Department for Victorian Communities

Review of *Go for your life* Community Walking Grants Program

FINAL REPORT

the Nucleus group

Table of Contents

EXECUTIVE SUMMARY

The *'Go for your life' Community Walking Grants Program* was designed to encourage participation in one of the most accessible forms of physical activity, walking, and to contribute to the Government's community strengthening goals. It has been shown that increased participation in physical activity improves health and wellbeing and can also provide people with a sense of belonging. Physically active and healthy people are more likely to participate in other aspects of community life[1].

The *'Go for your life' Community Walking Grants Program* is an initiative of Sport and Recreation Victoria, a division of the Department for Victorian Communities, and aims to:

- Give Victorians more opportunities to have fun, be physically active and enjoy their surroundings;
- Support communities to encourage walking and to overcome barriers to participation in walking; and
- Bring Victorians together in their communities.

The *'Go for your life' Community Walking Grants Program* funded Primary Care Partnerships and member agencies to undertake projects that would produce:

- New walking groups (in particular areas or for special needs groups within the community);
- Tools or strategies to overcome barriers to participation in walking; and/or
- Increased capacity within the community to deliver walking programs.

The Nucleus Consulting Group was engaged by the Department for Victorian Communities to conduct a review of the *'Go for your life' Community Walking Grants Program*. The aims of the review included:

- To assist Primary Care Partnerships and lead agencies to evaluate their projects and to further develop and use evaluation skills;
- To determine the extent to which the overall program was implemented as planned; and
- To review aspects of process, program impact and outcomes, including strategies and factors that might enable projects to become self-sustaining.

The review was managed by the Physical Activity Unit within Sport and Recreation Victoria and included extensive consultations with a wide range of stakeholders, including funded agencies and departmental program staff.

The review comprised three broad stages:

- Development of a research framework (see Attachment 1) incorporating evaluation questions, methods and data collection tools. The research framework was constructed around three central parameters - program structure, program delivery and program management.
- Completion of individual project evaluations by funded agencies and submission of evaluation reports to DVC. (A reporting template was developed in accordance with the research framework and distributed by Nucleus to guide funded agencies in data collection and development of their evaluation report – see Attachment 2).
- Completion of 'whole of program' analysis by Nucleus and provision of an overall report, drawing on consolidated material from funded projects and additional data collection initiatives.

[1] 'Go for your life' Community Walking Grants Application form, Department for Victorian Communities, Nov 2004

The review found that funded projects engaged in a wide variety of activities with no two projects being the same. Most, however, focused on walking group development, production of resources to promote walking and training of walking group leaders. Project participants came from a wide range of backgrounds - some projects focused on members of the general community while others focused on groups with particular or special needs. Projects were conducted right across Victoria, in metropolitan, regional and rural areas, including a number of disadvantaged communities.

Overall, projects reported very positive and encouraging results. Just over half of all projects (18 of 31) reported that they achieved their project goals, with the remainder partly achieving them. Where they were measured, some projects showed excellent results. For some however, program limitations and a lack of measurability in project goals made it difficult to determine the extent to which goals were achieved and levels of sustainability of project impact.

All projects reported a wide range of partner agencies and organisations involved in project planning and implementation. Analysis of these partnerships has provided many participating agencies with a deeper appreciation of key factors leading to successful partnerships and, conversely, issues that might compromise the effectiveness of the relationship.

In broad terms, the review found that Community Walking Grants have:

- Increased participation and awareness of the benefits of walking amongst project participants;
- Provided a safe, good quality and fun physical activity for participants;
- Enabled PCPs to further integrate physical activity as a health promotion priority; and
- Created sustainable linkages between project stakeholders.

Several factors have been identified as contributing to the success of Community Walking Grants projects, including:

- Building community capacity by increasing the number of walking group leaders and developing skills and methods amongst agency staff involved in the implementation of projects.
- Building on existing partnerships and developing some new partnerships between agencies that have an interest in health, wellbeing and fitness.
- Providing local, accessible programs that link people into their local communities (contributes to ongoing participation and sustainability).
- DVC support provided to funded organisations to help establish and resource programs and activities - DVC staff were a valued resource to projects, providing a most helpful and effective level of assistance.

Auspicing projects through PCPs was generally found to be an effective strategy as aims and objectives were often similar and it allowed leverage of established infrastructure and partnerships within regions.

The Community Walking Grants program also supported the PCP strategy by:

- Promoting a more integrated approach to health promotion, one likely to strengthen the capacity of the system to plan and deliver effective programs.
- Assisting to build the capacity and skills of individuals and agencies collectively to undertake some of the complex tasks inherent in the PCP strategy (such as inter-sectoral health promotion and evaluation).
- Creating opportunities for new agencies from outside the traditional health sector to join the partnership and get involved in health promotion activities.
- Assisting to address locally identified issues.

Evaluation reports and analysis has yielded a store of practical tips and advice, including a wide range of resources to build organisational capacity, that can be used to enhance the sustainability of future physical activity projects.

A list of recommendations arising from the review is provided below:

Summary of Recommendations

1. Increase the size of the grant available and extend the timeframe for completion of future walking grant projects.
2. Compile a *Walking Program Resource Kit* from the many useful tools and resources developed by CWGP funded projects.
3. Convene a workshop for new and/or ongoing projects to ensure that the findings and lessons from CWGP Phase 1 and Phase 2 project evaluation reports are shared and available to benefit all.
4. Ensure that all future walking grant projects are clearly linked to relevant local health promotion activities or catchment plans, and that there is community involvement in project planning and implementation.
5. Ensure that findings from project evaluation reports relating to key factors in successful partnerships and reasons why participants join and continue in walking groups are included in the *Walking Program Resource Kit* (or otherwise distributed) and available to new and/or ongoing walking projects for planning purposes.
6. Future project reporting should include both qualitative and quantitative measures against specified objectives.
7. DVC should commission a research project to collect information on strategies that impact on physical activity acceptance and adherence, including amongst special groups within the population, as input to future program planning.
8. Ensure that the potential benefits arising from using PCPs as auspices for physical activity programs are considered when planning appropriate programs in the future.
9. DVC should source information or develop a training workshop for agencies funded under future physical activity projects in partnership development and making partnerships work.
10. Develop a stocktake of existing walking maps throughout Victoria and allow the general community access via the internet.
11. DVC should develop the business case and an organised approach within DVC to promote the need for Local Government to enhance walking infrastructure.

INTRODUCTION

BACKGROUND

'*Go for your life'* is a cross-government strategy seeking to promote opportunities to increase levels of physical activity, improve eating habits, encourage involvement in local activities and increase contributions to the community through volunteering. '*Go for your life'* is part of the Victorian Government's commitment to building stronger communities and increasing the health and wellbeing of Victorians.

The '*Go for your life' Community Walking Grants Program* (CWGP) is an initiative of Sport and Recreation Victoria (SRV), a division of the Department for Victorian Communities (DVC). The CWGP aims to:

- Give Victorians more opportunities to have fun, be physically active and enjoy their surroundings.
- Support communities to encourage walking and to overcome barriers to participation in walking.
- Bring Victorians together in their communities.

The CWGP was designed to encourage participation in a most accessible form of physical activity and to contribute to the Government's community strengthening goals. Increased participation in physical activity improves health and wellbeing and can also give people a sense of belonging; physically active and healthy people are more likely to participate in other aspects of community life[2].

The CWGP was open to organisations working together through Primary Care Partnerships[3] (PCPs). Incorporated community-based agencies wanting to undertake walking projects were asked to contact the local PCP and, together, develop an Expression of Interest to be submitted to DVC. Initial information that needed to be provided included applicant's details, project overview, details about how the proposed project addressed the assessment criteria and a project budget.

Projects were sought that addressed one or more of the following areas:

- Establishment of new walking groups.
- Development of tools or strategies to overcome barriers to participation.
- Development of skilled individuals and community and organisational capacity to deliver walking programs.

Expressions of Interest were assessed against the following criteria:

- Capacity to increase walking participation by target populations.
- Linkages with PCP integrated health promotion activities.
- Nature of the partnerships that would be required to implement the project and potential to create/strengthen partnerships.

Grants of up to $10,000 were made available to successful applicants, for projects to be implemented over a 12 month period. Grants were delivered in two phases:

- Phase 1 (17 PCPs): September 2005 to August 2006.
- Phase 2 (the remaining 14 PCPs): January to December 2006.

A list of projects funded under the CWGP is provided over the page:

---

[2] 'Go for your life' Community Walking Grants Application form, Department for Victorian Communities, Nov 04

[3] PCPs aim to improve the health and wellbeing of the population by strengthening relationships between and within the primary care and acute sectors and through improved service coordination, planning and health promotion programs.

Phase 1 Funded Projects

PCP	LEAD AGENCY	PROJECT NAME	PROJECT SUMMARY
Barwon Primary Care Forum	Leisure Networks	Barwon 10,000 Steps – Secondary School Project	A training package for secondary schools to help incorporate walking programs into the curriculum and to support schools in implementing the package (a targeted extension of the well regarded Barwon 10,000 Steps project).
Bendigo Loddon Primary Care Partnership	Loddon Campaspe Sports Assembly (Sports Focus)	Small Town Walking Development Plans	Three small town walking development plans (Inglewood, Boort and Strathfieldsaye) to help build the capacity of local individuals and organisations and deliver sustainable walking opportunities.
Campaspe Primary Care Partnership	Shire of Campaspe	Themed Walks in Campaspe	Groups participating in a competition to award the 'best/most interesting walk in Campaspe' were given funds to promote routes and establish walking groups.
Central Highlands Primary Care Partnership	Central Highlands Sports Assembly	Central Highlands Walking Strategy	Extension of the Ballarat Walking Strategy within the broader catchment, by documenting and promoting existing walking paths and groups, and identifying opportunities to improve access to both the paths and groups for isolated community members.
Central West Gippsland Primary Care Partnership	Latrobe Community Health Service Inc	Latrobe Active Communities Walking Project	Established four walking groups including people with vision impairment and people from CALD backgrounds. A Walking Partnerships Network for the PCP was also established as part of the project.
Central Victorian Health Alliance	Mount Alexander Shire Council	Central Victorian WALK IT Campaign	Built on three Central Victorian Health Alliance *Walking Working Groups* from successful 2004 projects to engage more residents of all ages in regular walking.
East Gippsland Primary Care Partnership	GippSport (Regional Sports Assembly)	East Gippsland Walking Strategy	Established six targeted walking groups (e.g. push-a-pram; cardio-rehab) across five townships within the catchment, including a resource kit for new walking groups. Also established a regional steering committee on walking for the PCP.
Hume-Moreland Primary Care Partnership	Moreland City Council	Hume Moreland PCP Walking Group Project	Trained 20 representatives of community organisations in walking group leadership, who then established walking groups for clients of their organisations (targeting mainly older people and marginalised groups). A leader's network was established to share and support each other in establishing walking groups.
Inner South East Partnership in Community & Health	Christ Church Mission Inc	Stepping Stones Walking Group	Established walking groups for people who had been recently bereaved with the aims of increasing levels of physical activity and their social connectedness. Each walking session finished with a social opportunity and individual bereavement support was available to participants.
Kingston - Bayside Primary Care Partnership	Bayside City Council	Step Right Up	Developed new walking groups (structured and unstructured) through pedometer loan schemes (at public libraries), training of volunteer leaders and promotion of walking throughout the PCP.

PCP	LEAD AGENCY	PROJECT NAME	PROJECT SUMMARY
Northern Mallee Primary Care Partnership	Mildura Rural City Council	Be Smart – Walk your Heart	Extended the 2004 *Be Smart – Walk your Heart* campaign using a six part targeted communications approach.
South Coast Health Services Consortium	South Gippsland Division of General Practice	Step Out, Walk on	Recruited people to lead community walking groups (including development and provision of a train the trainer program) and promoted walking in the catchment.
South West Primary Care Partnership	South West Healthcare	South West Walking Groups and Walking Tracks Initiative	Established three walking groups in towns across the catchment and developed, disseminated and promoted walking track maps for two localities.
Southern Grampians & Glenelg Primary Care Partnership	Portland District Health	Glenelg Walking Strategy	Developed, disseminated and promoted a set of graded walking maps for six towns in the Glenelg Shire.
Southern Mallee Primary Care Partnership	Mallee Sports Assembly	*Walk Your Way* to what you want	Established a walking program in local shires within the catchment, including a program launch, leading to the establishment of new walking groups.
West Bay Alliance	Isis Primary Care	Walking WestBay	Established a new walking group in each catchment LGA, targeting people under-represented in physical activity. Walking group leadership training was also provided as part of the project.
Wimmera Primary Care Partnership	Wimmera Regional Sports Assembly	Have a COW	Extended the *Walking Wimmera* project by targeting local sporting and community groups to establish walking groups (walking group members became second tier members of the host clubs/groups, thus benefiting both clubs and walkers).

Phase 2 Funded Projects

PCP	LEAD AGENCY	PROJECT NAME	PROJECT SUMMARY
Banyule Nillumbik Primary Care Alliance	Nillumbik Community Health Service	Bridges to Better Health	Facilitation of transition for clients from health services to community based walking groups via the development of processes and program options.
Brimbank Melton Primary Care Partnership	Djerriwarrh Health Services	Walking for Wellness	Established four new walking groups, one targeting people with a mental illness through the Outer West Psychiatric Disability Support Service, one targeting people with a disability through SCOPE, and two targeting patrons at the Watergardens and Woodgrove Shopping Centres.
Central Hume Primary Care Partnership	The Centre for Continuing Education	Walk For Your Life	Developed resources (including maps, walking group contacts, walking log book etc) and used local media and marketing campaigns/events to promote walking across Central Hume.

