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Intergovernmental committee on HIV/AIDS, Hepatitis C and related diseases

Infrastructure benchmarks for the design, implementation and evaluation of HIV/AIDS, STI and Hepatitis C Health Promotion Programs

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Introduction

The *Infrastructure Benchmarks for the design, implementation and evaluation of HIV/AIDS, STI and hepatitis C health promotion programs* describe the range of elements essential for the delivery of effective health promotion programs.

The *Infrastructure Benchmarks* have been developed by the Inter-Governmental Committee on AIDS, Hepatitis and Related Diseases (IGCAHRD) for use by advisory bodies, policy-makers and program managers. The *Infrastructure Benchmarks* have been endorsed by the Communicable Diseases Network of Australia (CDNA).

The *Infrastructure Benchmarks* describe five key areas, including:

- leadership and management
- community participation and partnerships
- research, information management, planning and evaluation
- learning and workforce development
- health promotion practice.

The attainment of the described levels of activity across each of the benchmarks will provide the basis for effective health promotion programming and practice in HIV/AIDS, STIs and hepatitis C.

In developing this document, IGCAHRD has drawn significantly from work undertaken by Quality Management Services (QMS) as part of a consultancy for the Australian Government during 1999.[1]

The consultancy was commissioned by the Australian Government for the purposes of developing 'detailed and meaningful benchmarks for the levels of infrastructure required by the national programs, community agencies, and state and territory health authorities to undertake the design, delivery and evaluation of HIV/AIDS health promotion programs for gay and other homosexually active men'.

In drawing on the work of QMS, IGCAHRD has:

- updated the benchmarks in line with developments since the original consultancy was undertaken
- broadened the ambit of the benchmarks to enable their use with HIV/AIDS, STI and hepatitis C health promotion programs beyond those specifically targeting gay and other homosexually active men in relation to HIV/AIDS
- clarified the program level at which the benchmarks are expected to operate, focusing primarily on their use by state and territory health authorities and clarifying where this is not intended to be the case.

The *Infrastructure Benchmarks* have been developed to be as broadly applicable as possible across jurisdictions, disease areas, and population groups without loss of meaning.

[1] *Malcolm A, McCallum L, McDonald J, Wise M (1999) Infrastructure Benchmarks for the design, implementation and evaluation of HIV/AIDS health promotion programs for gay and homosexuality active men: Final report, Sydney: Quality Management Services.*

The finalisation of the *Infrastructure Benchmarks* occurs in the context of significant increases in HIV infections in many Australian states and territories, primarily among gay men. Within other priority target populations, rates of HIV infection remain relatively low, but continued effective programming is required to ensure that successes to date are sustained.

Hepatitis C prevalence among injecting drug users remains high, despite welcome falls in notifications in recent years. In 2004, 13,028 notifications were reported nationally, down from 20,188 cases in 2000.

Rates of STIs continue at high levels across a number of priority populations and are a significant source of morbidity. In 2004, 35,189 diagnoses of chlamydia were reported nationally with the population rate of chlamydia diagnoses doubling in the five-years to 2004. Significant increases in gonorrhoea occurred during the same period. Syphilis has re-emerged among gay men, including those living with HIV/AIDS in several states, posing a significant public health challenge.

In the context of these challenges, the *Infrastructure Benchmarks* have been developed to provide state and territory health authorities with an assessment tool for ensuring that they have in place the range of elements and activities that provide the basis for effective health promotion programs.

Area 1: Leadership and management

Rationale

Leadership is about promoting a vision and a commitment to working towards shared goals, creating the capacity for learning and development, and encouraging innovative practice through fostering a supportive environment.

Leadership in health promotion programs is essential at all levels through setting direction and priorities for practice, and through establishing ways to coordinate and resource programs. The establishment of sound management systems and clear mechanisms for accountability work to enhance program delivery and improve their outcomes.

1.1 Leadership

Strategic direction for the program is maintained through the existence of an agreed strategy or set of policies.

1.1.1 Existence of a documented strategy/health promotion policy that provides the framework for program activity.

1.1.2 The strategic direction is based on research findings, program evaluation and on consultation with community/stakeholders.

1.1.3 The program has a vision, mission and goals that support effective health promotion.

1.1.4 The program has identified priority target populations for HIV/AIDS, STIs and hepatitis C based on epidemiological and public health analysis.

