked well?
- What would we do differently next time?
- Were participants satisfied?

Process evaluation records how well the program was implemented as planned

Although Process evaluation describes what happens once the program has started, and may involve recording and counting

inputs and outputs such as number of sessions held, attendance and response rates, the number of resources

developed and distributed, program costs, and the time taken to develop resources. Using process evaluation to monitor program development is important for identifying the **strengths** of program delivery and **areas for improvement** to achieve optimal health outcomes.

Process evaluation also provides information that assists in understanding whether a program is **sustainable** and could be repeated.

5.2.2 Impact Evaluation

Do not evaluate the impacts of a program too early! Process evaluation should be done before impact evaluation

Impact evaluation measures the **immediate short-term effects of the program**, related to the program objectives. Impact evaluation can measure

short-term changes in behaviour, knowledge, social participation, environment, policy development and risk factors. An impact evaluation may include answering the following questions:

- What proportion of the target group has heard of the program strategies?
- Has there been a change in behaviour? (e.g. more people having STI tests)
- Do participants know more about the topic? (e.g. broader knowledge on STI's)
- What are the participants' attitudes towards this intervention? (e.g. positive attitudes towards more condom dispensers)
- Did the program increase knowledge and/or skills?
- How did the program change behaviour?
- What changed as a result of the program?
- What other changes were influenced by the program?

Impact evaluation is undertaken on completion of certain stages throughout implementation (after sessions, monthly intervals, on completion of the program).

5.2.3 Outcome Evaluation

Outcome evaluation could include follow-up surveys or phone calls

Outcome evaluation measures **long-term program effects** and assesses whether, or to

what extent, the program goal has been achieved. Long-term changes may include decreases in incidence or prevalence rates of a certain health problem, variations in mortality, quality of life improvements, effects of policy implementation and sustainable behaviour change.

Since outcome evaluation focuses on long-term change, this type of evaluation will generally be undertaken at some time after the intervention has ended. This time frame can vary between a few weeks after the program has ended, to several years.

Outcome evaluation could seek to answer questions such as:

- **Has there been a reduction in Chlamydia rates?**
- **Do people self-report regular use of condoms?**
- **Has the quality of life of people living with HIV improved?**

5.3 Evaluation methods

There are many ways to collect information for each type of evaluation. The evaluation method that you choose depends on the size of your program, your budget, time constraints, the characteristics of the target group (including determining methods that are acceptable and/or culturally appropriate), how big your target group is, what information you are aiming to collect and who the information is for.

Depending on the purpose of your evaluation you can use **qualitative** or **quantitative** data collection methods. These are described below.

Qualitative Evaluation

Qualitative evaluation methods will usually ask participants to use words and meanings in order to provide an in-depth assessment of their experience of the intervention issue and to describe their thoughts and feelings on the program. When using qualitative data collection it is best to use a combination of approaches (i.e. more than one source of data) to improve data reliability.

Quantitative Evaluation

Quantitative evaluation methods use numbers, frequencies, percentages and statistics to measure change. Quantitative methods are useful for large groups. Results can be generalised to the population level. Structured surveys undertaken online, by telephone or using paper-based surveys are the most commonly used quantitative evaluation methods.

Using a variety of evaluation methods and data sources can increase the reliability of your data for example, by engaging different subgroups in the target group, or to enable comparisons for assessing consistency.

Qualitative evaluation methods

- Open surveys/questionnaires
- Interviews
- Focus group discussions
- Observation
- Informal feedback
- Suggestion boxes
- Session notes/debrief
- Diaries/journals
- Text message polls (SMS)

- Drama/theatre/role play
- Games/competitions
- Art/music
- Photography/video
- Facebook
- Field notes

Quantitative data sources

- Multiple choice questions
- Quizzes
- Pre/Post Tests
- Surveillance reports
- Number of STI/BBV tests
- Number of STI/BBV notifications
- Program attendance records
- Resources produced/distributed
- Number of website visitors
- Website pages visited
- Program costs
- Medical records
- Number of requests for information
- Number of sessions conducted
- Project activity report

Table 5.2 provides a summary of the advantages and disadvantages of both qualitative and quantitative data collection methods and some examples for each.