PCP	LEAD AGENCY	PROJECT NAME	PROJECT SUMMARY
Frankston-Mornington Peninsula Primary Care Partnership	Brotherhood Community Care	Rosebud and Rye Coastal Walking Group	Established a structured walking group for older people in Rye and Rosebud, particularly those managing a chronic illness/disease, and carers. Volunteer walk leaders were trained and respite care was provided to enable carer participation.
Goulburn Valley Primary Care Partnership	Valley Sport	Walk your way to Health	Established a number of new walking groups (three for older people, two CALD women's groups, two general groups) and trained volunteer group leaders.
Grampians Pyrenees Primary Care Partnership	Grampians Community Health Centre	Walk the Walk and Talk the Talk	Developed a resource containing comprehensive information about existing walking tracks and walking groups that was launched at a community event and promoted through a range of networks.
Inner East Primary Care Partnership	City of Whitehorse	Walking for Wellness	Piloted an approach to increasing walking participation through primary schools (targeting parents, grandparents and guardians) and pharmacies (targeting older people). Volunteers were trained to lead walking groups.
Lower Hume Primary Care Partnership	Mitchell Shire Council	Put a Spring in Your Step	Promoted and introduced walking programs in settings including a local factory, two leisure centres, a maternal and child health centre and a kindergarten.
Moonee Valley/ Melbourne Primary Care Partnership	Doutta Galla Community Health Services	Walking for Wellbeing	Sought to improve the health and wellbeing of women from the Horn of Africa through increased participation in group walking. Self-nominating community members were trained as walking group leaders to build sustainability.
North Central Metro Primary Care Partnership	Darebin Community Health	Movin' Around	Sought to build participation amongst Aboriginal and Torres Strait Islander groups in a community walking program through a range of activities. The project also sought to increase mainstream health service staff understanding of issues associated with ATSI participation in physical activity programs.
Outer East Primary Care Partnership	Maroondah City Council	The Outer East Community Walking Conference and Workshops	Identified interested parties from across the region and invited them to a walking conference to showcase their achievements. The conference was a catalyst for six community workshops that acted as learning opportunities for communities that wanted to participate in or initiate community walking events.
South East Primary Care Partnership	City of Greater Dandenong	South East Primary Care Partnership Walking Strategy	Developed a strategy (that linked with municipal public health plans and other relevant catchment plans) to improve the walking environment and encourage increased walking.
Upper Hume Primary Care Partnership	The Centre for Continuing Education	Walk For Your Life	Developed resources (including maps, walking group contacts, walking log book etc) and used local media and marketing campaigns/events to promote walking.
Wellington Primary Care Partnership	GippSport	Taking Steps	Supported Neighbourhood Houses to develop walking activities for their local community through the development of walking groups, pedometer loans, information seminars and links to other physical activity opportunities.

METHODOLOGY

Measuring, monitoring and evaluating programs is important in DVC's approach to supporting and strengthening Victorian communities. In September 2005, the Nucleus Consulting Group was appointed to undertake a review of the CWGP.

The review was designed to present both DVC and funded agencies with opportunities for further development and more effective delivery of the CWGP.

The review was conducted within the context of:

- The *Healthy and Active Victoria Strategy* and the broader *'Go for your life'* campaign.
- The *Ministerial Statement on Community Sport and Recreation*.
- The stated future directions of DVC and SRV.

The review comprised three broad stages:

- Development of a research framework (see Attachment 1) incorporating evaluation questions, approaches, methods and data collection tools. The research framework was constructed around three central parameters - program structure, program delivery and program management.
- Completion of individual project evaluations by funded agencies and submission of evaluation reports to DVC. (A reporting template was developed in accordance with the research framework and distributed by Nucleus to guide funded agencies in data collection and development of their evaluation report – see Attachment 2).
- Completion of 'whole of program' analysis by Nucleus and provision of an overall report, drawing on consolidated material from funded projects and additional data collection initiatives.

Objectives of the project evaluation[4] (conducted by the funded agencies themselves and reported separately by them) included:

- To provide an opportunity to further develop evaluation skills (in line with the PCP publication *Planning for Effective Health Promotion Evaluation*[5]).
- To examine strategies and factors that lead to self-sustaining projects.
- To capture what happened in each project including project learnings.
- To examine changes in attitude and participation by project participants.

Objectives of the overall program evaluation[4] (this report) included:

- To describe the roles of all stakeholders in the implementation of the CWGP.
- To determine the extent to which the CWGP was implemented as planned.
- To identify whether the CWGP added value to the integrated health promotion priorities of the PCPs, and DVC's role in supporting this.
- To determine whether funded projects used other sources of funding or were linked with other projects funded by government.

PCPs and lead agencies, community organisations, project participants and other stakeholders were provided with opportunities to contribute to the review.

A list of PCPs and lead agencies that were involved in preliminary consultations, or that attended workshops or made submissions to the review, may be found at Attachment 3.

[4] Request for Quote: 'Go for your life' Community Walking Grants Program Evaluation, Department for Victorian Communities, July 2005

[5] Planning for Effective Health Promotion Evaluation, Department of Human Services Victoria, May 2005

RESOURCES SUPPORTING PROJECTS

DVC SUPPORT AND ASSISTANCE

All 31 funded projects were provided with a grant of up to $10,000 to implement their proposed project over a 12 month period.

Apart from direct financial support, a number of projects noted other resources or support provided by DVC. This included:

- Advice on project planning and development.
- Advice on government priorities.
- Copies of various publications such as the *Physical Activity Guide for Senior Victorians* and *GFYL Walking Tip Sheets.*
- Additional funding for events such as the major industry conference held in Melbourne in October 2006 (that included showcasing selected CWGP projects).

DVC provided a dedicated senior project officer to manage and monitor the CWGP (from time to time this person was also assisted by a graduate placement). The role of the project officer included acting as a contact point and assisting funded agencies in the planning and implementation of projects, and troubleshooting any issues experienced along the way. Several projects reported that DVC always provided a quick response to queries and issues, that staff were supportive and accessible, provided regular updates on other projects and the CWGP more generally, and attended launches when requested. DVC staff resources were almost unanimously seen to have been helpful to projects and were a valued resource.

Examples of innovative and successful approaches developed by DVC to support the take-up and implementation of the program included:

- A two step approach to funding approval - prior to commencement of the program, Expressions of Interest were sought from organisations that might be interested in CWGP funding. These underwent a preliminary assessment by the project officer and in a number of cases detailed commentary and support was provided to assist intending applicants to tailor submissions to better meet program objectives. After this, formal applications were assessed by a panel convened by DVC and comprising representatives from the Physical Activity Unit, the Office of Senior Victorians, regional DVC staff, DHS' Primary Health Branch and VicHealth.

- A workshop to assist project implementation - at the commencement of the program, DVC scheduled and conducted a major workshop attended by representatives from funded partner agencies. Attendees were able to discuss challenges in project implementation and to consider how project evaluation might occur. Feedback sheets and comments from attendees indicated that the workshop was of significant assistance, helping those that were experiencing some difficulties in defining and achieving their objectives and providing a forum where ideas and good practice could be exchanged amongst projects. The workshop had three major components:

    - Resources and promotional materials being developed to promote walking (including distribution plans; monitoring the impact of materials; barriers to promoting walking and what has been found to work well; how to build on the *Go for your life* campaign).

- Elements that contribute to establishing sustainable walking groups (including how to monitor participation in walking groups; barriers to establishing walking groups; issues associated with recruiting, training and retaining volunteer walking group leaders; challenges associated with targeting particular groups within the community).

- Evaluation (including setting measurable and achievable objectives; developing an evaluation plan; issues and challenges in data collection; reporting protocols).

- Provision of practical resources – for example, as a number of projects involved volunteers taking on roles such as activity leaders and mentors, DVC produced a resource that provided a snapshot of the various web based resources available to support community organisations and groups wishing to engage volunteers. Topics covered areas such as recruitment, attracting and retaining volunteers, involving volunteers from culturally and linguistically diverse (CALD) backgrounds, volunteer training and volunteer rights and responsibilities.

- A Monthly Update - DVC prepared a monthly 'newsletter' that was circulated electronically to all funded agencies to keep them informed and up to date with recent developments. Updates generally contained tips and guidelines, *Go for your life* website/infoline and branding information, program updates and reminders (e.g. reporting templates, due dates for reports and acquittals etc), staff changes and contact details.

- A Reporting Template - to assist achieve CWGP objectives and to facilitate overall program evaluation, a detailed Reporting Template was developed and circulated to all projects. The template incorporated all the information required by both DVC for acquittal and reporting processes, and by the consultants undertaking the program evaluation, thus eliminating any duplication and preserving agency efficiency. Attached to the Reporting Template were a number of tips and suggested tools helpful in evaluating projects (however, these were not mandatory). The attachments were compiled by the consultants after discussion with funded agencies to develop an understanding of progress and needs.

SUPPORT FROM PARTNER AGENCIES

Primary Care Partnerships (PCPs) are funded through the Victorian Department of Human Services (DHS) and were established to bring together community health services, hospitals, local governments, Divisions of General Practice and other local agencies to coordinate primary care services and undertake health promotion activities. PCPs have researched health needs in their local area and developed Community Health Plans to address issues. PCP staff coordinate and support partnership agencies to address health issues. There are 31 PCPs across Victoria with each PCP providing coverage across two or more local government areas.

During CWGP program development, DVC joined with DHS in partnership to explore strategic issues and obtain relevant advice and support, including exploration of the potential involvement of PCPs in CWGP projects and how best they might be engaged. DHS also assisted by reviewing draft documentation and providing valuable input, and by keeping DVC abreast of any changes in the PCP area and impact this may have on CWGP projects. The partnership between DVC and DHS was effective, particularly through program conceptualisation and instigation; later on, during project implementation, less involvement and liaison was required.

PCPs were selected as auspices for CWGP grants because they aim to improve the overall health and wellbeing of local communities, which is consistent with the aim of the CWGP, and because they had established infrastructure and pre-existing partnerships with local health and community services. Using PCPs as auspice bodies was also in step with the DHS strategy to position PCPs as the key platform for health promotion; DHS wanted to increase understanding of PCPs and promote recognition of their value as the preferred platform. PCPs had already undertaken detailed catchment planning and developed a strategic approach including, in some cases, project ideas. PCPs offered established communication channels and pre-arranged meeting schedules and/or calendars of events that CWGP projects could tap into.

While some CWGP projects were conducted by PCPs directly, the greater proportion were conducted by PCP member agencies such as community health centres, local government and sporting organisations, hereinafter referred to as 'lead agencies'.

Project reports indicated that PCPs provided varying levels of support to projects. Some PCPs provided additional funds while others provided in-kind support in the form of planning, advice, guidance, administrative support, feedback, assistance in compiling project resources and evaluation forms, as well as time from their health promotion officer. PCPs also helped to promote projects by providing space in newsletters. Not all projects quantified the level of support from PCPs, however where this was done it varied from $700 to $10,000.

In general, the PCP platform provided a stable foundation for project performance and made significant (sometimes critical) contributions to project success.

In a small proportion of cases however a number of issues were experienced:

- Staff turnover (a phenomenon not restricted to PCPs) sometimes created inefficiencies through disruption to project continuity and a requirement for additional time to orient new workers. In projects of limited timeframe (i.e. one year), such disruption often led to foreshortened projects or (more commonly) applications to extend the project beyond the expiration of the funding period. A number of projects also reported that handover between old and new staff was often inadequate.
- Staff inexperience in some cases meant additional assistance was required. Some projects believed that because health promotion is an emerging field and that staff sometimes appear to be poorly paid relative to other disciplines, some staff lacked the experience necessary.
- Other (major funding) priorities within the PCP sometimes meant that issues within small CWGP projects waited for resolution. Flexible and supportive program management was noted as essential where projects were effected by unanticipated events, and sometimes this was not immediately available.

Using PCPs as auspices for CWGP grants worked well in PCPs that already had a strong plan and that featured physical activity as a priority. In some other PCPs however, the project management component was sometimes found to be time consuming and out of balance with the size of grant provided. Consequently, in a small number of cases, PCPs were not well engaged and had only a peripheral relationship to the project.

Besides PCPs, other project partners also provided in-kind support and/or a direct financial contribution. The in-kind support provided included advice, facilitated links with other organisations or people, venues, marketing and promotion, guest speakers for training and education, office space, telephones and computers, project planning and evaluation, coordination, administrative support, recruitment and training of volunteers, transport, free access to facilities for project participants and catering.

Links were also established between CWGP projects and other projects or activities auspiced through the PCP or being conducted by member agencies. Perhaps chief amongst these was the Seniors *Go for your life* program, also part of the broader Victorian *Go for your life* campaign, administered through the Office of Senior Victorians within DVC. The objectives of Seniors *Go for your life* include funding PCPs to develop, promote and deliver physical activity programs (*Active Living Grants*) to increase the number of older Victorians who are socially and physically active, and to increase the capacity of professional organisations and local community groups to provide appropriate, accessible and attractive activity programs for older Victorians throughout the State.

Within DVC, the Physical Activity Unit and the Office of Senior Victorians were also able to establish a collaborative relationship that produced numerous positive outcomes including shared learning between (walking) grant programs and about how best to work with PCPs.

LEVELS OF SUPPORT

In addition to the $10,000 grant provided to each project by DVC, a number also secured additional cash and/or in-kind support from sources other than DVC:

- 14 projects (45%) raised additional cash totaling $48,799 (an average of nearly $3,500 per project). Across the program, additional cash raised 'leveraged' DVC's direct investment in CWGP grants by 16%.
- 26 projects (84%) received additional in-kind support valued[6] at $228,117 (an average of $8,774 per project).