1.1.5 Mechanisms exist for policy development, analysis and review.

1.1.6 Mechanisms exist for priority setting and resource allocation with criteria for each established in advance.

1.1.7 Existence of mechanisms for coordination of services/health promotion initiatives.

1.1.8 Existence of a supportive and enabling environment for the program.

1.1.9 The strategic research directions are based on research, community consultations and program evaluation.

1.2 Accountability

Accountability is maintained through transparent processes for communication and decision-making with stakeholders/communities.

1.2.1 The program has established and documented clear goals, expectations, roles and responsibilities for all collaborative decision-making bodies.

1.2.2 Existence of an evaluation framework.

1.2.3 Existence of systems to ensure financial accountability.

1.2.4 Existence of transparent reporting mechanisms.

1.2.5 Evidence of responsiveness to stakeholder/community input.

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1.3 Effective management

High quality and consistent program outcomes are achieved through effective and efficient management systems.

1.3.1 The program fosters a culture of participation, openness and learning.

1.3.2 The program has an appropriate organisational structure that supports efficient and effective management of health promotion programs.

1.3.3 Funded organisations have systems in place for effective people management, including recruitment and retention of staff.

1.3.4 Systems are in place for the development and monitoring of budgets.

1.3.5 Funded organisations have systems in place for monitoring the efficient use of financial and other resources.

Area 2: Community participation and partnerships

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Rationale

The development of alliances and coalitions with a range of agencies can facilitate community action and advocacy. This includes establishment of partnerships and collaborative alliances between organisations across the government, non-government and community sectors. Specific measures to enable community members to become actively involved in research, program development and implementation, and to increase their capacity for mutual problem solving and collaboration are essential for relevant and effective programs. These processes can build community skills, capacity and ownership of health promotion programs.

2.1 Community building and ownership

Reciprocal relationships are established with constituents to make decisions, act on common goals and build community capacity and ownership.

2.1.1 Mechanisms are established for communication with constituents and for the development of effective networks.

2.1.2 The policies and strategic directions support the programs' involvement in community action.

2.1.3 Mechanisms are established to support consumers and community groups in their role as advocates.

2.2 Community participation

A culture of community participation is supported by philosophy, management commitment, organisational systems and structures, and provision of resources.

2.2.1 Funded organisations have systems and resources in place to facilitate participation of consumers, community members and groups.

2.2.2 Funded organisations have mechanisms in place to ensure participation of a diverse range of stakeholders/communities, including hard to reach and minority groups.

2.3 Partnerships

Commitment to partnership is expressed through formal and informal collaboration in planning and delivery of programs and services.

2.3.1 Funded organisations have systems in place to identify opportunities to work in partnership with other services and organisations.

2.3.2 Mechanisms exist to formalise partnership agreements between government, community organisations, research and medical and health services.

2.3.3 Organisations review the effectiveness of partnerships and implement strategies to strengthen ongoing partnerships.

Area 3: Research, information management, planning and evaluation

Rationale

Appropriate data sources including existing surveillance databases and research projects are essential for effective planning, monitoring and evaluation of health promotion programs. Program staff need skills to find and analyse this information and to be able to incorporate this into their planning and review processes.

Evaluation needs to be timely and the methodology relevant to the stage of development or implementation of the program. Programs need to be planned, implemented and evaluated.

3.1 Research

The research agenda is developed collaboratively and research findings are used to improve the quality of the program.

3.1.1 Mechanisms are established for interaction between researchers and other partners.

3.1.2 Mechanisms are established for communication of research findings to partners and other researchers.

3.1.3 Opportunities are developed for collaborative research involving educators/practitioners.

3.1.4 Mechanisms are established to assist program staff to incorporate research findings into programs.

3.1.5 Mechanisms are established for learning and skill development between researchers and program staff.

3.2 Information management

The program collects, analyses and utilises appropriate data and information to inform planning, evaluation and quality improvement.

3.2.1 Systems exist for accessing high quality, reliable and accurate epidemiological and social research data.

3.2.2 The program records and collates qualitative and quantitative data to assess achievement of its outcomes.

3.2.3 There are regular processes to consult with stakeholders/communities on additional data/information needs, to collect, analyse and disseminate findings, and to develop timely and appropriate responses to data.

3.2.4 Mechanisms for production and dissemination of reports are developed.

3.3 Planning

The program is shaped by regular planning that involves all stakeholders in setting goals and planning activities.

3.3.1 Evidence that up-to-date data and information are used to inform and monitor planning processes.

3.3.2 Mechanisms for planning include needs assessment; review of previous activities; stakeholder input; development of priorities; identification of outcomes and strategies; measures of success; and assessment of resources required.