Table 5.2: Evaluation Methods

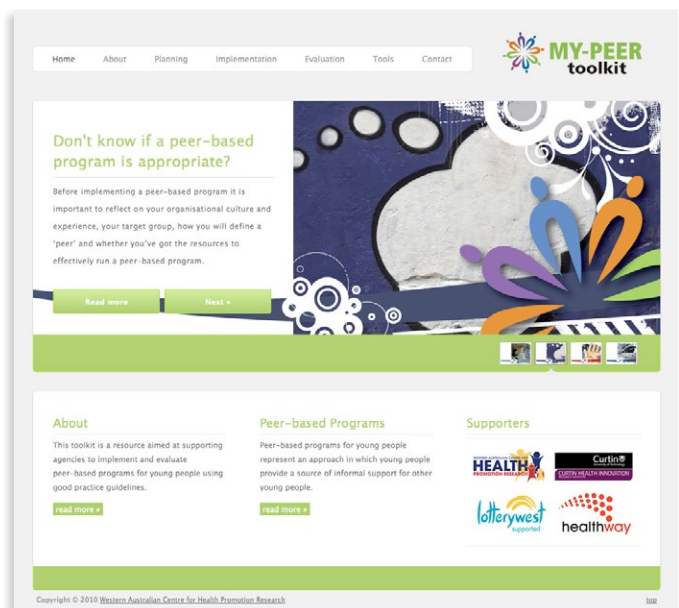
Method	Advantages	Disadvantages
Qualitative	<ul style="list-style-type: none"> • Provides in-depth, rich data • Good for assessing attitudinal information • Can use with individuals to better understand a community • Gives good information on why something changed 	<ul style="list-style-type: none"> • Can be very time-consuming • Costly • Requires high skill level to analyse results
Quantitative	<ul style="list-style-type: none"> • Generally easy to administer • Cost and time effective • Good for obtaining data from a large target group • Can do group comparisons • Can measure changes in a group/population 	<ul style="list-style-type: none"> • Not good for exploring complex ideas • May not demonstrate real reasons for attitude and behaviour change

MY-PEER TOOLKIT

The My-Peer Toolkit www.mypeer.org.au contains more information about different evaluation methods.

- The My-Peer Toolkit was developed by the WA Centre for Health Promotion Research at Curtin University to provide a free online resource for youth workers involved in planning, implementing and evaluating peer-based youth programs including sexual health peer education programs and drop-in peer support programs for LGBTIQ youth and teenage parents.
- The My-Peer Toolkit contains information about a range of evaluation methods including interviews, focus groups, observation, surveys, and creative evaluation strategies including photography, dance, drama, music, online simulation, art and sculpture. The information on evaluation is relevant for all programs, not just peer-based programs.
- The My-Peer Toolkit also includes a selection of evaluation case studies and tools.

Figure 5.5: My-Peer Toolkit www.mypeer.org.au



5.4 Analysing data

Data analysis can require specialist evaluation skills and knowledge. This section provides an overview of data analysis to help you determine if you can do the evaluation yourself or if you need to enlist specialist support.

Quantitative data analysis involves the analysis and presentation of numerical data, e.g. responses to structured surveys, attendance records, surveillance data, and quiz responses.

Qualitative data analysis involves the interpretation and presentation of visual or textual data e.g. interview or focus group transcripts, observation data, open-ended surveys, photographs, artwork, drama, and dance.

Quantitative Data Analysis

For quantitative data analysis, issues of **reliability** and **validity** are important:

- You need to show that the methods used were **valid and effective** in collecting the data needed (e.g. writing non-ambiguous survey questions, using a validated scale).
- You also want to be able to show that the data collection methods are **consistent** and **stable** – for example the method would collect the same data regardless of when the data was collected or by whom. A **test-retest** procedure is used to establish this type of reliability where data is collected at two different times and/or by different people using the same data collection method and the outputs are compared for consistency.
- Eliminating sources of **bias** introduced by the data collection method, the respondents or the researcher is important. For example, do paper-based surveys yield more responses than online surveys or do online surveys appeal to different sub-groups in the population who may have particular characteristics? If so, can the data be said to be representative of the wider population or is the data biased?

Don't underestimate the time needed for data entry!

Data entry can be time consuming before you are able to analyse quantitative data – consider the time

taken to enter the responses to a long survey from several hundred respondents! **Computer software** such as SPSS Version 21.0 (Statistical Package for the Social Sciences) is the easiest and quickest way to analyse large volumes of quantitative data once data entry is completed. Some basic knowledge of statistical techniques is needed.

