# New Zealand Intersectoral Initiatives for Improving the Health of Local Communities, 2005

An updated literature review examining the ingredients for success

MINISTRY OF
HEALTH
MANATŪ HAUORA

# Acknowledgements

# Disclaimer

# Contents

# Acronyms Used

| | |
|---|---|
| ACC | Accident Compensation Corporation |
| AIMHI | Achievement in Multicultural High Schools Initiative |
| ALAC | Alcohol Advisory Council |
| ARCAP | Auckland Regional Community Action Project |
| CAP | Community Alcohol Project |
| CAYAD | Community Action on Youth and Drugs |
| CRESA | Centre for Research, Evaluation and Social Assessment |
| CYF | Child, Youth and Family |
| DHB | District Health Board |
| FPTAC | Federal, Provincial and Territorial Advisory Committee on Population Health (Canada) |
| FSE | Full Service Education |
| GP | General Practitioner |
| HAZ | Health Action Zone |
| HNZC | Housing New Zealand Corporation |
| ICAH | Intersectoral Community Action for Health |
| LTSA | Land Transport Safety Authority |
| MAPO | Māori Co-Purchasing Organisation |
| NZ | New Zealand |
| NZLCT | New Zealand Landcare Trust |
| PHLT | Porirua Healthlinks Trust |
| PHO | Primary Health Organisation |
| RAP | Ranui Action Project |
| REAP | Rural Education Activities Programme |
| SCAF | Stronger Communities Action Fund |
| SCC | Safer Community Council |
| SHORE | Centre for Social and Health Outcomes Research and Evaluation |
| TAIERI | Taieri Alliance for Information Exchange and River Improvement |
| UK | United Kingdom |
| USA | United States of America |
| WHO | World Health Organization |
| YDC | Youth Drug Court |

# Summary

Intersectoral health action aims to achieve health outcomes 'in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone' (Harris et al 1995: 7). This recognises that the determinants of the health of populations and communities are diverse, complex and multifactorial and therefore frequently beyond the capacity of the health sector to influence on its own.

Central to the notion of intersectoral health action is the idea of setting up new processes for facilitating face-to-face dialogue between representatives of organisations and groups in the community who have the potential to influence health outcomes in various ways.

This report reviews the results of studies examining the success and effectiveness of intersectoral initiatives for improving the health of local communities, with a particular focus on New Zealand evaluation studies completed between 1980 and 2005.

Key characteristics of the initiatives covered in the report are:

- they are funded, governed and/or implemented across sectors under some kind of formal arrangement
- their aim is improving health status and reducing health inequalities
- they target people living in sub-national geographic areas (e.g. local region, city, small town or rural area).

## Factors influencing the success of community-based intersectoral action for health

The literature indicates a range of factors can influence the degree to which community-based intersectoral initiatives for health are considered effective or 'successful'. These factors can be summarised and grouped under six headings, corresponding to the six overarching requirements for effective intersectoral action identified in the document *Working Together: Intersectoral Action for Health* (Harris et al 1995). The categories are:

(1)    clear agreement exists on the necessity for intersectoral action

(2)    support exists in the wider community for action

(3)    capacity exists to carry through the planned action

(4)    relationships enabling action are defined and developed

(5)    agreed actions are planned and implemented

(6)    outcomes are monitored and evaluated.

## Clear agreement exists on the necessity for intersectoral action

A critical starting point is getting agreement from representatives of organisations and groups in a local community who together have the potential to influence health outcomes, that working together is necessary and desirable.

This includes getting agreement that the risks involved in working together are worth taking, that working together is likely to be more effective and sustainable than working alone, and that working together has the scope to directly benefit each participating organisation or group by helping it achieve its core goals.

Without this kind of agreement, there is unlikely to be firm ground upon which to build and develop the intersectoral initiative.  Nor is there likely to be much motivation or enthusiasm to work through the often difficult and time-consuming early stages of relationship building and planning that are frequently a feature of the initial stages of intersectoral working.

Many people and organisations are still unfamiliar with the broad philosophy and assumptions underlying intersectoral working.  In practical terms, this means there is scope for a degree of misunderstanding and/or talking at cross-purposes – 'talking past one another' – when people communicate about aspects of intersectoral working.  Recognising and attempting to resolve these conceptual differences and ambiguities is likely to be an important early step for any group setting out to undertake some form of intersectoral working together.

It is likely that some degree of initial 'consciousness-raising' or facilitated 'group work' will be useful to 'switch on' some organisations or people to the potential value of joining an intersectoral project.  This can help identify and stimulate common underlying values and interests, and align purposes.

Ideally the people who undertake the initial development work for intersectoral action should have a good knowledge of and access to the local community's resources, formal and informal communication networks, and opinion leaders and other natural allies within the community.

If effective structures for intersectoral action are already in place in a community, then piggy-backing a new initiative onto these structures can help the initiative advance more quickly.

When identifying potential participants in intersectoral action, the potential benefits of a highly inclusive approach must be balanced against the risk that working with a very large number of diverse people and organisations may make reaching consensus more difficult, and perhaps introduce more scope for misunderstandings and conflict.  Ideally the people and organisations recruited to an intersectoral project should have a degree of compatibility in attitude and outlook. A prior record of working together constructively is also a big advantage.

Intersectoral initiatives operate with essentially a consensus-based model of working.  The focus is on respecting different points of view, compromise, sharing, collaboration and teamwork. This approach may not suit people, groups or organisations that believe that the only way to secure their core objectives is through the application of competitive, conflictual or adversarial models of working.

**Support exists in the wider community for action**

Intersectoral initiatives for health always operate within a wider social, economic, political and environmental context. Ideally, this context should be conducive to the development and maintenance of locally-based intersectoral action, rather than presenting significant obstacles.

Contextual factors that can be especially influential in facilitating intersectoral action include: the presence of high-level political, central government and local government support; appropriate national- or local-level policy and legislative frameworks; appropriate organisational structures; supportive economic circumstances; and supportive beliefs and attitudes among members of the target community.

Locally-focused intersectoral action for health appears more likely to be initiated and sustained if it is high on the national political agenda and clearly mandated at different levels of central, regional and local government in policies, reports and legislation.

However, while the presence of high-level political and government support can confer several advantages, it can also be perceived by other participants in an intersectoral initiative as limiting their freedom to act. Problems can occur, for instance, if central government starts trying to set priorities and agendas for community-based action, such as stipulating that certain health priorities are addressed.

Overall, the evidence suggests that a combination of 'top-down' political and central government support and local-level 'bottom-up' planning and management is the most appropriate recipe for successful community-based intersectoral action.

Another important element shaping the conditions for successful intersectoral action is the organisational context – the ways in which national-, regional- and local-level organisations operate and the pressures they experience. Proactive organisations that are not under extreme pressure, that have a high organisational morale and that have a history of innovation and successful co-operative action are more likely to be supportive partners in intersectoral action.

**Capacity exists to carry through the planned action**

The capacity of intersectoral groups, including the capacity of their host and home organisations, and the capacity of the local community to participate also influence the success of intersectoral initiatives for health.

**Capacity of intersectoral groups**

A consistent message in the literature is that successful intersectoral action is heavily dependent on the capacity of the participants and their host or home organisations to devote meaningful resources to the process. This includes resources to sustain the basic infrastructure for intersectoral working (e.g. meeting spaces, administrative support, employment of co-ordinating staff or project managers); and sufficient capacity in people's host or home organisations and in local community groups or other organisations (e.g. voluntary agencies, businesses, Māori organisations) to contribute effectively to various kinds of intersectoral action or projects.

*Leadership and co-ordination*

The personal attributes of the people working at the front-line of community-based initiatives are widely recognised to be an important 'success factor'. A special kind of leadership and management is required. Ideally these people should have high-level verbal and written communication skills; a capacity to work well as team players in small and large group settings; an ability to build consensus; an ability to listen and value the contributions of others; good negotiation and conflict resolution skills; and good management skills.

In an intersectoral initiative, a variety of people can provide leadership or be part of a leadership team, depending on the stage of development of an intersectoral initiative, or other circumstances.

Many intersectoral initiatives appoint a co-ordinator who assumes responsibility for much of the day-to-day management and administration of the initiative.

Training opportunities, or management practices that encourage and reward expertise in working intersectorally, can be useful for fostering the various leadership and co-ordination skills described above.

*Funding issues*

In general the literature indicates that intersectoral working and effective collaboration are more challenging and complex than working alone, and the level of funding provided by participating organisations should recognise this fact.