3.3.3 Quality improvement objectives and activities are built into planning, evaluation and research at all levels.

3.3.4 Staff and management demonstrate adequate knowledge and skills in planning or have opportunities for professional development in this area.

3.3.5 The program has operational, team and individual work-plans that are linked to the strategic plan.

3.3.6 Planning processes are participatory and involve constituents and key stakeholders.

3.3.7 Coordination of activities is maximised and duplication is reduced by planning with other services.

3.4 Evaluation

The quality of the program is improved through participative evaluation processes.

3.4.1 Systems are in place to regularly review activities and to document achievements and learning.

3.4.2 Staff and management demonstrate adequate knowledge and skills in evaluation or have opportunities for professional development in this area.

3.4.3 The methodology of evaluation reflects good practice.

3.4.4 Evaluation methodology is relevant to the stage of development or implementation of the program and to the expected level of outcome.

3.4.5 Results are reported to community/stakeholders in a way that enhances understanding and use in ongoing program development.

3.4.6 Evaluation findings are used to modify and improve programs.

Rationale

Relevant skills and knowledge are crucial for the design and delivery of effective health promotion programs. Training and development programs need to include a broad range of learning strategies. In particular, ways to build community skills and capacity across a range of agencies through exchange of information and joint learning forums can strengthen partnerships and promote more sustainable programs.

4.1 Appropriate training and development

The skills of the workforce are maximised by a comprehensive training and development program.

4.1.1 Staff at all levels have access to an appropriate range of training and development opportunities.

4.1.2 Existence of a workforce development plan with designated resources for implementation.

4.1.3 Evidence that regular and appropriate supervision is provided to staff within funded organisations.

4.1.4 Existence and consistent application of performance management systems with funded organisations.

4.1.5 The program has adequate resources for training and development.

4.1.6 Evidence of the development of opportunities for inter-sectoral training and development.

4.2 Orientation

The consistency and continuity of programs is enhanced by effective staff orientation.

4.2.1 Funded organisations have an orientation program which includes information for staff on roles, functions, responsibilities, service values, philosophy and goals.

4.2.2 Funded organisations have systems to ensure that staff receive relevant and timely orientation.

4.2.3 Funded organisations provide staff with support, orientation and enhanced learning through effective mentoring processes.

4.3 Developing learning opportunities

A learning environment is fostered in the program.

4.3.1 Documentation of the program includes models of practice, achievements and lessons learned.

4.3.2 Funded organisations have regular processes for team and organisational learning.

4.3.3 Staff of funded organisations receive support and resources, including time to undertake critical reflection, to review and document their activities.

4.3.4 Funded organisations have processes for collaboration with staff from other health promotion programs to foster learning and information sharing on good practice issues and models.

Area 5: Health promotion practice

Rationale

In keeping with the principles of the Ottawa Charter, health promotion practice needs to ensure that a broad range of interventions are undertaken, balancing evidence-based approaches with innovation. Good practice also involves a focus on developing linkages with other sectors and on developing community skills and capacity. This health promotion approach needs to take account of social determinants of health – the contexts in which people operate as well as their social and health needs that may contribute to their ability to effectively respond to and sustain behaviour change. A multi-sectoral response can improve the design and delivery of interventions through a broader use of resources, development of consistent messages, avoiding duplication, identifying and addressing gaps in services and through paying closer attention to the needs of diverse and often marginalised groups.

This section is cross-referenced to Area 3: Research, information management, planning and evaluation.

5.1 Comprehensive approach for health promotion

The health and well being of the community is promoted through a comprehensive range of health promotion strategies.

5.1.1 The program takes account of the social determinants of health for the various priority target populations for HIV/AIDS, STIs and hepatitis C in the development and implementation of initiatives and campaigns.

5.1.2 The program is involved in a diverse range of health promotion strategies for action that are based on recognised international health promotion models.

5.1.3 The program has links with general practitioners and other clinicians and provides support for HIV, STI and hepatitis C prevention efforts in clinical settings.

5.1.4 The program encourages innovation in the development of its activities.

5.1.5 The program advocates to assist individuals and communities to overcome barriers to health.

5.1.6 The program contributes to the development of healthy communities by building community support for informed decision making.

5.1.7 Program interventions are based on needs identified through research, local community knowledge and program evaluation.

5.2 Coordination of health promotion programs

Effective health promotion programs are achieved through the use of coordinated multi-sectoral approaches.

5.2.1 Programs support staff working in an inter-sectoral and inter-agency manner.

5.2.2 Programs develop health promotion messages that are consistent with other health promotion programs.

5.2.3 Mechanisms are established for communication, information sharing, learning and problem solving with partners.