STATISTICAL TECHNIQUES

- **Frequencies** – how many, number of males, number of females, etc
- **Bivariate analysis** – relationships between two variables e.g. condom use and knowledge of condoms' role in preventing STIs
- **Multivariate analysis** – relationships between several variables e.g. factors influencing condom use – acceptability, availability, experience, cost, norms, etc

MEASURING DATA

- **Nominal data** – e.g. marital status, religious affiliation, gender
- **Ordinal data** – the answers form a scale, e.g. skill levels
- **Interval data** – e.g. age groups, income brackets, number of children
- **Mean** – the 'average' when a list of numbers is added together and divided by the number of items
- **Median** – the middle number in a list of numbers
- **Mode** – the number that occurs most frequently. There can be no mode or more than one mode

This **SHBBV Program Planning Toolkit** does not cover statistical data analysis in detail. For further information, please refer to one of the following books:

- Greasley, P (2008). *Quantitative data analysis with SPSS*. Maidenhead: Open University Press¹⁵
- *Quantitative Data Analysis with SPSS Release 12 and 13: A Guide for Social Scientists* (2005) by Alan Bryman and Duncan Cramer. East Sussex: Routledge¹⁶

Qualitative Data Analysis

The first step in qualitative data analysis is presenting the data in a way that can be analysed. For recorded interviews or focus groups this involves creating a **written transcript** of the interview or focus group.

Thematic analysis is a commonly used process for analysing qualitative data. The process involves identifying and highlighting major themes in written transcripts (see Figure 5.2). This process is called **coding**. The themes are found within the data but may be influenced by the researcher's previous reading or experience of the health issue being investigated.

Figure 5.2: Example of coded transcript

Fe With our GPs a client might come in to us **they start off with a headache but they are in there for ¼ of an hour**, the doctor says what's causing it . Butt with a general GP they go in and you get Panadol and walk out. **None of the underlying things get dealt with because the general GPs have only got 5 or 10 minutes appointment time** they only want to deal with what you present with and they don't want to know what's causing it. That's the feeling we are getting. I'm not saying that's across the board. I know with some of our doctors sometimes we are pulling our hair out because **the patients take so long. It could take up to an hour because once they start opening up they just keep talking**. Once you start that you can't say, "Sorry but your time is up. I cant talk to you any more".

Fe..... You also find with Aboriginal **people its not just one issue it could be ten different things** its quite complex. For example, you get a grandmother in, she's tired and got a headache **you don't just give her a Panadol** you find out why she has **got a headache**. It is because she has got half a dozen kids and she's looking after all of them because her daughter is probably in Bandyup There's **no income coming in** so there's all these sorts of things so its really bound to play a big part in their health. So that's why we say about **holistic health**.

The process of analysing qualitative data is a very **personal process**. For example, two researchers reviewing an interview transcript could identify different codes and meanings in the content based on their experience, perspectives and knowledge of the subject. A table defining each code is a useful tool to create when analysing qualitative data.

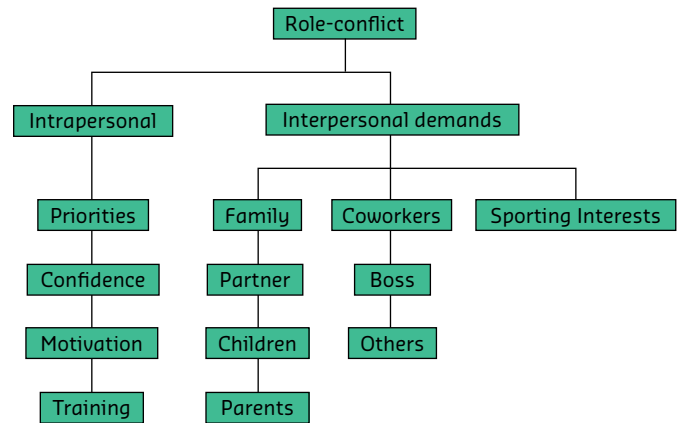
For example, in a program investigating attitudes to condom use, the overall theme might be 'condom use' with associated codes such as 'availability', 'cost', 'experience', 'acceptability' and 'knowledge'. Participants' comments about their condom use could then be grouped in relation to these codes. The table defines each code and can be used as a reference tool during the process of coding a number of transcripts about the same topic.

Example:

Theme:	Condom use
Codes	Types of comments relevant for each code
Availability	Where to buy condoms, ease of access
Cost	How expensive, do free condoms promote increased use
Experience	Effects of condoms on sexual pleasure
Acceptability	Friends and partners don't use condoms, hard to discuss
Knowledge	Awareness of how condoms can prevent STIs

Different techniques such as simple tables, SWOT (Strengths, Weaknesses, Opportunities and Threats) charts, tree diagrams and models can be created to present the coded data. See Figure 5.3 for an example of a tree diagram.

