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Prevention and Population Health Branch
Department of Health
prevention@health.vic.gov.au

Hi Natalie and Holly

Below is my feedback on the CHHP Guidelines (May 30 Draft). Sorry I didn't get it to you before the end of the week.

General Feedback

The guidelines are improved from previous iterations.

The guidelines are taking CHHP activity a step away from the core functions of Community Health and the role that services have historically played. The Community Health Integrated Program (CHIP) Guidelines, which most CHHP funded agencies are underpinned by, focus on vulnerable communities within a population. The draft CHHP guidelines are asking funded agencies to take a much broader population focus. This will undoubtedly dilute the effort and connection with vulnerable communities and could (without careful implementation) further increase inequity.

The draft CHHP guidelines success is dependent on a number of other system facets (LPHUs, Mental Health and Wellbeing Reform, Outcomes Framework, Impact of COVID-19). It is hard to give full feedback without having all the information available. For this reason I encourage the department to consider releasing transitional guidance directing agencies towards effort in the prevention priorities and collective impact measurement while further detail is ironed out.

I would like to see a section added about how DH will ensure the success of the guidelines. This particularly relates to ensuring there are mutually reinforcing policy environments to ensure that work of funded agencies is achievable. How is government ensuring that settings like schools and sporting clubs are motivated and resourced to work with CHHP providers? I do note a mention in the program logic as an input – but I think the what and how needs fleshing out in the guidelines.

Specific Feedback

4	Purpose of CHHP program	This point mentions that settings based approaches should be foundational to this work. I think it is important to provide agencies with greater clarity. Settings based approaches have their roots in the Health for All framework from WHO and are based around working with a setting to identify and address population health needs that are of importance to them.

		The measurement guidance in the draft guidelines suggests what settings agencies should focus their work (schools, out of hours care etc) but this is focussed on defined priorities. It would be good to see how the department sees settings based approaches being foundational in this work. This could be addressed in the practice principles.
5	2021-25 program aims	This suggests that CHHP agencies should focus on exposure to health-promoting environments for children and families. This was a point I had not noted before – I am interested how this has been determined? There are equity considerations here for populations like refugees, homeless, same sex attracted communities, older persons etc. There are also programmatic considerations like whether work with teens and young adults shouldn't be prioritised.
7	Mental wellbeing as part of 70/30 split	This point states the rationale for retention of mental health focussed prevention within the 70% allocation until resourcing is in place for the MHWPO. It is unclear which agencies will be resourced and if this resourcing is recurrent. With the appointment of the Mental Health Promotion Advisor this might be able to be made clearer. I think this needs firming up in this section and on page 30.
8	Lead and Support Functions	It is still not clear if these are suggested lead functions, strongly encouraged or mandated for CHHP agencies to deliver.
14	Priority Populations	The guidelines suggest focus for tobacco and e-cigarette related harm should address priority populations. How does this relate to the comments on page 5 of a programmatic focus on children and families?
17	Practice Principles	Local collaboration and community engagement is critical to success and reducing duplication of effort. How does the Department see that agencies can report on collaboration activity – particularly in early phases of partnership establishment before impacts might be realised?
17	Intersectional health equity lens	As mentioned in general comments – these guidelines will cause agencies to take a step away working with the most vulnerable. Proposed impact measures have agencies needing to 'count' the number of settings they are working within. Settings which face greater vulnerability and inequity are harder to engage. Despite good work, agencies could be penalised for not engaging with as many settings as those working in more affluent areas. It is important for the guidelines to state the importance of taking an equity lens to selection of settings and to provide examples to agencies to reiterate the importance. The measurements should also be revised to disaggregate counts of settings by measure(s) of equity (eg SEIFA)

19	Delivering outcomes based health promotion	The development of measure for active living and tobacco related harm after the release of the guidelines make it difficult for agencies to plan effort so that it is measurable. Even though the measures do not have to be applied until Jul 2023, the work starts in Jul 2022.
26	Proposed healthy eating measures	Please see comments re page 17. The measures have an unintended consequence of practitioners 'picking the easy wins' to make their reporting counts stronger. Impact measure should be disaggregated by an equity measure.
29	Prevention functions of LPHUs	The role in coordination that LPHUs play will be critical in the system reform that the Department is attempting to achieve. It needs to be clear what they role is and how CHHP agencies (and their planned action) articulates with this work before these guidelines are released. For example – if a catchment plan is developed by a LPHU that contradicts the work planned by the CHHP agency, what does this mean for the CHHP plan?
33	Program Logic	I think we need to make more of the program logic – this is a critical document to demonstrating (succinctly) the approach of the Guidelines. I think it is lost in the appendices.
34	Program logic Assumptions	An assumption that settings will engage with agencies for assistance with primary prevention – is difficult to reach. This is very much based on local relationships or reputation of practitioners or the CHHP agency itself. This factor is critical to what the Department is trying to achieve with collective action. Settings need to be enabled, resourced and encouraged by policy and system drivers to make CHHP providers their first choice as prevention allies.

I am happy to be contacted about the above.

Kind Regards

David Towl
Co-President Victoria/Tasmania Branch
Australian Health Promotion Association