Value of Additional Support Secured*	Number of Projects	
	Cash	In-Kind
$1 - $999	2	3
$1,000 - $4,999	9	10
$5,000 - $10,000	3	7
$10,000 and over	--	6
TOTAL	**14**	**26**
Nil or Did Not Report	17	5

* Based on project self-evaluation reports

A number of projects felt that DVC had "too many expectations" and that a grant ceiling of $10,000 was insufficient to accomplish project objectives. A significant proportion of PCPs did not believe that the size of the grant adequately acknowledged the time required of them, and this is perhaps borne out by the significant additional in-kind contributions reported.

[6] Valuations were provided by projects in their evaluation reports or project plans. While there was no consistent basis for valuation of in-kind support, much related to additional time contributed by PCP staff calculated on the basis of normal hourly wage plus employment oncosts.

SUGGESTIONS FOR ADDITIONAL SUPPORT

Aside from some concerns about the size of the grant, everyone was very happy with the assistance provided by DVC in project planning and implementation; most were also happy with the level of support provided by PCPs. Suggestions for additional support included:

- More facilitation from PCPs in accessing networks/established relationships.
- Increased size of grant to better reflect the inputs required.
- Development and provision of an initial package of materials that might include generic walking group resources, information about likely barriers and enablers etc., to save time in research prior to project commencement.
- Provision of a generic walking program survey that could be used by projects to access the suitability of walking paths.
- Extending project timeframes, to allow sufficient time to complete the project without undue pressure and to facilitate a more thorough internal evaluation.
- More support from PCPs at times of staff turnover, to facilitate a seamless handover and preserve momentum.
- Increased and earlier access to materials from the broader *Go for your life* campaign that could have been used within the CWGP.
- Additional support from DVC where the PCP did not have a strong focus on physical activity.

Key Points

- ❖ DVC staff were a valued resource to projects, providing a most helpful and effective level of support and assistance.
- ❖ A number of initiatives developed by DVC (such as the two-step grant application process and the major workshop for funded agencies at project commencement) were both innovative and successful in supporting take-up and implementation of the program.
- ❖ Auspicing projects through PCPs was an effective strategy as aims and objectives were generally similar and it allowed leverage of established infrastructure and partnerships within regions.
- ❖ Additional links and successful partnerships were also established between CWGP projects and other projects or activities auspiced through the PCP or being conducted by member agencies.
- ❖ Projects attracted a significant amount of additional cash and in-kind support.
- ❖ The grant ceiling of $10,000 was in many cases insufficient to support the scope and range of activities attempted (and additional support was required).

Recommendations

1. Increase the size of the grant available and extend the timeframe for completion of future walking grant projects.
2. Compile a *Walking Program Resource Kit* from the many useful tools and resources developed by CWGP funded projects.
3. Convene a workshop for new and/or ongoing projects to ensure that the findings and lessons from CWGP Phase 1 and Phase 2 project evaluation reports are shared and available to benefit all.

WHAT DID PROJECTS DO

Projects engaged in a wide variety of activities, with no two projects the same. However, activities however could be grouped into several main categories with projects often engaging in several of these at a time:

- **Development of resources** which included curriculum packages for teachers, training modules, maps of walking paths, directories of walking groups, walking group starter kits, an assessment tool to grade walking tracks, log books, promotional brochures, and websites.
- **Training of walking group leaders**. Those trained included staff in health and other services, existing volunteers from other services and new volunteers recruited from within the general community.
- **Walking group activities** incorporated pedometer loans, walking group challenges and establishing new walking groups. A number of projects targeted specific groups such as young mothers, the elderly, the bereaved, people with a mental illness, etc.
- **Health promotion/community education** including information nights, forums and a 'reality program' with selected individuals reported in the local press.
- **Walking path improvement** which usually resulted from audits of walking paths and was sometimes an unplanned result of the project activities.
- **Promotion of project activities** was a feature of most projects and included development of brochures, 'Come and Try' days, walking events, challenges and launches, articles in the local press, brochures, videos and websites.

A number of project activities appeared to correlate to the ongoing involvement of participants however this aspect was not specifically reported by projects (and is discussed further in a later section of this report). Some projects aimed to make their activities and projects link to existing initiatives or be part of a broader project. Some tried to encourage existing services, such as Neighbourhood Houses, to take on walking activities as part of their usual activities. The development of partnerships with sports groups, leisure centres and Sports Assemblies also appeared to be aimed at assisting the ongoing involvement of participants. By involving the community in planning and implementation, projects sought to ensure that projects met community needs and thereby facilitated participants' ongoing involvement.

Approximately 50% of reports noted that projects linked with PCP priorities as expressed in local plans (priorities included increasing physical activity, healthy weight, food and nutrition, and/or mental health and social connectedness). Some projects noted that their activities also linked with Municipal Health Plans and Community Health Service Health Promotion Plans. As noted earlier, some projects linked with existing or previous activities such as Seniors *Go for your life* and *Walking School Bus* projects.

However, a few projects did not appear to be linked with other health promotion activities or catchment plans and appeared to be at risk of not continuing past the expenditure of CWGP funding.

Project processes varied significantly depending on the type of project activity, the partners involved and local circumstances. The majority of projects established project steering committees or linked their project's management into existing committees. A number of projects involved the community in various ways in the planning of activities – by holding workshops, public meetings, focus groups, seeking input through surveys, and consultation with existing groups.

Project plans were generally of high quality, containing specification of the target group characteristics, description of the channel or way of reaching these people, clear objectives and strategies to achieve objectives, and succinct methodology. Project plans were prepared according to a pro forma provided by DVC and, in some cases, following detailed discussion and assistance from the project officer. Most projects went to significant efforts in project planning and this, together with initiatives from DVC, is reflected in documentation.

Project plans might be improved in a number of ways; however, this is not seen as necessary given the accomplishments of Phase 1 and 2 projects (and is perhaps not justifiable given the size of the grant). However, for consideration, suggestions include:

- Evidence that the target group has been consulted/involved in planning.
- Evidence that the project is appropriately resourced and that there are appropriately skilled staff to deliver the project.
- Empirical data with regard to the health problem, problem determinants and expected outcomes (and, where practical, provision for baseline measurement using data sources with accepted validity).

Evaluation was conducted in a number of ways including keeping registers of attendance, pre and post activity questionnaires, verbal feedback by participants and partners, and observation. While evaluation reports were generally detailed, and again reflected significant efforts from project partners, most reports focused on process and project outputs with relatively little emphasis on measurement of program effects (although this was always accepted as difficult with time-limited funding and few if any funds to devote to evaluation).

Key Points

- ❖ CWGP projects engaged in a wide variety of activities with no two projects being the same but most focusing on walking group development, production of resources to promote walking and training of walking group leaders.
- ❖ Agencies that involved the community in project planning and implementation were better able to ensure that they met community needs and more successfully able to encourage participant's ongoing involvement.
- ❖ Around half of all projects linked directly to PCP priorities as expressed in local catchment plans and most others linked to other relevant regional priorities (e.g. municipal health plans).
- ❖ Project plans were generally of high quality and effort in this area had a strong and direct influence on achievement of project objectives.

Recommendations

4. Ensure that all future walking grant projects are clearly linked to relevant local health promotion activities or catchment plans, and that there is community involvement in project planning and implementation.

WHO WAS INVOLVED IN PROJECTS

PARTNER ORGANISATIONS

Partnerships are an important mechanism for building and sustaining capacity in health promotion, particularly so when working across different sectors and/or with a range of organisations. Partnerships are important in bringing together, harnessing and maximising utility of the range of skills needed to produce more effective health promotion outcomes[7].

Grants provided under the CWGP required the development of partnerships, both in planning and project implementation. The use and understanding of the term 'partner' appeared to vary across projects, with some partners involved in the management of projects and others involved in project activities, either as project participants (e.g. members of a walking group) or in supporting the work of projects i.e. supermarkets promoting healthy products, schools, etc. However, all projects reported a very wide range of partners; among the most common were:

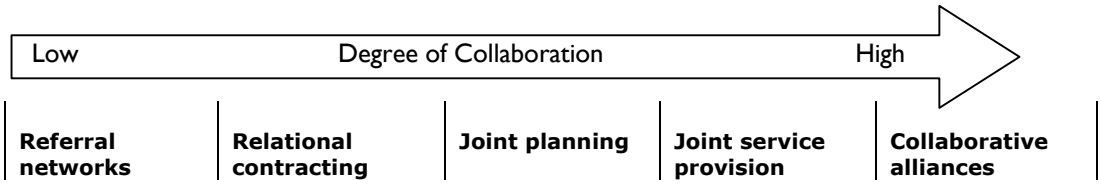
- Local councils such as the City of Greater Shepparton, Moira Shire, Ararat Rural City, the City of Yarra, City of Maroondah, City of Greater Dandenong, the Shire of Cardinia and Wellington Shire.
- District health services/hospitals such as Southern Health, Gippsland Women's Health Service, Timboon District Health Service, the Bendigo Health Care Group and Latrobe Regional Hospital.
- Community Health Services such as Banyule, North Yarra, Knox, Yarram and District, Dianella and Sunraysia, Buchan Bush Nursing and Mitchell Shire Maternal and Child Health.
- Fitness or leisure centres or other sports organisations, such as Diamond Creek Community Centre, Macleod Recreation Centre, YMCA, Womensport and Recreation Victoria, and the Kyabram Sports and Entertainment Centre
- Neighbourhood Houses such as Kensington, Heyfield, Sale and Loch Sport.

Less commonly, project partners included:

- Schools and universities, such as Kangan Batman TAFE, Deakin University and the University of Ballarat.
- Family services, such as Mallee Family Care, Isis Primary Care and Anglicare.
- Aged, disability and mental health services, such as the Ageing Well Centre, Carer Respite Centres, Vision Australia, Diabetes Victoria, and Reach Out Southern Mental Health.
- Neighbourhood Renewal Projects, such as Broadmeadows, Heathdale, Braybrook and Latrobe.
- CALD organisations, such as the Centre for Culture, Ethnicity and Health, the Centre for Multicultural Youth Issues, Kurdish Association of Victoria, Djerriwarrh Health Service and the Migrant Resource Centre.
- Divisions of General Practice such as Outer East, Dandenong District, WestVic, Ballarat and District, and Central West Gippsland.
- Other resources/organisations such as Flemington Police, Parks Victoria, Vic Fit, St John Ambulance, Rotary and Apex Clubs and local businesses.

[7] The Partnerships Analysis Tool, VicHealth 2004

In assessing the relative strength of partnerships, it is helpful to refer to a 'continuum of collaboration' proposed by researchers[8] following a general review of collaboration and alliances:



In subsequent work, VicHealth described different types of partnerships in health promotion, as follows[9]:

- Networking - involving the exchange of information for mutual benefit, requiring little time and commitment from the partners.
- Coordinating – involving the exchange of information and the refinement of activities for a common purpose.
- Cooperating - involving exchanging information, refining activities and sharing resources, and requiring a significant amount of time, a high level of trust between partners and sharing of turf between agencies.
- Collaborating - in addition to the foregoing, requiring the enhancement of the capacity of the other partner for mutual benefit and a common purpose.

Analysis of partnerships established within the CWGP showed that successful partnerships were characterized by one or more of the following:

- Cooperation between partners to develop appropriate guidelines and standards for project implementation.
- Joint identification of where the initiative sat within the bigger picture and determining future possibilities.
- Assistance to plan future directions.
- Provision of administrative support, equipment, office and meeting spaces.
- Provision of ideas and specialist advice through networks.
- Identification of knowledge or skill gaps and developing ways to address these.
- Planning formal and informal opportunities to share skills and knowledge.
- Identifying opportunities to raise awareness amongst key audiences.
- Helping to strategically manage resources and/or identifying other resources that might be mobilized.

The strength of partnership varied across projects. Key factors included having a defined and jointly agreed purpose, being clear about how each will add value to the work of other partners, and careful planning and monitoring. The strength of partnership also varied according to the purpose and willingness of participating agencies to engage and, particularly for collaborative partnerships, the support and involvement of senior agency personnel (especially given that project workers were often relatively junior and in many cases on short-term contracts, limiting their capacity to direct agency resources).

[8] Walker, R. Collaboration & Alliances: A Review for VicHealth 2000
[9] The Partnerships Analysis Tool, VicHealth 2004, adapted from Himmelman 2001, 'Collaborative betterment and collaborative empowerment', American Journal of Community Psychology, vol. 29, no. 2.

Successful partnerships also sought regular opportunities (including opportunities for informal contact) to communicate and engage with other partners or prospective partners. Partners were proactive in communication and took advantage of a range of structures/mechanisms, 'piggy backing' on existing initiatives where possible. Successful partnerships also appeared to feature efforts to ensure responsiveness and quick turnaround on any calls or issues.

Where partners identified shortcomings in the effectiveness of the relationship, contributing issues included:

- Failure to identify barriers within the partnership and ways to overcome these.
- Lack of attention to identifying opportunities to add value to the project.
- Lack of group reflection, discussion and analysis, including lack of acknowledgement of success.
- Failure to recognise and accommodate differences in culture or to understand the complexity of relationships and organisational agendas and values.
- Unrealistic expectations and timelines.
- Inadequate attention to documenting agreements, roles, expectations, commitments and timelines of all partners and tasks.
- Inadequate involvement of partners in the planning process and thus a lack of shared goals.
- Lack of attention to identifying requisite resources and the strengths and connections of each partner.