New Zealand is still in a period of innovation and experimentation with partnership projects, with a lot of local partnerships set up as one-off initiatives running on short-term or seed funding. The lack of long-term funding security can increase the pressure on project participants to concentrate on achieving shorter-term or perhaps more limited goals. It can also undermine the confidence of workers and other collaborating agencies. Staff can end up spending most of their time fundraising, rather than getting on with their core tasks.

*Timeframes*

Closely linked to funding themes is the issue of the length of time required to develop and implement effective intersectoral action. The literature indicates that effective intersectoral relationships and joint action usually take considerable time to develop. They cannot be expected to happen quickly, especially if the participants have not worked together before, or if there is a large number of disparate organisations and groups involved.

This need for sufficient time to be given for intersectoral initiatives to evolve and mature has inevitable implications for organisational capacity and resourcing. It is repeatedly stated in the literature that successful and effective intersectoral working relies on the commitment of stable resources over an extended period of time, typically several years, not just a few months.

*Capacity of host and home organisations*

Initially, engaging in intersectoral action for health may not be regarded as part of an organisation's core business, especially perhaps by middle- and senior-level managers in an

organisation.  They may perceive intersectoral working as risky, involving potentially a loss of a degree of freedom to act independently or a risky investment of scarce resources.  Therefore, the more levels of management in an organisation that are positively involved in and supportive of an intersectoral initiative, the more likely it is that the initiative will succeed.  If there is disagreement or conflict within an organisation about the value of the intersectoral action (for example, if people lower down the hierarchy get little or no support for their work from their senior managers), then success is less likely.

A further necessary element of organisational support is that each of the participating organisations has clear and easily understood decision-making processes.  If these processes are too complex or opaque, or are in a state of flux (say because of internal restructuring), this can make it difficult to identify who has influence or responsibility in an organisation to support intersectoral work.

Intersectoral working at the local level appears to be enhanced when there is a degree of devolution of power from the centre to the periphery, when the people in intersectoral partnerships are as free as possible to act (and make decisions) as individuals and are not tied too closely to the agenda of their own organisation, nor overly constrained by rigid, impractical timeframes.

## Capacity of the community to participate

The literature indicates that the capacity of community and volunteer groups, as well as of 'grassroots' members of the community, to participate in the planning and implementation of intersectoral health action can be highly variable.  While securing the participation of these kinds of groups in the development of intersectoral action is a desirable and in many cases vital goal, achieving it in practice can be difficult.

In general, New Zealand initiatives that have aimed to engage existing local organisations as partners (or funders), including the voluntary sector, local businesses, Mäori organisations, and established interest groups, have worked well.  This has been particularly so in localities with a history of, and infrastructure for, 'community' involvement.

On the other hand, initiatives that have tried to involve more loosely defined groups of 'flaxroots' community members or individuals, particularly in strategic planning processes, have often failed to attract sufficient participation.  The main reasons for this appear to be a lack of available time, resources and motivation of community members or citizens, especially if they are socially or economically disadvantaged and experiencing adversity in their lives.  Other impediments can be perceptions in the community that government-funded or led initiatives serve mainly bureaucratic or political ends, rather than being genuinely committed to improving the community's health and social problems in any significant way.

Suggested ways to encourage greater community participation in intersectoral action include building on existing mechanisms, maximising use of local authority and voluntary sector resources, identifying 'champions' within communities, and establishing new mechanisms to engender public-orientated perspectives.  It has also been argued that community representatives should be properly supported, resourced and remunerated so they can play a full role in local partnerships.

## Relationships enabling action are defined and developed

The fourth set of ingredients for running successful intersectoral initiatives for improving the health of local communities concerns the ways in which relationships between members of the intersectoral governance group are defined, planned, maintained and repaired if necessary.

Once an intersectoral initiative gets up and running and participants start meeting on a regular basis, an important task is to clarify and define what will be the nature of the ongoing relationships between the participants, including the organisations or groups that they represent. In practical terms, this means working out things such as what kinds of structures and processes the participants will use to interact with one another in 'joined up' ways (timing of meetings, meeting facilitation, meeting rules, how agreement will be reached, conflict resolution, etc) and what skills and resources each participant can be expected to contribute to the initiative.

There is scope for relationships between participants to be defined in terms of their degree of formality, intensity, duration of involvement and autonomy, with options ranging across a spectrum that includes information sharing, co-ordination, collaboration and formal partnerships.

Roles of individual partners should be clear. There should also be systems in place to enable reviews and revisions of relationships, especially if the goals of the intersectoral action change.

This kind of planning work is likely to be especially important if the participants in an intersectoral group come from organisations that work to different planning, budgeting and accountability requirements, or do not serve clients in the same or similar geographic boundaries.

As well, the more a group of people or organisations intends to share power to make decisions or allocate resources, the more clearly defined and formalised the nature of the relationships between the different people or organisations should be. In New Zealand, various kinds of written agreements have been used to clarify and consolidate the relationships and workings of intersectoral initiatives. These include memoranda of understanding, terms of reference, project protocols, charters, statements of intent and community action plans.

Initiatives should aim to keep their co-ordinating structures and decision-making processes as simple as possible.

An important issue is the accountability systems that should be used for intersectoral action. In general, the literature indicates that shared accountability frameworks are the most appropriate in these circumstances, with accountability for achieving common objectives – as well as the recognition and rewards for success – being shared.

The organisational structures of some intersectoral initiatives include an advisory or steering committee. This committee is usually made up of people from a variety of organisations and tends to take responsibility for decisions about the overall governance and direction of the work of the intersectoral initiative. Usually the initiative's co-ordinator or other staff and volunteers take responsibility for the day-to-day running of the initiative.

Retaining the interest of all partners in an initiative may become more challenging as time goes on. Maintaining the participation of central and local government staff with adequate seniority and authority has also been difficult.

Conflict between partners and with others in the community is probably an inevitable and even necessary part of partnerships based on devolved funding and decision-making. Mediation processes can be useful for helping to deal with these tensions, although some conflicts may take time to resolve and therefore impact significantly on project operation.

The presence of mutual trust and respect between partners in an intersectoral initiative is widely acknowledged to be one of the most important ingredients for successful intersectoral working. Trust and respect need to be consolidated as initiatives progress. Ideally, consensus-orientated decision-making processes should be used.

## Agreed actions are planned and implemented

Once structures and processes are set up enabling participants in a community-based intersectoral health initiative to communicate and interact effectively with one another on a regular basis, the next step is for the participants to develop a joint plan of action, and then implement it.

This process is likely to include preparing a formal action plan or clear statement of agreed actions. This would indicate why all the participating people and organisations regard it as important to work together, how they understand the nature of the health issues they are addressing, and what various actions they intend to take together in an effort to help solve these issues. A plan can also indicate the level and kinds of resources each of the participating organisations will commit to support the various actions.

The literature emphasises that it is important for initiatives to keep a strong action orientation and focus on concrete action and specific, visible and achievable deliverables. In addition, it is important that participants are clear about the logical connections between the actions they have chosen and the outcomes they are wishing to address ('programme logic' or 'intervention logic').

Needs assessments of the health status and health needs of the local population are sometimes carried out to help intersectoral groups prioritise issues and decide on which actions to carry out first.

'Patching' of action plans may be necessary in response to changing circumstances. There should also be clearly defined times when organisations can renegotiate the actions they have agreed to and the terms of their involvement in an initiative.

Planning for keeping initiatives going (or completing them) when funding runs out is also important.

## Outcomes are monitored and evaluated

Monitoring and evaluating how well a community-based intersectoral initiative is working, and its impact, are other key ingredients for successful intersectoral action.

Monitoring and reporting processes, which may be a condition of funding, can be onerous for initiative staff. Therefore these requirements should be kept to a minimum, be able to be negotiated, and be useful to the initiative itself as well as to the funders.

Setting up suitable evaluation systems to chart an initiative's activities and their impact can yield important information for thinking about how the initiative could be improved or developed in future.

Although certain authors may argue for the superiority of one kind of evaluation approach over another, the reality is that there is no single best method for evaluating intersectoral working. Rather, there is potential to select one or more of several different approaches. Decisions about which kinds of evaluation strategy to use are likely to be shaped by a variety of factors including what the participants in the initiative regard as the central purposes of the evaluation, its main audience, and the quantity and quality of evaluation resources available (e.g. personnel, time, funding). Decisions may also be shaped by discussions between initiative partners about what is meant by 'effectiveness' in the context of intersectoral action.

Whatever kind of evaluation strategy is used, its research methods and the quantity and quality of evidence it seeks to provide should be *acceptable* to all the people and organisations participating in the initiative. It is also important that the evaluation does not overpower the actual initiative or become the dominant driver of the intersectoral process.