Figure 5.3: Tree diagram



The **SHBBV Program Planning Toolkit** does not cover all aspects of qualitative data analysis. For further information, please refer to the following book: *Qualitative data analysis: a methods sourcebook* (2013). 3rd Ed. Miles, Huberman, and Saldana, Sage Publications¹⁷.

5.5 Using the results of an evaluation

Evaluation is only worthwhile if the results are used. When we collect data for evaluation purposes we need to ask two important questions.

So what?

This question asks: How important are the findings of our evaluation? Do the findings raise questions and prompt us to reconsider the programs and services we are implementing? Or do the findings simply validate what we already know? If so, perhaps they provide justification that the program/service should continue as before or evidence that the program is effective and could be expanded or adapted for other areas/populations?

Now what?!

This question asks: What will we do with the information we have gained from the evaluation? Do we continue to implement the program/service as before with no changes? Do we introduce any changes? Do we stop the program/service completely? Do we need to do further evaluation and collect more information before we can make an informed decision?

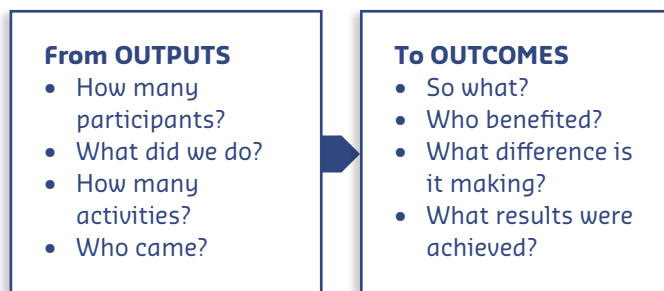
Consider the planning and evaluation cycle again:



Evaluation prompts us to check what we are doing and **adjust or refine** our programs and services if needed to achieve greater health gains.

We need to change our mindset about evaluation from measuring outputs to **measuring outcomes** (see Figure 5.3). Evaluation should not only be done for compliance reasons but should be seen as a tool to improve our practice.

Figure 5.3: Changing the mindset of evaluation



If we can adopt an outcomes-focused mindset, we are more likely to plan programs and activities which achieve intended outcomes. Thinking about evaluation early in the planning process can help us set a clear direction of where we want to go and what we expect to achieve.

5.6 I'm stuck! Where can I get more information?

Planning for effective health promotion evaluation

This resource was developed by the School of Health and Social Development, Deakin University, in association with VicFit, as part of the Department of Human Services' Evaluation Skills Development Project, May 2005 (reprinted 2008)

[http://docs.health.vic.gov.au/docs/doc/32F5DB093231F5D3CA257B27001E19D0/\\$FILE/planning_may05_2.pdf](http://docs.health.vic.gov.au/docs/doc/32F5DB093231F5D3CA257B27001E19D0/$FILE/planning_may05_2.pdf)

SiREN website

www.siren.org.au

The background of the slide is a complex, abstract pattern of overlapping, semi-transparent shapes in various shades of green and olive. These shapes, which include triangles, polygons, and curved forms, create a sense of depth and movement, resembling a woven or layered texture.

6.0 TOOLS

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This section contains blank templates of the tools discussed in this toolkit. Refer back to the Toolkit for further information and examples about each tool.

In this section:

- A. Stakeholder analysis
- B. PABCAR Model
- C. PRECEDE-PROCEED Model Planning questions
- D. Logic model
- E. Stages of Change Model
- F. Health Belief Model

A. Stakeholder analysis

Who are some of the individuals, groups, communities, agencies and organisations you may need to consult with to gain a clear understanding of your health problem? Circle those who you would want to have an ongoing partnership with or participation within the planning and implementation of the program.

Key individuals	Groups
Agencies/organisations	Communities
Other	Other

B. PABCAR Model

Think back to the PABCAR model for planning your program, and answer the questions below in relation to your intervention. This will assist you in identifying key factors of your program that will shape your goal, objectives and strategies. Refer back to Section 2 in this toolkit if you need further information.

1. What is the problem and is it significant?	
2. Is the problem amenable to change?	
3. Are intervention benefits greater than the costs?	
4. Is there acceptance for interventions?	
5. What actions are recommended?	