PROJECT PARTICIPANTS

Those targeted to participate in projects included a wide range of groups. While a number of projects focused broadly on members of the general community, others sought participants from more specific groups, including:

- Primary and secondary school students.
- Special needs groups such as people with vision impairment and other disabilities, people with chronic illness, people with mental health issues and older people with bereavement needs.
- Culturally isolated people and people from indigenous communities.
- Families, young people and mothers with young children.
- The ageing and elderly.
- People living in rural and isolated locations.
- People who were not physically active.

Attachment 4 provides more detail about characteristics of participant groups, and also provides information about particular geographic areas targeted. Analysis shows that coverage was spread right across Victoria, including a number of areas classified as 'disadvantaged' by DVC's Strategic Policy, Research and Communications Division, such as:

- In metropolitan areas, Dandenong, Kensington, North Melbourne, Footscray, Broadmeadows and East Geelong.
- In regional and rural areas, Sebastapol, Eaglehawk, Mooroopna, Shepparton, Seymour and Moe.

While projects did not always report on factors that led to an initial or ongoing involvement for participants (and this was not relevant to some projects), where such factors were reported they included:

- Participants had been involved in similar programs previously i.e. building on the success/momentum of a previous project or related activities.
- Participants were involved with existing community or walking groups.
- Engaging community leaders or 'champions' to promote and support projects.
- The provision of incentives such as pedometers, transport, child care, discounts at shops and sports venues, etc.
- Involving people in the planning, implementing and evaluation of projects.
- The creation of a supportive environment.
- Referrals from other services.
- Utilising existing support structures.
- Extensive promotion.
- Addressing the barriers to participation.
- In the case of CALD women, utilising a trusted member of the community to promote the project.

Factors that may have led to participants leaving a project were also rarely detailed in project reports. However where this was reported, it included the following:

- A significant time lapse between planning, implementation and completion of a project or activity.
- Changes in project personnel.
- Overly structured or formal walking groups, without any flexibility to adjust or adapt to conditions, circumstances or participant preferences.
- Categorising or 'labeling' a walking group (e.g. for older people) may restrict broader participation.
- Concern by a shopping centre that walks would interfere with cleaning schedules, customer safety, congestion and public liability.
- Colder weather (for outside walking groups).
- Some existing groups were not welcoming of new people.
- Older people were unable to recover from poor health.
- Work commitments of participants.
- Religious and cultural events i.e. Ramadan.
- Lack of interest.

Where projects involved the training of walking group leaders, factors that may have led to participants leaving a project included:

- Formality and complexity of walking leader training (for example, where it included first aid training) was sometimes too onerous for 'a simple activity'.
- Inability to address liability and the responsibility of walking leaders.

Where project evaluations included a survey of new walkers, some things that encouraged them to participate included:

- The walk was local/nearby.
- Participants already knew some of the people.
- The pace of group (slow/med/fast) and distance to be covered was suitable.
- People felt safe medically (for older people and the frail).
- Common interest group.
- Even surface.
- The path had seats where walkers could rest.

Initiatives that addressed either the physical (e.g. walking trails, signage) or social (e.g. provision of social support, provision of childcare) environments were shown to facilitate participation and were reported to have lead to increased levels of physical activity.

Key Points

- ❖ All projects reported a wide range of partner agencies and organisations involved in project planning and implementation.
- ❖ Analysis of partnerships established within the CWGP has provided many participating agencies with a deeper appreciation of key factors leading to successful partnerships and, conversely, issues that might compromise the effectiveness of the relationship.
- ❖ Those targeted to participate in projects included a wide range of groups. Some projects focused on members of the general community while others focused on specific target groups with particular/special needs.
- ❖ Project evaluation has revealed a range of factors associated with initial and ongoing participation by new walkers, and reasons why some choose to discontinue their involvement.

Recommendations

5. Ensure that findings from project evaluation reports relating to key factors in successful partnerships and reasons why participants join and continue in walking groups are included in the *Walking Program Resource Kit* (or otherwise distributed) and available to new and/or ongoing walking projects for planning purposes.

ACHIEVEMENT OF PROJECT GOALS

MEASURES OF ACHIEVEMENT

The goals set by most projects were general, such as 'to increase the number of people walking', 'to increase physical activity levels', 'to establish sustainable walking groups', etc.

Projects used a variety of methods to determine whether their goals were met. These included:

- Case studies.
- Focus groups.
- Pre- and post-project/activity surveys.
- Attendance registers.
- Resource kits distributed.
- Maps developed.
- Verbal feedback.
- Observation.
- Log books.
- Collection of base-line data and post-project data.

Just over half of all projects (18) reported that they had fully achieved their project goals with the remainder saying they had partly achieved their goals. Some projects indicated that their goals had been too ambitious, particularly within the limited project timelines.

Some projects had excellent results, where measured, including the following:

- Sixteen new walking groups established. Post-program evaluation indicated that the social connection of participants had increased; 58% had lost weight; 69% had increased fitness; 42% said the groups had helped them to meet new people; 64% said the project had encouraged them to adopt a healthier lifestyle; 32% had increased self-confidence; 90% had increased motivation to walk; 40% had improved their diet. Six months after the project, 67% were walking more than once a week. (Southern Mallee)
- From pre- and post-program evaluation and compared to base-line data (for young women from Horn of Africa communities), increases in a range of parameters were demonstrated: participation in walking; sense of community connectedness and inclusion; knowledge and appropriate use of local community services; awareness of walking as an active means of transport; awareness of the health benefits of walking; knowledge and participation in self managed behaviour related to health issues; and awareness of safety issues associated with walking. (Moonee Valley Melbourne)
- Parents reported increased fitness of children in 98% of cases; 81% participants reported a health benefit; 88% reported they are continuing their walking regime. (Central Victorian Health Alliance)

A number of projects reported changes in community involvement for participants, with increased connectedness reported as leading to enhanced well being overall.

A number of projects targeted CALD communities, based on evidence that certain groups often had low levels of physical activity. Findings from these projects support the existence of a positive relationship between participant take-up and adherence and the programs being conducted by bilingual community leaders in culturally appropriate and accessible settings. These projects also suggested a correlation between success and strong community support for the initiative.

The table below shows other statistics reported across the program. In considering these figures it should be noted that only principal project goals have been included (i.e. some projects undertook a number of activities and where a particular activity was a byproduct or subordinate goal it has not been counted. It should also be noted that not all projects provided statistics that could be used.

Project Goals	Measure
New walking groups[1]	84
New walkers[1]	1,843
Partner agencies contributing (not including PCPs or lead agencies)[2]	154
Walking group Leaders/volunteers trained[3]	173
Walking resource kits/maps distributed in local communities (not including website downloads) [4]	4,235
Attendees at Walking Forums for 'key influencers' (eg personal trainers, community health nurses, dieticians etc)[5]	261
Number of students participating (5 schools)[5]	2,100 (est)
Teachers involved in curriculum development[5]	30

Notes

1. Of 31 projects, 20 had the establishment of new walking goups as their principal goal but data from only 14 could be included in the count (ie six did not provide sufficient detail). New walking groups were defined as meeting once per week to walk for at least 30 minutes.
2. Includes data from 26 projects.
3. Of 31 projects, eight had the training of volunteer walk leaders as a significant goal. Data from all eight has been included in the count.
4. Of 31 projects, seven had the development and distribution of walking resource kits and/or local maps of walking paths as a significant goal. Data from all seven has been included.
5. Data from one project only.

Overall, projects reported very positive and encouraging results. For a proportion of projects however, the generality of goals and a consequent lack of measurability made it difficult to determine the extent to which goals were achieved. In addition, the short duration and small size of grant made it difficult for projects to undertake extensive evaluations and for the most part to determine real levels of sustainability of project impact.

If more conclusive evidence is required, particularly in relation to strategies that might impact on physical activity acceptance and adherence, including amongst special groups within the population, additional research would be required.

CHANGE IN KNOWLEDGE, SKILLS AND ATTITUDES

An important outcome indicator is change in knowledge, skills, attitudes or aspirations amongst project participants. This is best measured through pre- and post-activity surveys; however, very few projects conducted such surveys where it would have been appropriate.

Some projects conducted information sessions for walking group participants. Where this was undertaken, feedback was positive and included:

- Participants were made more aware of benefits and future effects if they continue to walk.
- Participants had a heightened awareness of the importance of physical activity in improving their health and well-being and linked it to a strong social connection.
- Participants had increased confidence, self-esteem and increased knowledge of information sources as a way to seek further assistance or guidance in the future.
- Participants were able to identify an increased number of services and activities relevant to them in the local community, and felt they could confide in a person they trusted in a safe environment should they wish. They were empowered to increase their everyday levels of activity in the community.

A number of projects provided training to volunteers who were to lead walking groups. Where it was obtained, feedback was mostly positive with participants commenting that they felt well equipped to run walking groups. In one project however, some participants commented that they felt overwhelmed by the training and the tasks expected of them.

Some projects included case studies in their reports, some included testimonials and others reported results from questionnaires and focus groups. Examples include:

- A case study was provided of a woman who participated in a walking group. The woman was an invalid pensioner, with two children, one of whom had behavioural problems. The woman was described as obese, smokes and buys take-away and frozen meals instead of cooking. Two weeks after she started walking, she bought her first new clothes in a number of years – a tracksuit. In week three she reported to the group that she 'hadn't felt so good in years' and after the walks she goes home feeling invigorated. She has started to cook healthy foods and is starting to take control of her son's behaviour. (Central Highlands)
- Parents of high school girls who disliked exercise and had weight issues reported that the girls now enjoyed walking in the group and exercising. (Hume Moreland)
- Another project conducted a reality-type program with community members and featured them in weekly updates. One of the participants stated "The program was so easy it actually felt like you weren't on an exercise program at all. After three weeks it became habit and not a chore, just part of your daily routine and it was just small lifestyle changes that we all know about but somehow forget." (Northern Mallee)
- Another project reported from post-activity surveys that 95% of participants planned to continue walking. Of those surveyed, 70% were still walking two months after the conclusion of the program, with 67% walking more than once a week six months later. (Southern Mallee)

- In another group, the women who participated said that they had learnt more about exercise, were drinking more water and feeling more energetic. (Wellington)
- A Carers Support Group that commenced walking reported that they now had the opportunity to de-stress, to experience sunshine, made time to exercise and had a reason to socialise. (Hume Moreland)
- A testimonial from a participant in a walking group for bereaved people said "I went along not sure what to expect and found a warm and welcoming group of volunteers and participants. I have enjoyed my time with this group and look forward to continued involvement". Another participant stated "I get so many benefits from this group – the walks we do help my mobility and independence efforts, it's good for my circulation and good for my lungs. Attending the group has also given me valuable social contact …" (Inner South East)
- In a group for CALD participants, the project coordinator observed decreased social isolation amongst participants. This was supported by participant comments: "For me it was very important to have a weekly walk and get out and meet people." "I am very happy because I meet and walk with my friends." Another participant was quoted as saying that after information sessions, "I have learnt new information about the women and what we can do to manage the many problems we have." (Moonee Valley)
- In a small rural town the major industry is agriculture, there is a high proportion of rental properties and low cost housing, and there are a number of households where both parents are unemployed or on pensions. The children of the town are involved in a variety of after school activities including a dance class, a football and netball club, and a soccer program. Regional Sports Assembly staff noticed that parents were generally spending a lot of time waiting around for their children, but very few themselves were participating in any informal or organised activities. There were obvious poor fitness levels amongst the women in particular. After seeking support from a couple of mums ("local champions") it was announced that they were going walking while the kids were participating in activities and that others were welcome to join them. After a few weeks, the mum's would go walking even if the "local champions" weren't there to lead the group. (Central Highlands)

Key Points

- ❖ Just over half of all projects reported that they achieved their project goals with the remainder partly achieving them. Overall, projects reported very positive and encouraging results. Where they were measured, some projects showed excellent results.
- ❖ For a significant proportion of projects however, program limitations and a lack of measurability in project goals made it difficult to determine the extent to which goals were achieved and levels of sustainability of project impact.

Recommendations

6. Future project reporting should include both qualitative and quantitative measures against specified objectives.
7. DVC should commission a research project to collect information on strategies that impact on physical activity acceptance and adherence, including amongst special groups within the population, as input to future program planning.

IMPACT ON THE PCP APPROACH

INTEGRATED HEALTH PROMOTION CATCHMENT PLANNING

The 31 PCPs funded across Victoria are made up of over 800 community and health agencies, local governments, Divisions of General Practice and related organisations. A key objective of PCPs is to improve the health and wellbeing outcomes of people using primary health care services through a greater emphasis on health promotion programs and by coordinating a service response to early signs of disease and people's need for support.

In order to achieve this, PCPs are required to facilitate catchment-wide integrated health promotion (IHP) planning. Catchment planning should address key priority topics and population groups, using a common planning framework outlining an evidence-based approach to planning, funding, organisational development, service re-orientation and partnership, as required to initiate and sustain a range of health promotion programs appropriate to population needs[10]. The planning framework is based on a social model of health, encouraging a multidisciplinary, intersectoral approach to address key population health and wellbeing issues.

IHP Catchment Plans identify key local priorities from a number of statewide priorities nominated by the Department of Human Services (DHS). For the period 2004 –2006, statewide health and wellbeing priorities included:

- Physical activity.
- Food and nutrition.
- Mental wellbeing and social connectedness.
- Tobacco, alcohol and other drug issues.
- Healthy weight.
- A Neighbourhood Renewal site (if one exists in the PCP catchment).

PCPs are not required to address all the statewide priorities, but must address at least one and no more than three. Completed plans include summaries of actions to address local priorities, estimated budgets and timelines for participating organisations and community stakeholders.