Most New Zealand evaluations of community-based intersectoral health initiatives have been so-called *formative* or *process* evaluations. This kind of evaluation chiefly focuses on the processes involved in setting up and running an initiative. These processes include examining issues such as the extent to which the partners in an initiative have developed appropriate working relationships with one another and the factors important in shaping the emergence of these new relationships.

Formative and process evaluations are mainly based on evidence collected from face-to-face discussions or surveys, reviews of project documents, or direct observations in the field or at meetings.

Other evaluation strategies aim to identify *intermediate* outcomes attributable to the work of an intersectoral initiative. Examples of intermediate outcomes include: changes in people's health-related knowledge, attitudes and behaviour; changes in organisational policies, structures and processes related to the delivery of health services; and changes in the built environment that affect people's health.

In most cases, evaluations aim to establish with a reasonable degree of confidence that these intermediate outcomes are visibly and directly connected to the work of the intersectoral partners and probably would not have occurred without it.

In some cases there may be scope for an evaluation to investigate if an intersectoral initiative has contributed to health status improvements, such as reductions in the incidence of certain health conditions, or reductions in hospitalisation or in use of other treatment services for certain conditions. This approach may be most feasible in communities where relevant and robust statistical information is collectable, available and easily accessible.

Evaluations of intersectoral initiatives focusing on *final* health outcomes are reasonably common in the United States of America, but much less so in New Zealand. There are several reasons for this, but perhaps the most significant is that substantial resource costs are usually required to undertake this kind of detailed, in-depth study. Others are the length of time an initiative and its associated evaluation may need to run before this kind of health outcome can be expected to be detected, and the difficulties in attributing any changes to the initiative itself rather than to external factors. Controlled studies can be used to reduce this latter difficulty.

Some recent New Zealand evaluations have managed to include valuable data on broader health outcomes attributable to intersectoral working.

## Features of specific initiatives

Of the 34 specific initiatives summarised in this report, three main types were identified:

- overarching area- or settings-based initiatives
- issues-based initiatives
- case-management services and one-stop shops.

Examples and features of these three types of initiatives are shown in Table S1.

**Table S1:** Examples and characteristics of the three types of intersectoral initiatives for improving community health

| | Overarching area- or settings-based initiatives | Issues-based initiatives | Case-management services and one-stop shops |
|---|---|---|---|
| Initiatives included in this report (and described in Appendix 1) | • Health Action Zones (HAZ)<br>• Healthy Cities<br>• Intersectoral Community Action for Health (ICAH)<br>• Take Ngakau Kaikohe Intersectoral Project<br>• Glen Innes Health Project<br>• Ranui Action Project (RAP)<br>• Stronger Communities Action Fund (SCAF)<br>• Community renewal projects<br>• Health Promoting Schools / Healthy Schools<br>• Finlayson Park School Health Action Zone<br>• Full Service Education in AIMHI schools | • Community alcohol action programmes<br>• Community Action on Youth and Drugs (CAYAD)<br>• Moerewa Community Project<br>• Safer Community Councils<br>• Safe Communities/ Community Injury Prevention Projects<br>• ACC ThinkSafe Community Projects<br>• Great Start Waitakere: Te Korowai Manaaki<br>• Peaceful Waves/ Matangi Malie<br>• Community nutrition programmes<br>• Pasifika Healthcare Gardening Project<br>• Housing and health initiatives<br>• TAIERI project | • Intensive home visiting<br>• Strengthening Families Collaborative Case Management<br>• Early Start/Family Start<br>• Social Workers in Schools<br>• Wraparound services<br>• Waitomo Papakainga Tracker Programme<br>• Rough Cut Youth Development Project<br>• Otago GP Link Project<br>• Christchurch Youth Drug Court<br>• Heartland Services<br>• Family Service Centres |
| Target population | Whole population of the area or setting and/or demographic subgroups based on age, sex, ethnicity, neighbourhood) | Whole population of the area or setting and/or demographic subgroups based on age, sex, ethnicity, neighbourhood) | People who require personal services across different agencies or sectors – often at-risk, disadvantaged individuals and their families or those with poor access to services |
| Target issues | A wide range of issues, e.g.<br>• health<br>• welfare<br>• economic situation<br>• employment<br>• education<br>• physical environment | One health (or other sector) issue, e.g.<br>• alcohol and/or drugs<br>• safety/injury<br>• family violence<br>• crime<br>• nutrition<br>• housing | A wide range of issue, e.g.<br>• health<br>• welfare<br>• economic situation<br>• employment<br>• education<br>• physical environment |

|  | Overarching area- or settings-based initiatives | Issues-based initiatives | Case-management services and one-stop shops |
|---|---|---|---|
| Population-based health promotion/public health/ prevention programmes | • Yes | • Yes | • Occasionally |
| Personal health and welfare services | • Often (but not always) | • Occasionally | • Yes |
| Community consultation in planning and/or governance | • Yes, usually | • Variable | • Not usually |

Source: Compiled by authors

# 1   Introduction

In October 2001, the Ministry of Health published *Intersectoral Initiatives for Improving the Health of Local Communities: A Literature Review* (Ministry of Health 2001d).  This was a wide-ranging review of New Zealand and overseas research examining intersectoral collaborative partnerships for improving the health of local communities.  The report included detailed case studies of selected New Zealand partnership projects, along with a consideration of the Health Action Zone initiatives (HAZs) underway at the time in the United Kingdom.  The report also summarised what the literature indicated were significant factors that contributed to the development of successful and effective intersectoral partnerships.

Feedback to the Ministry of Health indicated that the 2001 report proved useful as a core resource and guide to action for a variety of people responsible for funding, designing, implementing or evaluating community-based intersectoral initiatives for health in New Zealand.

Given this response, early in 2005 the Ministry commissioned a second review of the literature covering new reports and journal articles published since the 2001 review.  The results of this work are presented here.

## Aims of this report

The main objective of the report is to summarise the key advice and evidence on intersectoral working provided in the most recent research and evaluation literature (i.e. literature published between 2001 and 2005).

A second objective is to update the discussion of 'success factors' for intersectoral working provided in the original 2001 report, in light of the information covered in the latest research.

## Search methods

In the first stage of the review, beginning in February 2005, a range of health- and social science-related electronic bibliographic databases and catalogues (Index NZ, Australasian Medical Abstracts, PsycINFO, Social Science Citation Index, Social Services Abstracts, Sociological Abstracts, CINAHL, DARE, Current Contents, ABI/INFORM, Medline, Medline In-Process, Other Non-Indexed Citations, Auckland City Public libraries, University of Auckland library, Ministry of Health library, World Health Organization library [WHOLIS]) were searched to identify journal articles, reports and other documents covering issues connected with the design and implementation of intersectoral initiatives for improving the health of local communities.

Literature that was not already used in the first review and that was published between 2001 and 2005 was sought.

The main search term used was '(intersectoral or interagency or coalition or alliance or partnership or joint or collaboration) and community and health'.  This reflects the fact that in the international literature a range of different terms are used to describe initiatives or projects that may involve intersectoral action or working.

Literature from New Zealand and other primarily English-speaking countries like UK, the United States of America, Canada and Australia was given priority.

Other searching involved going directly to the websites of a range of New Zealand and overseas agencies including:

- **New Zealand government departments and ministries** such as Ministry of Health, Housing New Zealand, Ministry of Social Development, Ministry of Justice, Accident Compensation Corporation (ACC), Child, Youth and Family (CYF), Te Puni Kōkiri, Ministry of Pacific Island Affairs

- **New Zealand university research units** such as Injury Prevention Research Unit (IPRU), Injury Prevention Research Centre (IPRC), Centre for Social and Health Outcomes Research and Evaluation (SHORE)/Whāriki, Health Services Research Centre, Public Health Consultancy, Local Partnerships and Governance Research Group

- **New Zealand private research companies**

- **overseas websites** such as haznet, King's Fund, Canadian Department of Health, Victoria Health, Health Development Agency.

The priority for the literature search was retrieving documents containing expert advice and evaluation evidence regarding the success and effectiveness of community- or area-based intersectoral working for health. There were two main categories: New Zealand studies and overseas studies.

Similar to the 2001 review, the focus was chiefly on initiatives or programmes that met all or most of the following criteria:

- they were funded, governed and/or implemented across sectors under some kind of formal arrangement

- their aim was improving health status and reducing health inequalities

- they had been systematically evaluated, with a publicly-available record of the evaluation results.

Throughout the search, particular effort was put into collecting as much relevant information as possible on New Zealand initiatives. This included contacting a selection of New Zealand-based people working in the area and inviting them to forward relevant material. The Ministry of Health provided an initial list of potentially useful contact people for this exercise, including contacts in each of the 21 District Health Boards (DHBs).