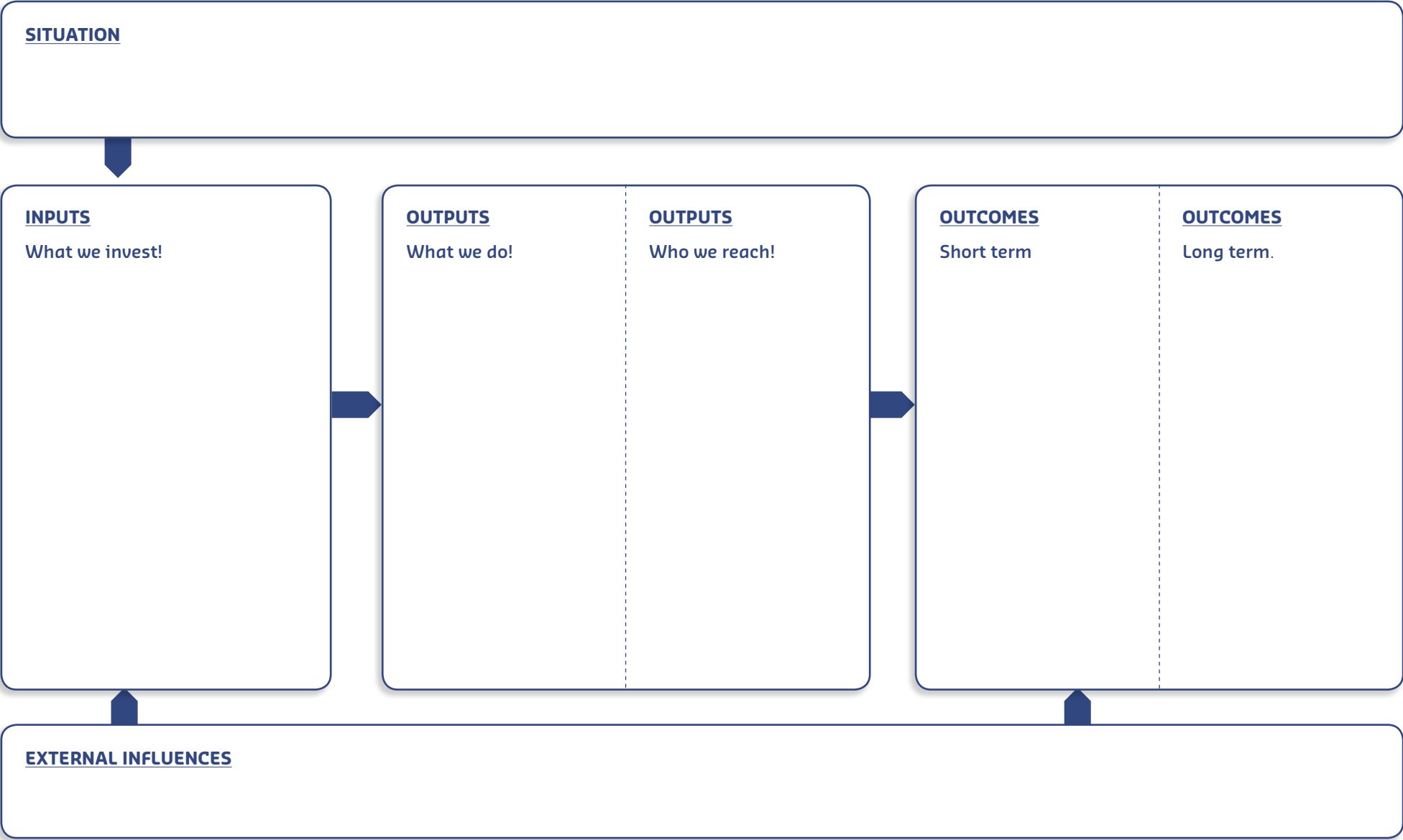
C. PRECEDE-PROCEED Model

Use the PRECEDE-PROCEED model to help you assess priority health issues and identify factors that should be focused on during an intervention. Answer the planning questions in terms of your program. Refer back to Section 2 in this toolkit if you need further information.

Health Issue:	
Planning Questions	Answers
How serious is the health problem?	
What health related behavioral and environmental factors are involved?	
What are the determinants of those behavioral or environmental factors?	
Which combination of health promotion interventions might change these determinants and factors?	
How can those interventions be implemented?	

D. Logic Model

Use the logic model to demonstrate the logical flow of your program elements. It will provide a one page visual map of the activities and outputs of your health based program. Fill in each box below, and refer back to Section 2 in this toolkit for more information.