Outcomes of the 2006 catchment planning process anticipated by DHS included:

- Partnerships that utilised a population health approach for health promotion activity with plans describing strategies to reduce inequities and improve the health and wellbeing of whole populations.
- Enhanced capacity of partners for mutual benefit and a common purpose through creation of interdependent systems to address issues/opportunities.
- Agreed and documented roles and responsibilities for individual organisations with catchment plans that demonstrated a collaborative process to determine priority for action, sharing resources and making commitments to achieving a common goal.
- Improvement in the quality of integrated approaches to health promotion planning including a mix of interventions and capacity-building strategies.

[10] Hahn, B: Primary Care Partnerships: Victoria's Answer to Primary Care Reform (Health Issues #72, 2002)

SUPPORTING THE PCP STRATEGY

A review of PCP IHP Catchment Plans showed that in PCPs where physical activity was a nominated health promotion priority (20), the activities incorporated in CWGP projects were directly relevant to expressed goals and objectives.

In broad terms, catchment planning aims to:

- Move towards a population health approach in health promotion.
- Strengthen collaborative partnerships.
- Improve the quality of integrated approaches to health promotion planning, implementation and evaluation.

The CWGP has contributed to each of these aims.

In line with catchment planning principles and complementing a range of existing PCP initiatives and strategies, the CWGP encouraged the identification of groups who were least active in the community and those who could derive significant health and wellbeing benefits from increased physical activity. The CWGP provided PCPs with another mechanism for developing interventions to address disparities for these groups, including the development of more supportive environments to make participation easier, safer and more enjoyable.

In numerous cases, implementation of CWGP projects required collaboration between agencies. Working in collaboration to agreed priorities means that the capacity of the sector is enhanced and duplication and fragmentation of health promotion effort and investment is reduced. In some cases, collaboration also resulted in efficiencies through combined resources and/or shared programs.

A more integrated approach to health promotion is likely to strengthen the capacity of the system to plan and deliver effective programs. Several PCPs reported that CWGP projects provided impetus and a focus within the planning process and actively contributed to catchment priority setting for IHP.

In some cases, CWGP projects were used by IHP planning committees and PCP governance groups to encourage participation from new or fringe groups in catchment planning, to enhance locally relevant and community driven problem definition and solution generation processes. For example, some projects underlined the value of Regional Sports Assemblies as PCP member agencies.

CWGP projects also increased the potential for sectors other than health to be involved in health promotion activities and brought a number of new agencies to the partnership. New partnerships and collaborations are likely to facilitate sustainable increases in levels of physical activity and changes in physical and social environments. Successful partnerships between sectors requires amongst other things a commitment to action and investment in building relationships, and to some extent, the CWGP was a vehicle for this to occur.

In terms of evaluation, the CWGP helped to reinforce and develop relevant skills in the workforce. For example, the DVC Reporting Template developed specifically for CWGP projects (but which was not compulsory) included tools to build evaluation skills and experience, and to contribute to the health promotion evidence base.

Other impacts noted in CWGP final project reports (about half of all reports commented on the impact of the project on the PCP approach) included:

- The project helped to consolidate links and relationships between the PCP, local government and community health and other members.
- The project helped to strengthen links within areas of Council.

- The project provided good networking opportunities for the PCP.
- The PCP had included the project in its 2006-09 plan.
- One PCP had since included physical activity as a priority and others reiterated their commitment to physical activity as a priority.
- "The grant generated such enthusiasm for the concept of walking groups and their potential within the PCP that it has been decided to make walking the major focus for the next planning period" (Hume Moreland). The PCP also undertook to provide funds for any further volunteers that were interested in leadership training for walking groups.
- The PCP took on a monitoring and support role to ensure the program continued to gain momentum.
- "The project has resulted in increased partnership activity, stronger community engagement and a greatly enhanced PCP" (Grampians Pyrenees).
- CWGP projects provided a range of opportunities/demonstration projects that might be replicated across the state by other PCPs.
- The CWGP raised the profile and established a relationship between *Sport & Recreation Victoria* and a range of agencies not previously associated (e.g. community health centres).
- The CWGP built awareness of the *Go for your life* brand amongst key audiences.

Key Points

- ❖ In PCPs where Physical Activity was a nominated health promotion priority, CWGP projects were directly relevant to expressed goals and objectives.
- ❖ The CWGP provided PCPs with another mechanism to address the needs of key target audiences who could derive significant health and wellbeing benefits from increased physical activity.
- ❖ The CWGP promoted a more integrated approach to health promotion, one likely to strengthen the capacity of the system to plan and deliver effective programs.
- ❖ CWGP projects contributed to catchment priority setting for IHP and enhanced locally relevant and community driven problem definition and response.
- ❖ CWGP projects created opportunities for new agencies from outside the traditional health sector to join the partnership and get involved in health promotion activities.

Recommendations

8. Ensure that the potential benefits arising from using PCPs as auspices for physical activity programs are considered when planning appropriate programs in the future.

SUSTAINABILITY

KEY FACTORS IN SUSTAINABILITY

The term 'sustainability' in health promotion is often used to mean different things. It can relate to the maintenance of health benefits achieved by an initial program, continuing the program within an organisation, or building the capacity of communities targeted by the intervention.

A number of CWGP projects did not appear to fully understand the concept of sustainability nor did they address critical factors leading to sustainability in their final reports. Many projects simply indicated that the activities would be sustainable if further funding was provided to maintain them. Certainly this is a factor (research has noted that 'inadequacy of long-term resources' is a major issue in many programs that ended up being unsustainable[11]), however program design and CWGP literature sought to make clear that the issue of sustainability was intended to have broader meaning than just funding.

Accordingly, a number of projects in their planning and design attempted to make their activities sustainable. While not true for all projects, those that developed skills and resources for other individuals and organisations were generally more likely to make their activities sustainable than those that used their funds to conduct time limited activities such as walking activities. Project activities more likely to lead to long-term sustainability included:

- Development of a schools curriculum package and a training module to support teachers.
- Development of a Walking Starter Kit and Train the Trainer package for agency staff and community groups.
- Encouragement and training of community members to take on leadership roles with walking groups.
- Development and promotion of walking route maps and path assessments.

Besides funding, critical factors identified as leading to sustainability included:

- Working in an established partnership (or establishing strong partnerships).
- The mission of the program being compatible with the mission and activities of the host organisation.
- Incorporation of the activities into the core business of organisations.
- Investing properly in development, design and printing of materials i.e. maps.
- The use of websites and directories (including making arrangements for future website updates, subscriptions and promotion).
- Encouragement of group participants to take on leadership roles.
- Physical improvements made to walking paths by Councils/Shires.
- Formal and/or informal training of people whose skills and interests are retained in the program or its immediate environment.
- Having a coordinator or support person for groups, including a consistent key contact person and/or a champion to keep up group motivation.

[11] Pluye et al 2004 'Making public health programs last', Evaluation and Program Planning, Vol. 27: 121-133

- Consulting and working with/involving the community rather than having them as passive recipients (community engagement needs to be planned and sustained).

Secondary factors identified in project reports that are likely to support sustainability included:

- The utilization of existing structures.
- Planning sustainability from the beginning.
- 'Piggy-backing' on existing initiatives.
- Demonstrating the success or effectiveness of a program (ensuring that effects are visible and acknowledged).
- Incorporating walking development issues and opportunities into broader Local Government planning.
- Planning to pursue new submissions to build on/extend successful initiatives.
- Opportunities to share resources (eg the *Walk 21 Conference*).

In particular, community consultation leading to community ownership is vital when aiming for an eventual result of increased sustainability within the community. Projects that attributed part of their success to community consultation recognised the time required and planned to allow for this, and found that their initiatives worked best when integrated with existing processes/programs.

A number of the factors above relate to 'routinization' of the process whereby activities stimulated by a program continue within an organisation after the program has ceased. Some studies have postulated routinization as the primary source of health promotion program sustainability[12] with a key aspect being the stabilization of resources in the form of financial, material or human resources.

Within the term of the CWGP, numerous staff changes were experienced in funded agencies, often due (it was said) to staff responsible for project implementation being employed part time or on fixed term contract. When staff changes occurred or when strategies to ensure continuity fell down, sustainability was compromised.

Sustainability is often conceptualised in relation to the ability of a program to generate longer term effects in the target population[13] (i.e. that health benefits will continue after the program has finished). Long-term behaviour change is considered to be both difficult to achieve and to evaluate, and certainly within the scope of this review it was not possible to consider change much beyond cessation of funding. However, some projects asked participants about future walking intentions and reported that factors associated with improved adherence were seen to include:

- Group leadership and supervision.
- Ongoing availability of resources including loan equipment.
- Frequent contact with other members of the group or a group coordinator.
- Ongoing availability of support components.

Also important in sustainability, through empowerment of people and communities, is the provision of information. A number of CWGP projects actively promoted the benefits of physical activity through awareness campaigns. In addition, a range of media coverage was secured (mainly local press e.g. Kensington Flemington News).

[12] Pluye et al 2005. 'Program sustainability begins with first events', Evaluation and Program Planning, Vol. 28: 123-137

[13] Crisp and Swerissen 2002. 'Program, agency and effect sustainability in health promotion', Health Promotion Journal of Australia, Vol. 13(2): 40-43

RESOURCES DEVELOPED

Given difficulties measuring long term effects, it has been pointed out that "an alternative to considering sustainable program effects as being long-term changes in specific knowledge, attitudes or health behaviours, is to consider the extent to which individuals, organisations or communities have *built their capacity* to deal with health issues.'[14] Thus, improvements to capacity can form a foundation for the sustainability of health promotion activities. Organisational capacity can have at least three components[15]:

- Organisational commitment - as evidenced in available resources, job descriptions, mission statements, policies, number of levels or parts of the organisation involved, inclusion in strategic plans etc.
- Skills - competence in implementing or managing project related tasks and functions, problem solving capability.
- Structures - networks within and across organisations, decision-making forums, communication mechanisms, formal and informal partnerships, learning development pathways etc.

A range of resources were developed by CWGP projects that support organisational capacity in these three areas:

- Resource kits for organisations considering starting a walking group.
- Information kits and walking kits for potential walking group participants (some that contain pedometers and instructional videos).
- Walking tally sheets, log books, participation certificates and other resources that can be used to motivate/involve walking roups participants.
- Promotional material including brochures, posters, walking development plans, case studies, sample press releases and flyers advertising particular walks, flyers to advertise walking group leader training courses, walking presentations etc that could be adapted for future use.
- Community surveys and walking group participant surveys, to develop a needs assessment and to evaluate aspects of the program.
- Audit tool for assessment of the suitability of walking paths and tracks (including for use by special needs groups such as people with vision impairments).
- Walk Leader fact sheets, induction kits and a Volunteer Walk Leader Manual.
- Key safety and health information and contacts for walking groups.
- Articles, publications and discussion papers in relevant journals.

The list above does not include 'primary' products of CWGP projects such as specific maps of, for example, Warrnambool, Port Fairy or Central Highlands walking tracks.

[14] Ibid
[15] Capacity Building Indicators to Help with Better Health, Australian Centre for Health Promotion, NSW Health 1999

GOOD PRACTICE IDEAS

Project reports and evaluation activities have also provided a range of good practice examples and ideas that might contribute to sustainability:

- Ongoing commitment to project activities built into Council Municipal Public Health Plans (Bayside).
- Walking maps installed at local tourist offices and brochures available at central locations throughout the township (Port Fairy).
- Designing a generic program that existing clubs and groups can take ownership of and adapt/rebadge to suit their own needs (Wimmera).
- Negotiating cut price activities for walking group members (Melton Waves Leisure Centre).
- Combining funding from different sources i.e. *Seniors Go for your life* and Parks Victoria (for the Worlds Greatest Pram Stroll).
- Using a safe and comfortable common area to sit, chat and have coffee after a walk, to support social connectedness (Kilmore).
- Providing incentives to encourage joining up (eg hat with name of walking program inscribed; shopping bag; water bottle; vouchers at local supermarket).
- Lobbying Council for infrastructure funding to upgrade the walking environment (e.g. link paths, provide crossings, signs, distance markers, public toilets, lighting etc), recognising that 'walkability' is the key, not simply walking. This includes identifying a range of walks to suit a variety of preferences (eg different lengths, challenges and directions).

Key Points

- ❖ A number of projects attempted to address critical factors that might lead to sustainability; however, a number did not.
- ❖ Projects that developed skills and resources for other individuals and organisations were generally most likely to make their activities sustainable.
- ❖ Evaluation reports and analysis has yielded a store of practical tips and advice, including a wide range of resources to build organisational capacity, that can be used to enhance the sustainability of physical activity projects.

Recommendations

9. DVC should source information or develop a training workshop for agencies funded under future physical activity projects in partnership development and making partnerships work.
10. Develop a stocktake of existing walking maps throughout Victoria and allow the general community access via the internet.
11. DVC should develop the business case and an organised approach within DVC to promote the need for Local Government to enhance walking infrastructure.