The search also included efforts to trace recent New Zealand literature containing evidence or comment regarding the participation of Primary Health Organisations (PHOs) in the development and promotion of local community intersectoral initiatives.

## Content of the report

Chapter 2 covers key principles and definitions relevant to intersectoral action for community health. It looks at the justification for and history of intersectoral action for health and describes some common features of New Zealand initiatives.

Thereafter Chapter 3 offers a detailed discussion of what are considered to be the six key 'ingredients for success' for intersectoral health action:

(1)    clear agreement exists on the necessity for intersectoral action

(2)    support exists in the wider community for action

(3)    capacity exists to carry through the planned action

(4)    relationships enabling action are defined and developed

(5)    agreed actions are planned and implemented

(6)    outcomes are monitored and evaluated.

Appendix 1 presents an overview of the 33 New Zealand initiatives and the one UK initiative (Health Action Zones) from which much of the illustrative material in Chapter 3 was drawn. The initiatives are divided into three groups:

(1)    overarching area- or settings-based initiatives

(2)    issues-based initiatives

(3)    case-management services and one-stop shops.

# 2   Key Principles and Definitions

Intersectoral health action aims to achieve health outcomes 'in a way that is more effective, efficient or sustainable than could be achieved by the health sector working alone' (Harris et al 1995: 7).

Community-based intersectoral health initiatives are distinguished from other kinds of health initiatives by being:

(1)   *area-based*, focusing on specific groups living in a defined geographic area or place

(2)   *cross-sectoral*, meaning they involve relationships or connections between a part or parts of the health sector and a part or parts of other sectors such as the social services sector, the justice sector, the education sector or the housing sector (Harris et al 1995; Federal, Provincial and Territorial Advisory Committee on Population Health [FPTAC] 1999).

The New Zealand Ministry of Health endorses intersectoral action in its health strategies such as the *New Zealand Health Strategy* (Minister of Health 2000); the *New Zealand Disability Strategy* (Minister for Disability Issues 2001); the *Primary Health Care Strategy* (Minister of Health 2001); and *He Korowai Oranga: Mäori Health Strategy* discussion document (Ministry of Health 2001a).  Intersectoral action is also considered by the Ministry as a key strategy to reduce inequalities in health (Ministry of Health 2001b).

The rest of this chapter discusses:

- the justification for using intersectoral action to address health issues
- the origins and history of intersectoral working for health
- what New Zealand intersectoral initiatives involve – including initial meetings and impetus for initiatives, choosing intersectoral group members, initial planning, resources, activities, and continuing or finishing initiatives.

## Justification for intersectoral action

The key justification for intersectoral action given in the literature is that the determinants of the health of populations and communities are diverse, complex and multifactorial and therefore beyond the capacity of the health sector to influence on its own (WHO 1978; WHO 1986; Harris et al 1995; WHO 1997; O'Neill et al 1997; National Health Committee 1998; Kuhn et al 1999; Howden-Chapman and Tobias 2000).

> At a practical level, many of the problems that affect the health and wellbeing of people in communities – such as substance abuse, poverty, environmental hazards, obesity, inadequate access to care, and terrorism – cannot be solved by any person, organization, or sector working alone.  These problems are complex and interrelated, defying easy answers. They affect diverse populations and occur in many different kinds of local contexts.  The local context, in turn, is dependent on decisions made at state, national, and international levels.  Only by combining the knowledge, skills, and resources of a broad array of people and organizations can communities understand the underlying nature of these problems and develop effective and locally feasible solutions to address them (Lasker and Weiss 2003: 14–15).

Intersectoral action involves building constructive relationships with people and agencies from outside the health sector, in an attempt to jointly influence these broader determinants of health and wellbeing by sharing knowledge, skills and resources.

Specifically in the New Zealand context, Larner and Butler (2003) list several reasons why it can be advantageous for central government to support local partnerships and other forms of 'joined up' working. One is the ability to develop community capacity by dealing with 'multi-faceted outcomes'. Another is that no single agency could achieve this type of outcome on its own. Local partnerships also offer opportunities to develop new relationships with 'intermediate' institutions (like local authorities) and communities. As well, they can enable hierarchical funding arrangements and service criteria to be replaced by more inclusive, locally-specific approaches.

The SHORE/Whäriki meta-analysis of 10 New Zealand community action projects observes that involving multiple stakeholders in the planning of projects ensures the 'participation of key organisations and individuals who will be affected by, or benefit from, the initiative ... Collaboration of government and community organisations ... maximises financial, knowledge and people resources, and minimises duplication' (Greenaway et al 2004a: 12). Collaborative working practices also often continue after a project is completed.

Sometimes attempts are made to justify intersectoral action on economic grounds; i.e. it is a more efficient way to work (decreased duplication) and may produce outcomes that save money (for instance, improved health status). However, there appears to be little or no convincing evidence that intersectoral action is a cheaper option in terms of efficient working practices. In fact the opposite is likely to be true in many cases, at least in the short term, because of the cost and effort involved in building relationships. The evidence that intersectoral action produces better cost benefits than other ways of addressing health issues is also limited, mainly because of technical issues regarding the measurement of outcomes and a lack of comparative data (see Chapter 3, Section 6: Outcomes are evaluated and monitored).

## Origins of intersectoral working for health

The notion that broad, population-level health outcomes can be improved by changing the beliefs and practices of people in local communities has a long history and rests at the heart of the public health enterprise. However, a question that continues to exercise the minds of public health practitioners is, 'What are the most appropriate and effective strategies for generating meaningful, long-lasting positive changes in a community's health-related beliefs and practices?'

Historically, initial attempts to change these factors tended to involve interventions devised and implemented by health professionals in a largely 'top-down' managerial style with little substantial input from community members or non-health sector organisations. While some of these interventions achieved a degree of success in certain contexts, in others it was obvious that large sections of the communities targeted by these interventions showed no appreciable change in their health practices, health beliefs or health status. This was particularly so in communities containing high proportions of people from lower socioeconomic groups or disadvantaged indigenous or ethnic minority groups.

In the second half of the 20th century, more sophisticated theories of public health intervention evolved, as demonstrated for example in the Ottawa Charter. Underpinning these new theories is

the recognition that the origins of many public health problems are complex and multifactorial and shaped by a host of diverse social, cultural, economic and biological influences. In these circumstances, the key to achieving broad, community-wide health improvements is for public health practitioners to identify and implement a wide variety of interlocking strategies to positively influence people's health status. These strategies range from altering legal frameworks and developing advertising and marketing campaigns, through to lobbying governments for policy changes in areas such as education, employment and income support.

In the last decade or so, this perspective has evolved to a point where it is now widely accepted that these diverse, wide-ranging and complex kinds of public health strategies cannot be expected to be designed, driven and delivered by the health sector alone. Rather, the health sector needs to seek and secure knowledge, skills and resources from various non-health sector organisations and community members, working closely with them as genuine partners to implement health-orientated change.

A central tenet of this new approach is that health-promoting initiatives and actions implemented in a community are unlikely to be accepted or effective unless local organisations and community members play a central role in their design and implementation (i.e. the community must 'own' the actions) (Gillies 1998).

Intersectoral partnerships or coalitions for health are an attempt to operationalise this approach. These initiatives essentially consist of governance- and management-type processes aimed at fostering joint working between people from relevant health and non-health sector organisations and groups from within a local community. In contrast to early public health intervention strategies, the focus is often on avoiding a dictatorial, top-down style of management and control by health sector representatives. Rather, the emphasis is on all participants in the partnership contributing in a meaningful way to:

(1)    negotiate and operationalise the nature of their coalition or partnership relationships

(2)    define the public health issues confronting their community

(3)    devise and support suitable actions to address these problems.

Projects involving partnerships between health and non-health sector organisations or people are not a new idea. The USA, for example, has a history of more than 40 years of public health investment in intersectoral health initiatives of one kind or another (Lasker and Weiss 2003). The point, though, is that as just noted, in the decades leading up to and including the 1970s and 1980s, most of these initiatives consisted of health professionals or researchers working with community members to secure support and co-operation for the implementation of multi-component interventions (e.g. mass education campaigns), the features of which had already been largely predetermined using existing medical, epidemiological and behavioural knowledge (Roussos and Fawcett 2000).

Evaluation findings from these projects showed that initiatives tended to be implemented most successfully in situations where there was good community participation in decisions about intervention components during the early stages of programme development (Roussos and Fawcett 2000). As a result, in the late 1980s and throughout the 1990s in the USA, a so-called 'new generation' of community health initiatives was introduced, where the central aim was the development of collaborative partnerships for health in local communities, and where the nature of the health actions to be implemented was not predetermined but instead was left to the partnership members to work out together. One key feature that appears to have encouraged growth in support for this approach in the USA was new federal policies devolving responsibility for solving public problems from national to state and local authorities (Roussos and Fawcett 2000).