E. Stages of Change

Here is a blank template for the Stages of Change model. Try applying it to your program to determine your target group's motivation and readiness to change their behaviour. Identify the stage or stages relevant for your target group by describing the behaviours seen currently. Next determine the strategies you could use to move people to the next stage of change. Refer back to Section 3 in this toolkit for more information.

HEALTH ISSUE:

1. Pre-contemplation

2. Contemplation

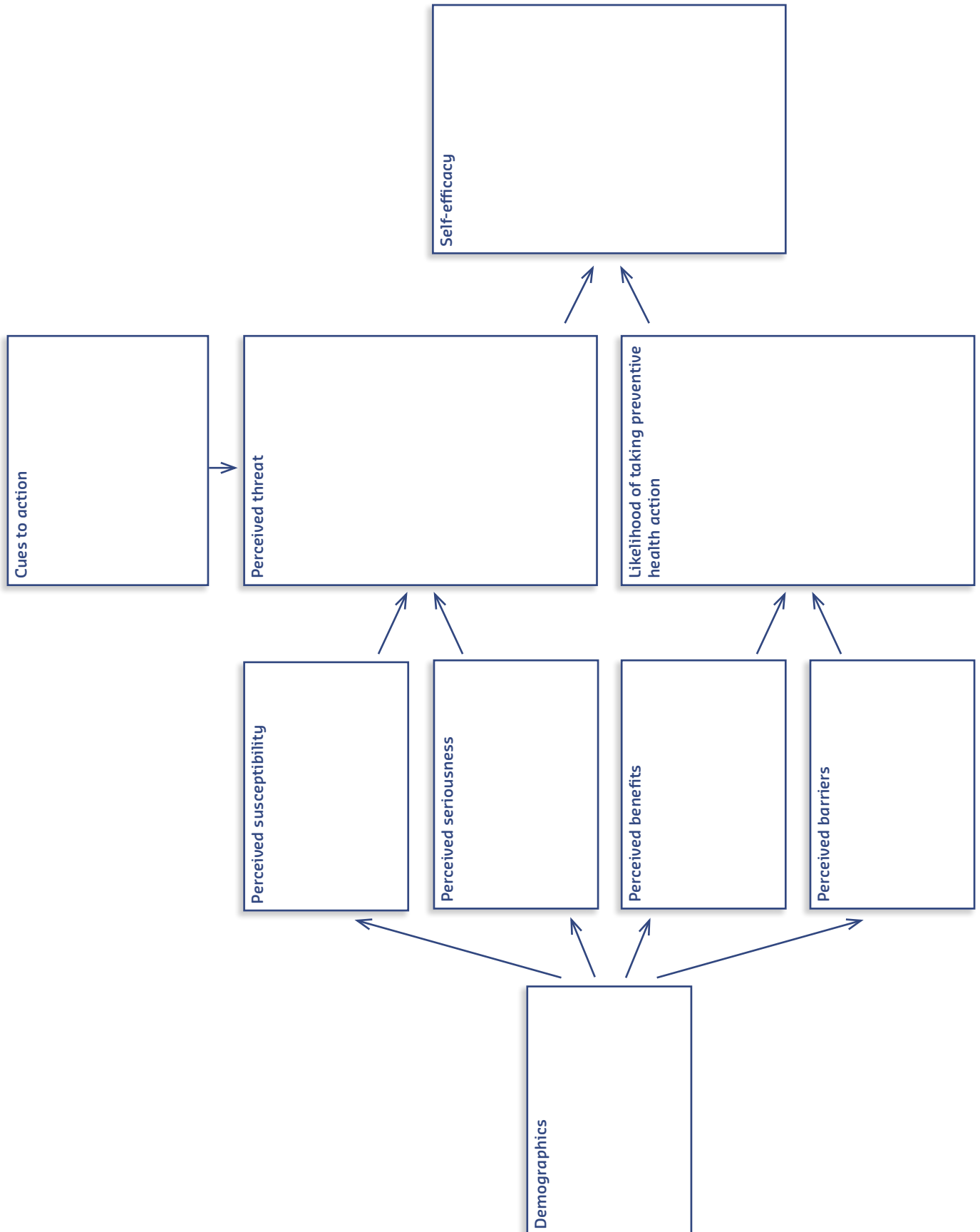
3. Preparation

4. Action

5. Maintenance

F. Health Belief Model

Use the Health Belief Model (HBM) to help you predict the behaviours of your target group. The HBM can assist you in developing your strategies based on the target group's likely behaviour. If you need further information refer back to Section 3 of this toolkit.





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REFERENCES

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