ATTACHMENT 1 – RESEARCH FRAMEWORK

Community Walking Grants Program: Evaluation Framework

AREA	EVALUATION QUESTION	INFORMATION REQUIRED	DATA SOURCE
PROCESS	1. What resources are supporting the project?	• Identify the resources provided by DVC, the PCP and/or other project partners	• EOIs and Project Plans • Partnership Map • DVC Reporting Template
	2. Who has been involved in the project?	• Identify the partners in the project • Identify the community participants (primary target group, postcode, volunteers – new/ongoing etc) • Identify factors leading to participants' initial and ongoing involvement • Identify factors leading to participants leaving the project	• EOIs and Project Plans • Partnership Map • DVC Reporting Template • Walking Group logs, attendance lists, minutes of meetings etc (for volunteer training, information sessions, planning forums etc) • Pre/post survey (walking group participants
	3. How has DVC worked with PCPs to promote physical activity and health promotion?	• Identify the role and activities of DVC • Identify how the project linked to PCP Integrated Health Promotion priorities • Identify success factors leading to integration of physical activity and health promotion	• EOIs and Project Plans • Interviews with DVC/DHS staff • Focus groups with project staff and PCP personnel
	4. What happened during the project?	• Identify project activities (what did the project do?) • Identify barriers to implementation and ways that these were overcome	• EOIs and Project Plans • DVC Reporting Template • Interviews with project staff
		• Identify better practice examples and evidence to support	• DVC Reporting Template
		• Identify project processes (including administration, promotion, monitoring and evaluation), materials and resources etc	• DVC Reporting Template • DVC files

Community Walking Grants Program: Evaluation Framework

AREA	EVALUATION QUESTION	INFORMATION REQUIRED	DATA SOURCE
IMPACT	5. Did the projects achieve their objectives?	• Identify whether the projects achieved what was planned	• DVC Reporting Template
	6. What impact has the project had on the PCP approach?	• Identify how the project impacted the PCP (resources, time, priorities, overall goals) • Identify if/how evaluation activities complemented *Planning for Effective Health Promotion Evaluation* and built PCP skills	• DVC Reporting Template • Focus groups with project staff and PCP personnel
	7. How have participant knowledge, skills, attitudes and aspirations changed?	• Identify changes in knowledge, skills, attitudes and aspirations during the project • Identify participant experiences	• Pre/post survey • Project focus groups, participant interviews and/or testimonials
	8. How have connections within the community changed?	• Identify changes in community involvement for stakeholders and participants	• Pre/post survey • Project focus groups, participant interviews and/or testimonials • Sustainability Checklists (survey)
	9. What unexpected impacts have there been because of the project?	• Identify positive and negative unexpected impacts that have arisen out of the project	• DVC Reporting Template • Focus groups with project staff and PCPs • Interviews with DVC staff
OUTCOMES	10. What has been learnt about increasing physical activity as part of a health promotion strategy?	• Identify impact of including physical activity on achievement of health promotion goals • Identify barriers/challenges	• Focus groups with project staff and PCP personnel • Interviews with DVC/DHS staff
	11. Are the projects/benefits sustainable?	• What has been achieved by the CWGP • Analyse sustainability of the resource base • Identify critical factors leading to sustainability • Can/will the project be replicated in other areas within the catchment	• Sustainability Checklists (survey) • DVC Reporting Template • Focus groups with project staff and PCP personnel • Interviews with DVC/DHS staff

Community Walking Grants Program: Evaluation Framework

Stakeholder Participation Plan

STAKEHOLDER	TOOL	TOPIC
DVC	Interviews and/or small group meetings	Resources, sustainability, participants, success factors for participant's involvement, other stakeholders, project activities, reactions to project, activities of DVC leading to integration of health promotion and physical activity Draft evaluation report
	Audit project files	Project objectives and activities, evaluation plan and data collection tools Media coverage, links, contacts and other resources of future benefit
DHS	Interview	Barriers to participation, strategies that developed, impact on PCPs, positive/negative unexpected impacts, success factors leading to integration of physical activity and health promotion
PRIMARY CARE PARTNERSHIPS and LEAD AGENCIES	Survey	Resources, sustainability, success factors for stakeholder involvement, reactions to project, activities of DVC leading to integration of health promotion and physical activity, changes in community involvement/connectedness
	Interviews	Project activities, barriers to participation, strategies that developed, impact on PCPs, positive/negative unexpected impacts, success factors leading to integration of physical activity and health promotion
	Focus Group	Sustainability, success factors for stakeholder involvement, reactions to project, activities leading to integration of health promotion and physical activity, changes in community involvement
	Final Report	See attached DVC Reporting Template
PROJECT PARTNERS	Survey and/or Focus Group	Success factors for stakeholder involvement, reactions to project, activities leading to integration of health promotion and physical activity, positive/negative unexpected impacts, sustainability
PARTICIPANTS	Pre/Post Test Survey	Knowledge, skills, attitudes and aspirations; levels of physical activity; participation levels Demographics, success factors for participant's initial and ongoing involvement, factors influencing participants leaving the project, community connectedness
	Focus Group	Project impact on community engagement, links that have developed with the community, links with health promotion and activity, reaction to the project

ATTACHMENT 2 – REPORTING TEMPLATE

'Go For Your Life' Community Walking Grants Program

DVC Reporting Template
(including Evaluation Requirements)

Name of Primary Care Partnership:
Lead Agency:
Project Title:

Aims/Objectives
- What is the overall aim of this project - why was it developed? Give some background rationale for the project in the context of PCP Integrated Health Promotion priorities.
- State the objectives of the project (for some projects, in planning your evaluation, it will be helpful to rephrase objectives using the guide at Attachment 1).
- What was the target town/suburb/region for the project/activity? What postcode(s)?
- What was the primary target group (aged, disability, CALD, general community etc)?

Inputs/Process
- What resources (funding, people, infrastructure) made the project happen? Who provided these resources?
- What other agencies were involved in implementing the project and how did they contribute? (Attachment 2 may be helpful in responding to this question).
- What was the primary activity that resulted from the DVC grant?

Results/Evaluation
- Describe the process used to monitor/evaluate the project? (Attachment 3 may be helpful in responding to this question). Please attach evaluation reports, data etc.
- What changes/benefits happened as a result of the project?
- How many (a) participants and (b) volunteers participated in your project? How many were new to your activities?
- Did the project achieve its aims/objectives?
- Were there any unexpected outcomes? What are they?

Sustainability
- Will the project and its benefits continue into the future? Provide comments on critical factors leading to sustainability? (Attachment 4 may be of assistance in responding to this question).
- Can the project be replicated with other groups in other areas within your catchment?
- What were the main challenges in implementing the project? How did you meet these challenges or difficulties?
- Present one 'better practice' idea that would assist others in implementing a similar project (include what evidence you have to support your idea; what are the practical steps required to implement the idea; and what you see as the key success factors in making this idea work).
- What additional support could have been provided (a) by the PCP or (b) by DVC.

Resources
- Please attach details of any reports/materials/media articles produced as a direct consequence of this project.
- Please list any contacts, links or resources that you found helpful in carrying out the project and which could be of use to others.
- Please attach any photographs that may illustrate aspects of your project.

ATTACHMENTS

TIPS & SUGGESTIONS

NOTE: OPTIONAL

The following tips and suggested tools may be of some assistance in evaluating projects and completing the DVC Reporting Template; however, it is not mandatory to use any of the material attached. Some projects will already be well advanced in evaluation and need little or no assistance; others may be at an early stage and may find it helpful to pick and choose from the attached (and adapt or refine) as required.

Attachment 1

SMART Objectives

Some projects have written their objectives in a fairly general way that may make it difficult to evaluate. It will be useful for some to review their stated objectives against the guide below to enure sufficient specificity both to direct project activities and to facilitate a successful evaluation.

S - In the context of developing objectives for projects, *Specific* means that an observable action, behaviour or achievement is described; it must also be linked to a rate, number, percentage or frequency. For example, 'answer the phone quickly' is a precise description of behaviour - it can be clearly seen whether someone answers the phone or not. However, there is no rate, number, percentage or frequency. Instead, 'answer the phone within three rings' indicates a rate and the behaviour is now much more specific.

M - An objective should be *Measurable* – there is a system, method or procedure in place to track and record the behaviour described in the objective. Setting an objective that requires phone calls to be answered in three rings is fine, provided a system exists which measures whether this is actually being achieved.

A - The objective needs to be *Achievable* – it is capable of being reached, there is a likelihood of success. The objective should also be agreed by the parties involved - setting impossible targets does not motivate people, they will apply no energy or enthusiasm to a task that is futile.

R - *Relevant* means that the goal or target being set is something that the project can actually impact upon or change. For example, telling the cleaners that they 'have to increase market share over the next financial quarter' is not actually something they can do anything about - it's not relevant to them. However, asking them to reduce expenditure on cleaning materials by $50 over the next three months is entirely relevant to them.

T - The objective should be *Time based* – it should contain a clearly stated start and/or finish date.

Attachment 2

Partnership Map

Partnerships are an important vehicle for bringing together a diversity of skills and resources for more effective health promotion outcomes. Partnerships can increase the efficiency of the health and community service system by making the best use of complementary resources.

VicHealth's *Partnerships Analysis Tool*[1] provides a number of activities to assess, monitor and maximise partnership effectiveness. One of these – 'A Map of the Partnership' (see over page) may be used in completing the DVC reporting template.

Completing the partnership map requires the links between partners to be described in the following terms[2]:

- **Networking** involves the exchange of information for mutual benefit. This requires little time and trust between partners. For example, youth services within a local government area may meet monthly to provide an update on their work and discuss issues that affect young people.
- **Coordinating** involves exchanging information and altering activities for a common purpose. For example, the youth services may meet and plan a coordinated campaign to lobby the council for more youth-specific services.
- **Cooperating** involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, high level of trust between partners and sharing the turf between agencies. For example, a group of secondary schools may pool some resources with a youth welfare agency to run a 'Diversity Week' as a way of combating violence and discrimination.
- **Collaborating** - *in addition to the activities above*, collaboration includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up part of their turf to another agency to create a better or more seamless service system. For example, a group of schools may fund a youth agency to establish a full-time position to coordinate a Diversity Week, provide professional development for teachers and train student peer mediators in conflict resolution.

If you elect to use this resource in your evaluation, it is recommended that the lead agency complete the map and present the results to a meeting of the partnership (or is some other way, canvass the various partners' views as a way of testing the accuracy of perceptions). Ideally, the map would be completed as a group activity when all partners are together; however, this may not always be practical.

[1] Downlaodable at http://www.vichealth.vic.gov.au/Content.aspx?topicID=98

[2] Adapted from: Himmelman A 2001, 'On coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment', American Journal of Community Psychology, vol. 29, no. 2.

ACTIVITY 2

A Map of the Partnership

Background

The concept of partnerships used in this tool implies a level of mutuality and equality between agencies. There are different types of partnerships in health promotion, ranging on a continuum from networking through to collaboration (see below).

A continuum of partnerships in health promotion

A distinction can be made between the purposes and nature of partnerships. Partnerships in health promotion may usefully be seen to range on a continuum from networking through to collaboration.

- **Networking** involves the exchange of information for mutual benefit. This requires little time and trust between partners. For example, youth services within a local government area may meet monthly to provide an update on their work and discuss issues that affect young people.
- **Coordinating** involves exchanging information and altering activities for a common purpose. For example, the youth services may meet and plan a coordinated campaign to lobby the council for more youth-specific services.
- **Cooperating** involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, high level of trust between partners and sharing the turf between agencies. For example, a group of secondary schools may pool some resources with a youth welfare agency to run a 'Diversity Week' as a way of combating violence and discrimination.
- **Collaborating.** In addition to the other activities described, collaboration includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system. For example, a group of schools may fund a youth agency
  to establish a full-time position to coordinate a Diversity Week, provide professional development for teachers and train student peer mediators in conflict resolution.

Adapted from: Himmelman A 2001, 'on coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment', American Journal of Community Psychology, vol. 29, no. 2.

Not all partnerships will or should move to collaboration. In some cases, networking is the appropriate response. The nature of the partnership will depend on the need, purpose and willingness of participating agencies to engage in the partnership.

As a partnership moves towards collaboration, the more embedded it will need to become in the core work of the agencies involved. This has resource and structural implications. In particular, collaborative partnerships require the support and involvement of senior agency personnel, since project workers may be relatively junior or on short-term contracts. This can affect their capacity to mobilise the agency resources required for collaboration.

Working at partnerships

Working collaboratively is not always easy. Rae Walker, in her review on collaboration and alliances,[1] acknowledges the challenges and tensions created by working collaboratively as well as the importance of deciding when partnership is not an appropriate or effective strategy. Walker also describes the critical factors for successful collaboration including the need for partners to establish a process ensuring that organisations develop a shared vision and objectives. Ongoing monitoring and shared reflection of how the partnership is working is critical to strengthening and sustaining relationships between organisations and achieving effective outcomes.

Available at
www.vichealth.vic.gov.au

[1] Walker R Sep 2000 Collaboration & Alliances: A Review for VicHealth.

ACTIVITY 2

A Map of the Partnership

The mapping exercise

This mapping exercise is designed to place all of the partners in relation to each other. Lines are drawn between them to show the strength and nature of the relationship. Mapping the relationship is a way of clarifying roles and the level of commitment to the partnership. This is important as partners may have different understandings or expectations of what their involvement means. If done collectively, this exercise can help to strengthen a partnership because people are able to raise issues of concern. This provides an opportunity to address areas in which there is a lack of consensus.

It is interesting to note patterns in the relationships and how these change over time. Many partnerships are strong on networking and coordinating but considerably weaker on collaborating. Completing the map provides an opportunity to look at ways in which relationships can be strengthened and made more effective.