The 1990s and early 2000s also saw an increase in the number of these types of health-orientated community coalitions and partnerships being trialled in other western countries, such as Canada, England, Scotland, Wales, Ireland, Australia and New Zealand.

In the United Kingdom, a substantial number of new intersectoral health partnership projects were funded by central government agencies, following the election in 1997 of the Blair-led Labour government, with the goal of operationalising 'Third Way' principles of joined-up services and community regeneration. Probably the most important of these new projects were the Health Action Zone projects implemented in various areas of high socioeconomic deprivation and disadvantage. The aim of these projects was to foster local-level intersectoral collaborations as a solution to health inequalities linked to the apparent fragmentation of local statutory services and community relationships. This fragmentation was attributed to, amongst other things, the policies of previous Conservative governments as well as the impacts of broader factors such as globalisation, individualism and consumerism. These collaborative approaches were touted as representing a middle course between so-called 'anarchic' neo-liberal, free-market style solutions based on competition and earlier 'old style' hierarchical, statist solutions imposed from the centre by 'big government' (Crawshaw and Simpson 2002).

In New Zealand, a range of intersectoral health initiatives have been trialled and tested in local communities over the last 20 years; examples of these have been discussed in detail in the previous literature review (Ministry of Health 2001d). Newer initiatives implemented in the last five years have been modelled on elements of the 'Third Way'-style, place-based collaborative partnerships trialled in the United Kingdom, such as HAZs. These developments have been supported by various top-level formal government policy statements emphasising the potential benefits of decentralisation, joined-up solutions and partnerships. (For an overview and critical assessment of these, see Craig 2003. See also Larner and Butler 2003.)

## What do New Zealand intersectoral initiatives involve?

Intersectoral community initiatives for health are certainly not all the same. In fact, the more closely that case study descriptions of individual initiatives are examined, the more obvious it is just how much variation there is in the kinds of philosophical principles, structures, systems and people that can form the basis of an initiative.

Having said this, it is still possible to pinpoint certain key structural or organisational components of intersectoral initiatives that are relatively common. These may not be found in all intersectoral initiatives, but they are likely to be found in most.

The SHORE/Whāriki meta-analysis of 10 community action projects identifies three general phases that projects tend to move through (Greenaway et al 2004a). The first is an activation phase that involves processes such as identifying the need for a project, matching funding to projects, building and facilitating project relationships and participation, creating project structures, negotiating visions and planning, and creating activities. The second is a consolidation phase that includes skill development, accessing people with community development knowledge and skills, developing a project culture, sharing project experiences, managing conflict, accessing resources, developing knowledge, and carrying out evaluations. The third is a transition phase that includes completion of the funding term and a focus on issues linked to organisational change and sustainability.

### Initial meetings and impetus for initiatives

Central to the notion of intersectoral working for health is the idea of setting up new processes for facilitating face-to-face dialogue between representatives of organisations and groups in the community who have the potential to influence health outcomes in various ways. In practical terms, this typically means holding large and perhaps quite lengthy meetings at a suitable venue, such as a community centre or local council offices. A variety of individuals from an array of local, regional and/or national organisations and groups are invited to participate in these meetings, which may be held reasonably regularly, say every month or every few months.

The initial impetus or stimulus for planning and holding the meetings may come from a variety of sources. In some cases, certain local health events or crises may be the spur to action; these can be regarded as a kind of 'bottom-up' stimulus, where the initiative is propelled by a groundswell of support from local citizens.

In other cases, government agencies may advertise the availability of one-off or project funding to support the development of intersectoral working for health in local communities. Interested individuals from various local organisations then form a group to work together on the development of a funding application. This may include preparing a community profile, using predetermined measures or statistics to indicate the degree of disadvantage experienced by residents (Larner 2004). If its bid is successful, the group forms the basis of the intersectoral group responsible for managing the initiative. This kind of trigger for the development of intersectoral working can be regarded as largely 'top-down', though obviously it still relies heavily on the ability and enthusiasm of at least a few individuals in the local community.

In the USA in particular, over the last 20–30 years philanthropic organisations such as the WK Kellogg Foundation and the Robert Wood Johnson Foundation have played a leading role in the funding of community-level intersectoral projects that are orientated towards public health. Examples include nationwide initiatives such as *Turning Point: Collaborating for a New Century in Public Health* (Berkowitz 2000). However, in New Zealand it is much less common for philanthropic organisations or the business sector to sponsor intersectoral working, especially in order to provide core start-up funding (Larner and Butler 2003).

In most of the 10 New Zealand community action projects examined in the meta-analysis by Greenaway et al (2004a), the initial idea for action came from groups in the community who had been interested in an issue for a while. When funding became available to address the issue, 'these communities were poised for action' (Greenaway et al 2004a: 28). For example, in the

Moerewa Community Project, people were already working voluntarily on the community's drug and alcohol problems.

By contrast, the Christchurch Early Start pilot programme, established in 1995, did not use a community development approach to planning its services. Instead it used:

> ... a 'top down' organisational model in which a series of agencies with leadership in health care, service provision, research and cultural issues came together to build a programme for their community using the best available knowledge from their respective areas. The strength of this approach was that it built on existing expertise and leaderships rather than letting programme directions be shaped by an unstructured community based democracy (Fergusson 2003: slides 46 and 47).

## Choosing intersectoral group members

Published reports tend to provide only scant detail of the processes used to identify which kinds of people, from which organisations and groups, will be invited to participate in the first intersectoral meetings. Nonetheless, these initial decisions, irrespective of how they are worked out and operationalised, play a crucial role in determining the initial overall make-up and character of the intersectoral governance group.

It would be rare for an intersectoral group focusing on local health issues not to include representatives from the local health and disability services. In the New Zealand situation these services could include DHBs, PHOs, ACC, Plunket, and so on.

However, by definition, the key to intersectoral working is getting buy-in from organisations and groups from outside the heath sector. These might include, for example, organisations in the social services sector (e.g. CYF), the justice and policing sector, the housing sector, or the education sector (e.g. schools and early childhood education centres).

Many intersectoral initiatives also aim to include community representation, drawing on the resources and advice of selected individuals from groups in the community that are seen to be particularly affected by the health issues under consideration, such as Māori, Pacific peoples, youth, children, and people on very low incomes.

In New Zealand it appears there are often direct or indirect links between different intersectoral projects in certain locations. So existing intersectoral groups apply for funding for another intersectoral initiative. For example, the Aranui Stronger Communities Action Fund (SCAF) site in Christchurch had links to the Community Renewal Project in the same area (Bee and Milne 2004). In Waitakere, the Ranui Action Project (RAP) was funded as a 'health action zone' by the Health Funding Authority and also by CYF as a SCAF site (Conway et al 2003a). In Counties Manukau there is a raft of different intersectoral initiatives going on; the Manukau City Council and Counties Manukau DHB have a hand in many of them. The large number of such initiatives may have resulted because, once intersectoral structures and processes are set up for one project, it becomes easier to successfully apply for funding for other projects and to put these projects into operation. Members of the community and of organisations may also become accustomed to working intersectorally with one another.

## Initial planning

At the first meetings of the intersectoral group, it seems common for much of the time to be spent discussing and clarifying what should be the core objectives of the group and how each of the participants in the group may be able to contribute to achieving these objectives, while also advancing the goals of the organisation or group to which they belong.

## Resources

Obviously, running meetings of this nature implies resource costs. These include the costs of meeting rooms, information services, photocopying and other secretarial or administrative services, catering and so on. As well, of course, meeting participants provide their time and expertise either on an unpaid basis or as part of their current job or position in the community.

In some cases, organisations involved in the intersectoral initiative will provide meeting facilities or other kinds of infrastructural support as part of their contribution to the development of the initiative. In other cases, one-off or seeding funding obtained from government or other agencies will be used to pay for all or some of these 'extra' costs. Where suitable funding can be arranged, some initiatives may also employ full- or part-time co-ordinators to undertake various tasks on behalf of the group, such as organising meetings, carrying out consultation projects, or doing other kinds of networking, information gathering or research.

## Activities

Depending on the way that relationships evolve within the intersectoral meetings, a variety of clearly visible outputs or actions may be produced. For example, participants may agree to support and resource specific one-off or ongoing health promotion activities in their locality, such as a traffic safety campaign or a campaign to reduce the numbers of under-age drinkers in local pubs.