Activity 2: Completing the Mapping Exercise

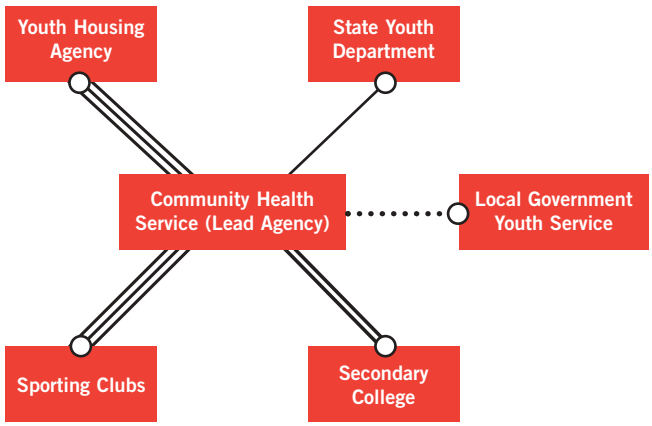
1. Look at the examples below then follow this suggested approach to complete the mapping exercise:
2. List all the agencies involved in the partnership. The lead agency (if there is one) can be placed in the centre.
3. Using the legend below, link the agencies in terms of the nature of the relationship between them. The lead agency is likely to have a relationship with all of the others; however, there may also be important links between partners that do not rely on the lead agency.
4. The strength of the links between partners should be based on evidence of how the partnership actually works rather than how people might like it to work or how it may work in the future. Where possible cite concrete examples as evidence of the strength of the coalition.

Mapping Example

A project to increase participation for young people at risk.

Legend

Nature of relationships between partners	
Networking	.....
Coordinating	———
Cooperating	═══
Collaborating	≡≡≡



Nature of relationships

Community Health Service → is the lead agency, coordinates funds and project steering group.

State Youth Department → provides funds for the project and requires report at completion of funding.

Sporting Clubs → provides sports facilities, equipment and a coach.

Youth Housing Agency → provides office for project workers, coordinates and provides transport for young people to travel from school to the club.
→ provides training for volunteers, sports coaches and generalist workers about youth issues, in particular it promotes this project.

Secondary College → refers young people to project.

Local Government Youth Service → member of steering committee.

Attachment 3

Planning Your Impact Evaluation[3]

Impact evaluation considers what immediate or short term effects can be observed in relation to your project objectives.

Outcome evaluation is often complex, difficult to trace, and likely to take place over a period of time well beyond the conclusion of most Community Walking Grant projects. For these reasons, when assessing the effects of health promotion projects, more immediate changes in populations, individuals or their environments are considered. These changes are known as *impacts* and relate to judgements about whether the objectives of the project have been achieved.

Depending on the objectives of a particular project, impacts may include:

- Better knowledge, attitudes, motivation, intentions or personal skills relating to healthy lifestyles.
- Improved actions and control by social groups over the determinants of health, including community participation, community empowerment, social norms and public opinion.
- Implementation of policy statements, legislation and regulations, resource allocation, supportive organisational practices and settings experiencing enhanced engagement with integrated health promotion programs.

Other impacts (called 'second level' impacts) can emerge at a later stage than those described above. However, depending upon design of your evaluation, it may still be possible to incorporate some of these and where this can occur it would be of significant value. Second level impacts that relate to healthier lifestyles, more effective health services and healthier environments can include:

- Personal behaviours, such as ongoing increased levels of participation in physical activity, which may increase or decrease the risk of ill health.
- Access to appropriate provision and use of health services (acknowledged as an important determinant of health status).
- Healthy environments, which consist of the physical, economic and social conditions that can have a direct impact on health and support healthy lifestyles.

Some projects may find it helpful to use the table below as a tool to plan their evaluation (and also to inform responses to the questions contained in the DVC reporting template):

Objective	Key Questions[A]	Measures[B]	Method[C]	Result
1	1.1 1.2 Etc	1.1.1 1.1.2 1.2.1		
2	2.1 Etc	2.1.1		

[A] What do we need to know to decide if we have achieved this objective? (Some objectives may require more than one question).
[B] What information do we need to answer each question? (A question may require more than one measure).
[C] How will it be collected (eg survey, interview, attendance list etc), by whom, when?

[3] Adapted from *Planning for Effective Health Promotion Evaluation* (May 2005) downloadable from http://www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm#planning

Measures You Might Use

Sometimes the most difficult task in evaluation is choosing the right 'measures' for your objectives. Some measures can be very difficult or time consuming to collect - the effort in collecting the data can outweigh the usefulness of the information!

Given the size and nature of Community Walking Grants projects, measures should be kept as straightforward and efficient as possible. Depending upon your particular objectives, the following is a list of suggested measures[4] that might be considered:

Focus of Objective: Increased Activity Opportunities

- ❑ Number, type, frequency and duration of activity
- ❑ Number of new activities
- ❑ Location (suburb/town) for each activity and the type of venue
- ❑ Whether activity targets a specific group eg (CALD)

Focus of Objective: Increased Participation

- ❑ Uptake of walking leader training (numbers participating)
- ❑ Number of people joining a new walking group
- ❑ Number of volunteers involved in an activity
- ❑ Number of new participants in activity programs
- ❑ Number of participants by age range (eg 50-60, 60-70, 70-80, 80+)
- ❑ Number of participants from CALD and indigenous backgrounds

Focus of Objective: Marketing and Promotion

- ❑ Number of events/forums and number of participants at each
- ❑ Number and type of promotional resources produced
- ❑ Distribution list and locations of resources
- ❑ Number of media articles and advertisements
- ❑ Number and type of promotional resources in other languages

Focus of Objective: Information Provision

- ❑ Number and type of all information resources produced and distributed
- ❑ Awareness of wellbeing benefits arising from physical activity
- ❑ Number of page hits where information has been made available electronically
- ❑ Number and type of information resources produced in other languages
- ❑ Number of enquiries/requests from community members

Focus of Objective: Addressing Barriers to Participation

- ❑ The type/s of barriers addressed (e.g. transport, cost, language etc)
- ❑ Changes to the physical environment achieved (e.g. safe paths etc.)
- ❑ The number of people for particular target groups who received assistance

Focus of Objective: Building Local Capacity

- ❑ Number and type of organisations involved in the project
- ❑ Number of walking leaders trained and qualification type
- ❑ Number of volunteers involved in the program

[4] Adapted from a checklist provided by DVC for the *Healthy and Active Living for Seniors* program

Methods of Data Collection

Depending upon the 'measure' selected, you will need to devise data collection forms and processes.

A number of useful forms are provided in a manual developed by the Western Australian Department of Sport and Recreation[5] to guide the training of walking group leaders. Two in particular are reproduced (and adapted) on the following pages: a walk route planning form and a stats sheet for walking group leaders to record the number and characteristics of walkers in the group. Please feel free to use these if they suit your project.

Another key resource is a short survey that may be used in pre and post testing of walking group participants: the International Physical Activity Questionnaires (IPAQ)[6] comprises a set of questionnaires (long or short versions) for use by either telephone, self-administered or assisted methods. The purpose of the questionnaires is to provide a common instrument that can be used to obtain comparable data on health–related physical activity. Reliability and validity testing suggests that these measures have acceptable properties for use in many settings and in different languages, and are suitable for population-based prevalence studies of participation in physical activity.

Attached over the page is the short version IPAQ (modified in consultation with DVC) that you might use to survey walking group participants. Many Community Walking Grant projects are focussing directly on increasing the level of walking group participation and so a survey of participants is likely to be an important part of any evaluation.

In practice, depending upon the particular objectives of a project, you might choose to supplement the survey (and/or other data collection forms) with some additional questions around, for example:

- Increased understanding or awareness of the benefits of physical activity.
- Increased social connectedness as a result of joining a walking group.
- Feedback on usefulness of information sheets, websites etc.
- How new walking group participants first heard about the walking group.
- Special characteristics of participants (eg CALD).

Please note that these resources are provided as suggestions only and, if you decide to use them, may be used as they are (if they suit your particular objectives) or modified.

[5] http://www.dsr.wa.gov.au/programs/walking/walk_leader/manual.asp
[6] http://www.ipaq.ki.se/dloads/IPAQ_SHORT_LAST_7_SELF_ADM-revised_8-23-02.doc

INTERNATIONAL PHYSICAL ACTIVITY QUESTIONNAIRE

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Where **vigorous** activities are referred to, we mean activities that take hard physical effort and make you breathe much harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time.

1. During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

   _____ **days per week**

   ☐ No vigorous physical activities → ***Skip to question 3***

2. How much time did you spend doing **vigorous** physical activities in the last week?

   _____ **hours per day**

   _____ **minutes per day**

   ☐ Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

   _____ **days per week**

   ☐ No moderate physical activities → ***Skip to question 5***

4. How much time did you spend doing **moderate** physical activities in the last week?

   _____ **hours per day**

   _____ **minutes per day**

   ☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

_____ **days per week**

☐ No walking → ***Skip to question 7***

6. How much time did you spend **walking** in the last week?

_____ **hours per day**

_____ **minutes per day**

☐ Don't know/Not sure

The last question is about the time you spent **sitting** during the **last 7 days**. Include time spent at work, at home, other places and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting** down?

_____ **hours per day**

_____ **minutes per day**

☐ Don't know/Not sure

8. Now, thinking about your answers on vigorous activity, moderate activity and walking, are you doing more or less of each type of activity now than you were one year ago?

Vigorous - - **More / Less / Not sure**

Moderate - - **More / Less / Not sure**

Walking - - **More / Less / Not sure**

You may elect to add or attach questions of you own, for example:

- *Through coming on these walks, has your understanding of the benefits of physical activity increased?*
- *As a result of the joining in walking group, have you developed any new social connections or joined any new networks (away from walking group), accessed new services etc?*
- *How did you first hear about this walking group?*
- *Special characteristics of participants (eg CALD).*

This is the end of the questionnaire, thank you for participating.

Walking Group Stats Sheet

Walk leader: ……

Name of walk/group:.……..……...…….

Date of walk:…….

Start Time: ……...

Finish Time: ……..

Approx Distance: ……

Is this a new walking group (i.e. started just for this project)? Yes ☐ No ☐

	Age							***Gender***		***New***
Participant Names	**< 30**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**>80**	Male	Female	

Comments:
……
……
……
……

Walking Group Leaders: Please return this sheet weekly to the Project Officer

WALK ROUTE PLANNING CHECKLIST

Name of Walk: ……..…….. Day: ……..…

Start & finish point: …….. Start time: ……...….

Walk duration: ……..... Approx length of walk: …….……..….

Date commencing: …… Date finishing: ……....……..…

✓ **Tick when checked**

- ❑ Adequate parking
- ❑ Access to public transport
- ❑ Contacted local council regarding any path maintenance planned
- ❑ Availability of public toilets
- ❑ Shade
- ❑ Points of interest on route (check with Council if unsure eg. History brochure or a recently renovated house for example)
- ❑ Check walk route for dangers eg. Uneven path, tree roots, overhanging bushes/ trees, busy roads, slippery surfaces, obstacles
- ❑ Rest spots for the less fit
- ❑ Pre-walk route, time the walk and pace
- ❑ Grade route (consider hills, distance and speed to walk in less than 1 hour)
- ❑ Are there public telephones on route or do you have a mobile phone in case of an emergency?
- ❑ Can the route accommodate shorter alternatives for the less fit. Can they turn around at a shorter point? Are there any short cuts? Include these on your mud map
- ❑ Organise time and table numbers with café for social coffee option
- ❑ Draw mud map, identify any key landmarks, toilets, rest spots, water fountains etc meeting point, day, time start and finish dates
- ❑ Liaise with Co-ordinator to confirm and approve walk route
- ❑ Photocopy mud map for participants
- ❑ Inform current participants of upcoming route change, date and meeting point

Attachment 4

Sustainability Checklists[7]

CHECKLIST 1: ASSESSING THE STRENGTH OF A COALITION

This checklist is about the processes of coalition, which refers to the group formed when agencies join forces and work together on a common problem or issue. If you elect to use this as apart of your evaluation, the lead agency should complete this checklist and also ask its partner agencies to do the same, consolidating responses (noting any exceptions) and returning a copy with the DVC Reporting Template.

To complete the survey, answer the statements listed by giving a score for each:

2 = yes, fully
1 = yes, in part
0 = no
DK/NA = don't know, not applicable (Circle one only for each statement)

Remember that these are general statements - give the response that best fits overall. These items are based on research on making coalitions work well and relate to process issues, not your achievements or purpose.

1. There is enough variety among members of the group to gain an appropriate view of the problem or issue the group is tackling.

2 1 0 DK/NA

2. There is enough variety among members of the group to access a variety of resources e.g. people, places to meet, administrative support etc.

2 1 0 DK/NA

3. Members feel that the benefit of being involved in the collaboration outweighs any associated costs, e.g. time involved, travel.