Harris et al (1995) list some of the types of potentially beneficial 'outputs' that could be produced by the participants in intersectoral group. They include:

- networking to share information or undertake advocacy work
- jointly managing cases
- co-locating services and providing resources
- providing sponsorship or endorsement of activities
- providing technical support, information and training
- co-ordinating the delivery of services and programmes
- providing funds for activities undertaken in other sectors
- jointly sponsoring projects
- forming coalitions to promote a particular issue
- developing joint policies
- creating formalised agreements
- developing legislation that applies within other sectors.

In some cases the intersectoral partners may end up agreeing to jointly support a whole raft of different health promoting actions in their local community, signalling this in a detailed, formal,

written statement of intent which all the participants sign up to. The participants in the intersectoral group, or the organisations to which they are affiliated, may then take various steps to implement these agreed actions, many of which will probably be quite practical, down-to-earth activities such as improving the signage or lighting on a road identified as an accident black-spot or running a campaign offering free car-seat hire to the caregivers or whänau of preschool children.

Other intersectoral groups may be less inclined or able to embark on such visible, practical projects. Instead they may agree to focus simply on promoting greater networking and information exchange among the core group members. One spin-off from this may be that the participants gain a better appreciation of the different roles and responsibilities of people working in other local agencies. Eventually this knowledge may contribute to the development of subtle but nonetheless valuable improvements in the way in which local services relate with each other or the citizens they serve.

## Continuing or finishing initiatives

A number of New Zealand intersectoral initiatives for community health have continued to operate for a number of years – well after their original funding has ended. They may receive ongoing funding from their original sponsor (e.g. after a successful one-off initiative) or they may obtain more sustainable funds from elsewhere. For other initiatives, their activities are mainstreamed into those of other organisations (e.g. host or home organisations of members of the intersectoral group). Other initiatives struggle to find ongoing funding and either completely cease to run or revert to doing the same work on a voluntary basis.

# 3 Factors Influencing the Success of Community-based Intersectoral Action for Health: An update

As indicated in Chapter 2, the process of developing an intersectoral initiative usually involves a fairly standard series of steps. Essentially what happens in practical terms is that a number of representatives of local organisations and other community representatives meet up to share skills, knowledge and resources and undertake various joint actions aimed at improving the health and wellbeing of certain groups in the local community.

This might sound simple enough but in fact, as many studies observe, in most cases the process of successfully establishing a locally-focused intersectoral initiative is likely to be quite challenging and complex. It is not a process to be entered into lightly. As Shortell et al (2002: 51) suggest, 'this effort involves a huge managerial and leadership challenge involving the management of complex interorganizational relationships'. By its very nature, intersectoral collaboration is a change process, the success of which is often conditional on a number of people and organisations making significant shifts in their assumptionsabout who they are, how they work, and the stance they should adopt in their relations with other community members, groups and organisations.

This chapter presents a summary of factors that various research-based studies have identified as important for shaping the degree to which these kinds of community-based intersectoral initiatives for health are likely to be effective or 'successful'. It is an updated and somewhat revised and reworked version of the summary provided in the original 2001 review (Ministry of Health 2001d).

The summary is a synthesis of ideas and evidence drawn from a range of sources.

(1) **Evaluations of New Zealand intersectoral initiatives published between 1980 and 2005.** See Appendix 1 for descriptions of the 34 New Zealand initiatives for health covered in the current review.

(2) **Evaluations of the United Kingdom's Health Action Zone initiatives.** These are included because the HAZ programme was an initial source of key learning during the development of recent New Zealand area-based intersectoral health initiatives, such as Intersectoral Community Action for Health (ICAH) projects. Results from early evaluations of HAZ initiatives were examined in the original 2001 literature review (Ministry of Health 2001d).

(3) **New Zealand and overseas review articles and reports summarising 'key learnings' from multiple intersectoral initiatives, as well as advice from expert practitioners closely involved in the design and delivery of intersectoral projects.** In some cases these studies have applicability to projects focusing on *not just* health-related action (e.g. Dowling et al 2004; Foster-Fishman et al 2001). Examples of New Zealand reviews of this type include: Craig and Courtney (2004); Gray (2002); Greenaway et al (2004a, 2004b);[1] Larner and Butler (2003);[2] Ministry of Social Development (2003); Ministry of Social Policy (2000). In other cases, studies focus on 'success factors' relevant to health-related

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[1] See Appendix 3 for a list of initiatives included in these meta-analyses.
[2] See Appendix 2 for a list of initiatives included in this review.

initiatives (e.g. Harris et al 1995; FPTAC 1999; Berkowitz 2000; Roussos and Fawcett 2000; Wolff 2001; Shortell et al 2002; Lasker and Weiss 2003).  The previous Ministry of Health report (2001d) is the only example of this type that we have found.  In addition, a few studies look in detail at just certain elements of intersectoral working or provide an extended analysis of selected 'success factors'.  For example, the recent Canadian paper by Baillie et al (2004) focuses on the potential constraints to community involvement in intersectoral projects, while, closer to home, the paper by A Walker (2004) examines the extent to which trust is central to the success of intersectoral working in New Zealand.

(4) **New Zealand and overseas studies examining the policy context in which intersectoral initiatives are developed and run.**  These studies tend to be more academic and theory-driven than, for example, evaluation reports on individual programmes.  Nonetheless they are important for making plain how much the day-to-day running of intersectoral initiatives is potentially open to indirect influence from 'big picture' contextual factors.  Examples of this kind of study include, from the UK, the paper by Crawshaw and Simpson (2002), which offers a critique of the policy context underlying the development of HAZs and other area-based partnerships for health.  A thoughtful New Zealand analysis along similar lines is offered by Craig (2003).

(5) **New Zealand and overseas studies covering the theory and methods of evaluating intersectoral initiatives.**  These include studies assessing the value of using formal assessment or measurement tools (Granner and Sharpe 2004; Halliday et al 2004) and studies highlighting the diverse and sometimes conflicting expectations people have of evaluation studies (El Ansari et al 2001).

## The six groups of 'success factors'

The discussion of 'success factors' is arranged under six headings, corresponding to the six main requirements for effective intersectoral action identified in *Working Together: Intersectoral Action for Health* (Harris et al 1995).  The categories are:

(1)  clear agreement exists on the necessity for intersectoral action

(2)  support exists in the wider community for action

(3)  capacity exists to carry through the planned action

(4)  relationships enabling action are defined and developed

(5)  agreed actions are planned and implemented

(6)  outcomes are monitored and evaluated.

These same six headings were used in the original 2001 literature review (Ministry of Health 2001d).  However, the present document includes a more extensive discussion of specific elements of these factors, as well as providing a number of new illustrative examples drawn from more recent New Zealand initiatives (which are described in Appendix 1).

### (1)  Clear agreement exists on the necessity for intersectoral action

A central objective of community-based intersectoral action for health is to create new processes facilitating face-to-face dialogue between representatives of organisations and groups in a local community who together have the potential to influence health outcomes.  A critical starting

point for this is getting agreement from these people that working together is necessary and desirable.  This agreement forms the basis for the gradual development of a shared vision of what they hope to achieve together.

This section discusses these early stages of intersectoral initiatives for health under the following headings:

- promoting organisations and groups
- building up the intersectoral group
- size and diversity of intersectoral groups
- choosing partners
- agreeing that working together is necessary and desirable
- having a shared vision
- sharing language, philosophy and understanding.

## Promoting organisations and groups

In New Zealand, many initiatives get started because certain individuals or agencies in a particular locality (city, town, neighbourhood, etc) are motivated enough to put their hands up and assume the role of a 'promoting' group that leads the initial effort to set up and develop an intersectoral initiative.

In some cases, people from local or national health sector organisations or city councils have taken on this role.  In other cases, it has been people from already-established intersectoral groups or partnerships in the community.

In the United Kingdom, recent studies indicate primary care groups run by general practitioners (GPs) and other primary care practitioners are being increasingly encouraged to engage in partnerships with local authority social service departments, for example to better co-ordinate the delivery of older people's services or of mental health care (Callaghan et al 2000; Glendinning et al 2001; Secker and Hill 2001; Peck et al 2002; Rummery and Coleman 2003).

This literature review has found little documented evidence of New Zealand primary care providers like PHOs promoting local intersectoral initiatives, apart from the Otago GP Link project (Otago District Health Board 2003/2004).  There were also links between the Kapiti and Porirua ICAH projects and the local PHOs (Martin et al 2004).

In many cases, these 'promoting' groups will be responding to calls for project proposals from a government agency, or group of government agencies that have funding available to support the setting up of community-based intersectoral initiatives.  The promoting group or organisation has to submit a suitable funding application and the community usually has to fulfil certain eligibility requirements.

In other cases, promoting organisations or groups initiate intersectoral projects themselves in response to a local health need.  Alternatively, other New Zealand or overseas intersectoral initiatives may inspire them to try out a similar approach themselves.  In either case the organisations or groups will need to seek funding from appropriate sources.

There are advantages in existing groups taking primary responsibility for establishing an initiative as they often have track records of providing services and are able to use existing partnerships and other networks to plan and undertake projects and activities more quickly than new groups. On the other hand, favouring existing groups makes it difficult for newcomers to compete for funding, and 'well-established groups may become set in their ways and not take on new challenges and information' (Greenaway et al 2004a: 28).

The literature suggests that ideally the people who undertake this initial development work should have a good knowledge of and access to the local community's resources, formal and informal communication networks, and opinion leaders and other natural allies within the community (Bourdages et al 2003).

## Building up the intersectoral group

Another critical early step in the development of an intersectoral initiative is the recruitment to the intersectoral group of participants who will govern and run the initiative. (See also Section 4 for a discussion about building and maintaining relationships between intersectoral partners.)

Potentially there are several different ways that the membership of an intersectoral group can be identified and recruited.

One is to hold a public meeting, or series of public meetings, in which the possibility of setting up an intersectoral project is discussed. Groups and individuals participating in the meeting are then asked for an indication of whether they would be interested in contributing to the project.

Another is to approach representatives of selected local agencies and invite them to consider joining the project.

The four New Zealand ICAH projects took different approaches when setting up their intersectoral group. In both Porirua and Kapiti, health advocacy groups were already established and working together in the Porirua Kapiti Health and Disability Services Integration Project. The original project committee was restructured to form the two ICAH governance groups and included the local authority mayors, iwi representatives, Pacific peoples representatives, a community health group trust and a Ministry of Health official (Martin et al 2004).

The Counties Manukau ICAH governance group consisted of an existing intersectoral alliance of relevant central and local government agencies. This contrasted with the Northland ICAH governance group which was not formally constituted and comprised three local Mäori health providers in a joint venture (Martin et al 2004).

The SHORE/Whäriki meta-analysis of 10 New Zealand community action projects found that it was an advantage to have funding specifically set aside for early work associated with building up the intersectoral group, including project scoping, consulting with community members and creating participation (Greenaway et al 2004a).

Where effective structures and processes for intersectoral action are already in place in a community, then piggy-backing a new initiative onto these structures can help the initiative advance more quickly by, for example, making it easier to identify community needs. Evaluations of the Stronger Communities Action Fund projects showed that progress was more

rapid at the Whakatane, Ranui and Glen Innes sites for this reason. The Mangakino, South Hokianga and Porirua sites were slower to get up and running because they lacked well-established intersectoral structures (Research and Evaluation Unit 2004).

The Otago GP Link Project was developed after a needs assessment was done to identify how effective linkages among mental health services, GPs, government agencies and non-governmental organisations could be made. A survey of local GPs and a baseline assessment had suggested that the physical needs of mental health clients were not being met. This led to a pilot scheme being set up to remove the cost barrier through a partnership between GPs and other agencies, in particular Work and Income, to increase access to primary health care (Otago District Health Board 2003/2004).

### Size and diversity of intersectoral groups

Reports generally observe that for the best chance of success, initiatives should aim to put together a large and diverse mix of groups and individuals. This is thought to increase the scope for long-term buy-in from different sections of the community and therefore to produce a more enduring and effective collaboration (Zahner and Corrado 2004).

Lasker and Weiss, for example, observe that participants in intersectoral projects should include:

> ... people and organizations from many different backgrounds, disciplines, sectors, and levels, including not only various kinds of service providers, but also people directly affected by health problems, formal and informal community leaders, academics, government agencies, schools, businesses, and faith-based organizations (Lasker and Weiss 2003: 27).

However, the potential benefits of a highly inclusive approach must be balanced against the risk that working with a very large number of diverse people and organisations may make reaching consensus more difficult, and perhaps introduce more scope for misunderstandings and conflict.

As Shortell et al suggest:

> ... while size and diversity are needed to achieve legitimacy, they also create significant management and policy implementation challenges involving co-ordination, communication, conflict management, priority setting, and monitoring activities (Shortell et al 2002: 65).

One example of the effects of diversity is that hierarchical organisations may find it difficult to work with highly decentralised organisations, because of different decision-making processes (e.g. 'discretionary' versus 'chain-of-command'), timeframes, methods for prioritising work, and accountability and performance monitoring systems (Harris et al 1995: 80).

### Choosing partners

Craig and Courtney (2004) suggest that '[d]oing everything with everyone is neither practical nor sensible; it's time to pick winners!'. The focus should be on getting and keeping the right people round the table. 'Right people' are those able to speak on behalf of their organisation, commit to goals and funding, take information back and forward from their organisation, deal

with multiple cultural and community contexts, support and value community representation, and make collaborations fun.

In selecting participants, studies also note that the people approached, and their organisations, should have credibility, visibility and influence in the community (Bourdages et al 2003).

Other studies add that ideally the people and organisations recruited to an intersectoral project should have a degree of compatibility in attitude and outlook. A prior record of working together constructively is another big advantage (FPTAC 1999). It is also important to be aware of situations where the scope for building constructive working relationships between certain organisations may be hampered by past rivalry and competition (Bourdages et al 2003).

### Faith-based organisations and private businesses

A key challenge historically overseas has been to get people from non-health-related sectors, such as business and faith communities, to adopt and engage in disease-prevention and health-promotion projects (Roussos and Fawcett 2000: 372).

Apart from the involvement of churches in Pacific initiatives such as Peaceful Waves/Matangi Malie (Greenaway et al 2004a), this literature review found little documented evidence that New Zealand faith-based organisations are engaging currently to any degree in intersectoral initiatives for health.

The same applies to private businesses in New Zealand. One objective of community renewal projects was to improve the run-down appearances of shopping centres. To do this required securing the interest and goodwill of private local businesses. However, it was difficult to gain these when businesses regarded the scheme as offering only very small financial benefits. Seeking socially-minded businesses and educating others about the non-monetary benefits were seen as possible solutions to this issue (Nunns 2004).

### Local authorities

New Zealand evaluations suggest that local authorities (e.g. city councils, regional councils, district councils) have the potential to play an important role as supportive partners, both as funders and providers, in community-based intersectoral initiatives for health. Some, like Manukau and Waitakere City Councils have taken on this role in significant ways. However, other local authorities are not experienced in working collaboratively or do not accept that they have a role in promoting health.

### Education sector

Evaluations of partnership projects in Waitakere City indicate that getting education sector representatives to participate in intersectoral social and community development initiatives can be difficult (Craig and Courtney 2004). However, there has been successful integration of health and social services into schools in initiatives such as Social Workers in Schools and Full Service Education (FSE) in Achievement in Multicultural Schools Initiative (AIMHI) schools (Belgrave et al 2002; Thomas et al 2003).

*Citizen representation*

A related question is the extent to which the core intersectoral group or partnership should aim to include citizen representation from different sections of the community (e.g. Mäori, youth, Pacific peoples, low income neighbourhoods), as opposed to confining membership to the staff of local service agencies and so on.

Some initiatives have sought to include a significant element of citizen representation and have been successful at achieving this, whereas others have tried but have not really succeeded.  (See Section 3 below for further discussion of the key issue of community participation.)

## Agreeing that working together is necessary and desirable

Whether it happens before the first formal meetings of the intersectoral group, or after they start, a key initial requirement is getting agreement from the participants that working together to promote the health and wellbeing of people in the local community is necessary and desirable.

This includes getting agreement that the risks involved in working together are worth taking, that working together is likely to be more effective and sustainable than working alone, and that working together has the scope to directly benefit each participating organisation or group by helping it achieve its core goals (Harris et al 1995; Murphy and Thomas 1999; R Walker 2000). The perceived benefits should outweigh the perceived costs (Shortell et al 2002).

Without this kind of agreement, there is unlikely to be firm ground upon which to build and develop the intersectoral initiative.  Nor is there likely to be much motivation or enthusiasm to work through the often difficult and time-consuming early stages of relationship building and planning that are frequently a feature of the initial stages of intersectoral working.  In this situation, there is the risk that some participants may simply become 'passengers' in the intersectoral action.  Although they may *seem* to be involved, in fact they may neither contribute resources nor express a high degree of commitment (Harris et al 1995).

### *Reasons for joining intersectoral groups*

The *Mosaics* review (Ministry of Social Development 2003: 13) notes that intersectoral working by diverse organisations is more likely to be regarded as mutually advantageous when:

- organisations have common objectives and recognise that co-ordinating their activities will help them achieve outcomes

- many agencies are active in a geographical area, or focused on a particular issue or population group, and they want to ensure that their activities are mutually reinforcing and do not cut across each other

- there is overlapping activity between agencies, and efficiencies in time and resources could be made by better co-ordination of their activities

- senior managers, with the authority to make decisions and shift resources, are available to participate.