2 1 0 DK/NA

4. Members work together, but at the same time, the circumstances under which a member could act autonomously is clear.

2 1 0 DK/NA

5. Members have confidence in the organisation that takes the lead in convening meetings.

2 1 0 DK/NA

6. Members have enough experience and skill in meeting procedures and processes for things to run smoothly.

2 1 0 DK/NA

7. All the potential groups or organisations that may have a stake in the problem have been identified (even those who are not coalition members)

2 1 0 DK/NA

8. Members of the coalition have acknowledged the issue that joins them together

2 1 0 DK/NA

[7] Adapted from Hawe P, King L, Noort M, Jordens C, Lloyd B (1999) Indicators to Help with Capacity Building in Health Promotion. NSW Health. Checklists at a glance H:\HPU\SHARE\HPSS\CAPACITY\Grants\Grant case studies\casestu_for_web\Checklists at a glance.doc

9. A common purpose and mission has been identified

2 1 0 DK/NA

10. Most members have a good feel for the values that motivate each to be involved (what they represent, why they are there, why they think it is important)

2 1 0 DK/NA

11. Success indicators or performance targets have been set i.e., members know what is to be achieved by when

2 1 0 DK/NA

A mutually acceptable way of managing the following processes has been identified:

12. Decision making 2 1 0 DK/NA
13. Communicating with group members 2 1 0 DK/NA
14. Gathering information to help with group tasks 2 1 0 DK/NA
15. Working on specific tasks e.g. working groups, task allocation 2 1 0 DK/NA
16. Reviewing progress and structures 2 1 0 DK/NA
17. Reviewing member satisfaction 2 1 0 DK/NA
18. Resolving internal conflict or disagreement 2 1 0 DK/NA
19. Resolving conflict with external agencies 2 1 0 DK/NA
20. Managing the media or public relations profile 2 1 0 DK/NA
21. Monitoring how resources are used 2 1 0 DK/NA
22. Documenting process and outcomes of activity 2 1 0 DK/NA
23. Setting and reviewing timeframes for coalition activities 2 1 0 DK/NA

24. There is a general feeling of confidence in the group's capacity to achieve its goals

2 1 0 DK/NA

TOTAL SCORE …… (maximum possible is 48) % ……

CHECKLIST 4: ASSESSING IF A PROGRAM IS LIKELY TO BE SUSTAINED

When completing this checklist the project should be finished. The following factors are known to predict uptake and continuation of a program. Give your answers for each item according to the following rating scale:

2 = yes, fully
1 = yes, in part
0 = no
DK/NA = don't know, not applicable (Circle one only for each statement)

Note that the term 'host organisation' refers to the organisation that you see as the one most appropriate to house or support the program.

The first set of items is about program design and implementation

1 People with a stake in the program (funders, administrators, beneficiaries, other agencies) have been aware of the program and/or involved in its development
2 1 0 DK/NA

2 The program has shown itself to be effective. Effects are visible and acknowledged
2 1 0 DK/NA

3. Organisations that may host the program in the future have been making some real or in kind support to the program in the past
2 1 0 DK/NA

4. Prospects for the program to acquire or generate some additional funds or resources for the future are good
2 1 0 DK/NA

5. The program has involved formal and/or informal training of people whose skills and interests are retained in the program or its immediate environment
2 1 0 DK/NA

The next set of items is about factors within the organisational setting which are known to relate to the survival of a program

6. Organisations that may host the program in future are mature (developed, stable, resourceful) and likely to provide a strong organisational base
2 1 0 DK/NA

7. The purpose of the program is compatible with the mission and activities of the likely host organisations
2 1 0 DK/NA

8. Part of the program's essential 'business' is integrated into other aspects of the host organisation e.g. in policies, practices, responsibilities etc. That is, the program does not simply exist as an entirely separate entity
2 1 0 DK/NA

9. There is someone in authority or seniority, other than the project officer, who is an advocate for the program at high levels in the organisation
2 1 0 DK/NA

10. The program is well supported in the organization (it is it is not under threat and there are few 'rivals' that could benefit from its closure)

2 1 0 DK/NA

11. Possible host organizations haves a history of innovation or developing new responses to situations in their environment

2 1 0 DK/NA

The next set of items is about factors in the broader community environment which affect how long programs last

12. There is a favourable external environment for the program, that is, the values and mission fit well with community opinion, and the policy environment

2 1 0 DK/NA

13. People in the community, or other agencies and organisations, will advocate for and maintain a demand for the existence of the program should it be threatened

2 1 0 DK/NA

14. There are ways to register or record ongoing demand for the program and these show that community members remain willing and wanting to participate

2 1 0 DK/NA

15. Organisations that are similar to the intended host organisation have taken the step of supporting programs somewhat like your program

2 1 0 DK/NA

TOTAL SCORE: ……..(maximum possible is 30) % ……

ATTACHMENT 3 - CONSULTATIONS

Initial Consultations – Project Development

Erin Bonavia - Djerriwarrh Health Services
Vicki Bradley - South Gippsland Division of General Practice
Alex Butler - Moreland City Council
Jackie Carmody - Portland District Health Service
Deborah Cocks - Maroondah City Council
Meredith Davey - Central West Gippsland Primary Care Partnership
Nicole Dunn - Echuca & District YMCA
Paul Elshaug - The Centre for Continuing Education Inc
Jill Evans - Leisure Networks
Heather Farley – Latrobe City Council
Meredith Herold - Kingston Bayside Primary Care Partnership
Michael Hillier – Brotherhood of St Laurence
Shane Hughan - Valley Sport
Linda Kelly - Southern Mallee Primary Care Partnership
Lee Kennedy - WestBay Alliance
Bernadine Kenyon - Mitchell Community Health Service
Jan Lewis - North Central Metro Primary Care Partnership
Carmel Mackay - Mallee Sports Assembly
Dawn Martin - Gippsland Regional Sports Assembly
Wendy Mason - South East Primary Care Partnership
Rob McGlashan - Sunraysia Community Health Service
Jake McMinn - GippSport
Shelley Mulqueen - Loddon Campaspe Sports Assembly
Kate Nicolazzo - ISIS Primary Care
Sue O'Brien - Central Highlands Sports Assembly
Mark Patterson - City of Greater Dandenong
Kathryn Peters - South West Healthcare
Jonathan Pietsch - Inner East Primary Care Partnership
Mary Quinn - Christ Church Community Centre, St Kilda
Elizabeth Rider - Mount Alexander Shire Council
Allison Ridge - Bayside City Council
Janine Scott - Nillumbik Community Health Service
Kate Serrurier - Grampians Pyrenees Primary Care Partnership
Beth Sheffield – Central West Gippsland Primary Care Partnership
Pia Sim - Christ Church Community Centre, St Kilda
Leanne Skipsey - Whitehorse City Council
Neil Stott - Goulburn Valley Primary Care Partnership
Di Trotter - Wimmera Regional Sports Assembly
Bruce Watson – Brimbank Melton Primary Care Partnership
Yvonne Westcott - Bayside City Council
Shannon Wilkie – Gippsland Women's Health Service
Brooke Williams - Leisure Networks
Chrissie Williams - Doutta Galla Community Health Service

Workshop Attendees

Vicki Bradley - South Gippsland Division of General Practice
Morgan Kate Cameron - GippSport
Heather Farley – Latrobe City Council
Nikki Hale - Peninsula Health
Janet Kelly - City of Greater Dandenong
Dawn Martin - Gippsport
Sue O'Brien - Central Highlands Sports Assembly
Elizabeth Rider - Mount Alexander Shire Council
Kate Serrurier - Grampians Pyrenees Primary Care Partnership
Katrina Toomey - Grampians Pyrenees Primary Care Partnership
Brooke Williams - Leisure Networks
Chrissie Williams - Doutta Galla Community Health Service

Other Interviews/Submissions

Jo Cockwill - Wellington Primary Care Partnership
Michelle Harris - Mitchell Shire Council
Meredith Herold - Kingston Bayside Primary Care Partnership
Valerie Kay - Inner South East Partnership in Community and Health
Carmel Mackay - Mallee Sports Assembly
Wendy Mason - South East Primary Care Partnership
Leanne Skipsey - Whitehorse City Council
Tony Vivian - Lower Hume Primary Care Partnership
Tony Widdison - The Centre for Continuing Education Inc

Other Stakeholder Interviews

Kristina Basile - Nutrition & Physical Activity, Department of Human Services
Lisa Cameron - Sport & Recreation Victoria, Department for Victorian Communities
Arden Joseph - Sport & Recreation Victoria, Department for Victorian Communities
Katherine Koesasi –Sport & Recreation Victoria, Department for Victorian Communities
Brent Phillips – Sport & Recreation Victoria, Department for Victorian Communities
Emily Raven - Sport & Recreation Victoria, Department for Victorian Communities
Sally Rose - Department of Human Services
Genia Sawczyn - Office of Senior Victorians, Department for Victorian Communities

ATTACHMENT 4 – PROJECT ACTIVITIES

Phase 1 Funded Projects

PCP	TARGET GROUP	TARGET AREA
Barwon Primary Care Forum	Secondary school students	Barwon Region (3218 – 3280)
Bendigo Loddon Primary Care Partnership	General community	Inglewood 3517, Boort 3537, Strathfieldsaye 3551
Campaspe Primary Care Partnership	General community	Lockington 3563, Rochester 3561, Nanneella 3561, Kyabram 3620, Stanhope 3623, Rushworth 3612, Tongala 3621
Central Highlands Primary Care Partnership	General community	City of Ballarat and Hepburn, Moorabool and Golden Plains Shires (3330 - 3357, 3460 – 3461)
Central West Gippsland Primary Care Partnership	General community; special needs groups (vision impaired and culturally isolated) in Moe	Yallourn North 3825, Yinnar 3869, Boolarra 3870**,** Moe 3825
Central Victorian Health Alliance	General community and primary school children	Woodend 3442, Kyneton 3444, Malmsbury 3446, Gisborne 3437, Castlemaine 3450, Chewton 3451, Elphinstone 3448, Maldon 3463, Newstead 4362, Maryborough 3465
East Gippsland Primary Care Partnership	Older adults, families, youth, indigenous, remote communities	Bairnsdale 3875, Lakes Entrance 3909, Orbost 3888, Buchan 3885, Lake Tyers 3909
Hume-Moreland Primary Care Partnership	Older adults, visually impaired adults, CALD, particularly women's groups, people with mental illness	Sunbury 3429, Moreland 3058, Broadmeadows 3047
Inner South East Partnership in Community & Health	People over 55 years of age recently bereaved	City of Port Phillip (3182 – 3185)
Kingston - Bayside Primary Care Partnership	General community	Cities of Kingston and Bayside (3186 – 3197)
Northern Mallee Primary Care Partnership	Individuals not currently physically active on a regular basis	Mildura 3500, Robinvale 3496, Ouyen 3498, Irymple 3490, Red Cliffs 3505, Merbein 3505, Werrimull 3496, Nangiloc 3549
South Coast Health Services Consortium	Potential walking leaders	Grantville 3984, Korumburra 3950, Mirboo North 3871, Loch 3945, Leongatha 3953, Wonthaggi 3995, Yarram 3971
South West Primary Care Partnership	Initially school students and then general community	Timboon 3268, Port Fairy 3284, Warrnambool 3280, Terang 3264
Southern Grampians & Glenelg Primary Care Partnership	Individuals not currently physically active on a regular basis and older adults, walkers with disabilities	Portland 3305, Heywood 3304, Narrawong 3285, Dartmoor 3304, Casterton3311, Nelson 3292
Southern Mallee Primary Care Partnership	Inactive older members of the community, disability and disadvantaged groups	Swan Hill 3585, Kerang 3579, Wycheproof 3527
West Bay Alliance	Neighbourhood Renewal areas and people linked to other services	Werribee 3030, Altona 3015, Footscray 3011, Footscray West 3012, Braybrook 3019

PCP	TARGET GROUP	TARGET AREA
Barwon Primary Care Forum	Secondary school students	Barwon Region (3218 – 3280)
Bendigo Loddon Primary Care Partnership	General community	Inglewood 3517, Boort 3537, Strathfieldsaye 3551
Wimmera Primary Care Partnership	People over 55 years of age	Horsham 3400, Nhill 3418, Dimboola 3414, Hopetoun 3396, Jeparit 3423, Warracknabeal 3393 Murtoa 3390

Phase 2 Funded Projects

PCP	TARGET GROUP	TARGET AREA
Banyule Nillumbik Primary Care Alliance	Men and women over 50; some CALD	Heidelberg West 3081, Yallambie 3085, Greensborough 3088, Eltham 3095,
Brimbank Melton Primary Care Partnership	People with a disability; people with a mental illnes; young mothers	Melton 3337, St. Albans 3021
Central Hume Primary Care Partnership	Older adults and families in disadvantaged neighbourhoods	Benalla 3672, Mansfield 3722, Wangaratta 3677-3678
Frankston-Mornington Peninsula Primary Care Partnership	Older people (frail/managing chronic illness/disease/ social isolation) and carers	Rosebud 3941, Rye 3939
Goulburn Valley Primary Care Partnership	Older adults; CALD women; youth; general community	Yarrawonga 3730, Numurkah 3636, Avenel 3664, Cobram 3644, Shepparton 3630, Euroa 3666, Nagambie 3608
Grampians Pyrenees Primary Care Partnership	General community	Ararat 3377, Stawell 3380, Halls Gap 3381, Avoca 3467, Beaufort 3373, St Arnaud 3478
Inner East Primary Care Partnership	Older people	Ashburton 3147, Balwyn 3103, Hawthorn 3122
Lower Hume Primary Care Partnership	Young mums and families, factory workers, carers, wider community	Kilmore 3764, Seymour 3660, Broadford 3658, Wallan 3765
Moonee Valley/ Melbourne Primary Care Partnership	Arabic and Somali speaking young women from Horn of Africa communities	Kensington 3031, Flemington 3031
North Central Metro Primary Care Partnership	Aboriginal and Torres Strait Islander peoples	Collingwood 3066, Preston 3072, Reservoir 3073
Outer East Primary Care Partnership	Women, families/children, older adults	City of Maroondah (3132 – 3140, 3152 – 3180) Shire of Yarra Ranges (3767 – 3799)
South East Primary Care Partnership	General community	Greater Dandenong (3170 – 3175), City of Casey (3802 – 3980), Cardinia Shire (3781 - 3783, 3807 - 3815, 3978 – 3984)
Upper Hume Primary Care Partnership	Older people	Wodonga 3690, Indigo and Towong (3683 - 3747)
Wellington Primary Care Partnership	Women and older adults	Dargo 3862, Heyfield 3858, Briagolong 3860, Maffra 3860, Sale 3850, Wurruk 3850, Loch Sport 3851, Yarram 3971, Gormandale 3873, Rosedale 3847