It is likely that some degree of initial 'consciousness-raising' or facilitated 'group work' will be useful to 'switch on' some organisations or people to the potential value of joining an intersectoral project.  This could help identify and stimulate common underlying values and

interests, and align purposes related to improving the health and wellbeing of people in the local community (Angus 1999; FPTAC 1999).

Shortell et al (2002) identify three types of motive for joining partnerships for community health:

(1)    instrumental motive – joining will help the organisation achieve its goals

(2)    legitimacy motive – the organisation will look credible to others

(3)    altruistic motive – it is the right thing to do.

However, certain organisations or people may not immediately recognise the potential benefits to themselves or their community that may arise from joining an intersectoral group. Indeed, even when participants start attending formal meetings of the intersectoral partners, they may still feel somewhat unsure of what benefits it could have for them, their organisation or the community at large.

Ideally, the agreed purposes of the intersectoral initiative should be sufficiently broad-ranging and all-encompassing that each of the intended partners in the initiative can 'see how participation will help them to achieve their mandate, as well as make a contribution to the greater good' (FPTAC 1999: 14). In short, the initiative must be clearly recognised as offering a 'win–win' situation for all participants. This is in contrast to situations where the initiative is simply perceived to be an exercise in 'bureaucratic imperialism', with people from one sector setting out to persuade people from other sectors to help them fulfil their own agenda.

Coupled with the need for a win–win approach is the need to minimise the extent to which the participants perceive the goals of the initiative to be unfocused, opaque or ambiguous. New Zealand evaluations refer to feedback from some intersectoral initiatives indicating that participants perceived only '... vague responsibilities and uncertainty about what participation in local interagency strategies and collaboration forums entails' (Craig and Courtney 2004: 10).

### Having a shared vision

Having, or developing, a shared vision with other partners is important for successful intersectoral health initiatives. Shortell et al (2002: 57) suggest the shared vision 'must be sufficiently broad and inspiring to engage the interests of multiple organizations and yet realistic in terms of being able to motivate action toward achievement'.

SHORE/Whäriki's meta-analysis of 10 New Zealand community action projects suggests that having funding organisations and evaluators involved in early planning meetings can be helpful for smoothing the process of developing a shared vision for the work of the initiative (Greenaway et al 2004a).

Partners in the ICAH initiatives tended to have a shared vision for specific, individual projects, rather than for the initiative as a whole. They found it difficult to maintain a wider shared vision that was necessary for potential partners to know if they wanted to join the group. The evaluation found that 'commitment to the vision needed to be readdressed with new members and staff' (Martin et al 2004: 17).

As part of aligning purposes, it is also important to achieve agreement on the substance and implications of information compiled about the nature and magnitude of the issue. As much as possible, this information should be congruent with prevailing ideals and values among the participating people and organisations (FPTAC 1999).

### Sharing language, philosophy and understanding

Many people and organisations are still unfamiliar with the broad philosophy and assumptions underlying intersectoral working. As well, there is no standard set of terms for describing the many different features of intersectoral working. In practical terms, this means there is scope for a degree of misunderstanding and or talking at cross-purposes – 'talking past each other' – when people communicate about aspects of intersectoral working. Different people may have different ideas about the meaning and implications of words such as 'intersectoral', 'partnership', 'collaboration', 'coalition' and 'community' (Lasker and Weiss 2003).

Recognising and attempting to resolve these conceptual differences and ambiguities are likely to be important early steps for any group setting out to undertake some form of intersectoral working together.

> ... listening, empathy, and a common language have been highlighted as critical characteristics of group discourse. Participants in a group dialogue need to be able to listen as well as talk, and as Friere notes, this listening is not the same as conducting a needs assessment. Instead, it is a participatory and ongoing interaction that uncovers issues of emotional and social significance to those involved and enables participants to see a situation from each others' perspectives. This level of understanding is only possible if the group develops common meanings so that they are all speaking the same language (Bourdages et al 2003: 29).

More broadly, in the New Zealand context, it is clear that some initiatives have devoted quite a lot of time to sorting through definitions and meanings. These include the boundaries or dimensions of the community or local population the initiative is focusing on, as well as what is meant by health and wellbeing, and the key factors or determinants that can shape health and wellbeing.

In the SCAF projects, both geographic and ethnic definitions of 'community' were applied, with the first being predominant. Boundaries of central government agencies, local authorities and iwi were not always the same, and living in a particular geographic area did not necessarily mean people shared common interests (Larner 2004).

In the ICAH initiatives, different members of the ICAH groups had different levels of understanding about determinants of health and their connections to health status and health inequalities. They were also unclear about what constituted 'intersectoral' action. With the exception of Counties Manukau, it appears to have been difficult to establish a clear understanding of the 'programme logic'. In some of the ICAH projects, a high staff turnover has made efforts to do so even more difficult (Martin et al 2004).

In the Health Promoting Schools initiative, Northland and Auckland schools had only a very short time to decide whether to apply to be a Health Promoting School. There was a lack of consultation with the wider school community before the decision was made and a lack of

understanding about what being a Health Promoting School really involved.  Some schools subsequently dropped out of the scheme because of these factors (Wyllie et al 2000).

The lack of community involvement before the Take Ngakau Kaikohe Intersectoral Project was established meant that the community was not really ready for a community action or community development approach towards health issues.  It took a long time to introduce the concept, and even longer for it to be understood.  The evaluators observe:

> The concept of public health has also been difficult to understand in a community where people are more familiar with a personal health and individual focus approach.  For some public health fits with the notion of a holistic whänau approach to health but while referred to regularly it is not common practice for most (Henwood and Adams 2003: 32).

Likewise, the gardening project in Glen Innes struggled to gain adequate support from community workers.  Evaluators conclude that this lack of support may have been due to the workers' perceptions of their roles as purely service providers, or a lack of understanding of community development approaches (Scott and Conway 2005).

### *Consensus versus adversarial models*

Intersectoral initiatives operate with an essentially consensus-based model of working.  The focus is on respecting different points of view, compromise, sharing, collaboration and teamwork.  This approach may not suit people, groups or organisations that believe that the only way to secure their core objectives is through the application of competitive, conflictual or adversarial models of working (Lasker and Weiss 2003).

As Craig and Courtney (2004: 20) observe, a focus on advocacy is not likely to be suitable in a collaborative framework.  If there are big local issues where certain people or agencies need to retain their own voice and advocate strongly for change, then other mechanisms apart from participating in intersectoral grouping may be more appropriate for this.

## (2)    Support exists in the wider community for action

Intersectoral initiatives for health always operate within a wider social, economic, political and environmental context.  Ideally, this context should be conducive to the development and maintenance of locally-based intersectoral action, rather than presenting significant obstacles.

Wider contextual factors that the literature indicates can be especially influential in facilitating (or impeding) intersectoral action include: the presence (or absence) of high-level political, central government and local government support; appropriate national or local-level policy and legislative frameworks; appropriate organisational structures; supportive economic circumstances; and supportive beliefs and attitudes among members of the target community (Harris et al 1995; Kuhn et al 1999).

These issues are discussed in two main groups:

- political, central and local government influences – including: central and local government contexts; limitations on the freedom to act, make decisions and speak out
- other contextual features – including: economic circumstances; organisational pressures and change; timing and location; beliefs and attitudes of the target community.

## Political, central and local government influences

Locally-focused intersectoral action for health appears more likely to be initiated and sustained if it is high on the national political agenda and clearly mandated at different levels of central, regional and local government in policies, reports and legislation (Harris et al 1995; FPTAC 1999).

### *The central government context*

Broadly, the success of intersectoral action for health has been noted to be highly dependent on the presence of a public policy environment that supports and facilitates collective action, rather than having an ethos emphasising the primacy of individual freedoms and rights (FPTAC 1999).

### Context for collaboration

Earlier intersectoral initiatives in the UK and New Zealand operated in a central government context that was relatively unfavourable to collaborative working.

The *Mosaics* review (Ministry of Social Development 2003) outlines various central government barriers to collaboration identified in the New Zealand State Services Commission's Review of the Centre:

- the large number of government agencies (including Crown entities) that Ministers and citizens have to interact with
- frequent structural change within government agencies
- differing regional boundaries for different departments
- the centralisation of agencies' services, leaving some agencies without representation at a local level
- the variation in levels of delegations within departments
- the division of financial resources into a large number of small pools
- outputs that focus organisations on the delivery of core business at the expense of whole-of-government approaches
- a public service culture that is risk-averse, and doesn't foster innovation and progress.

The research for the *Mosaics* project also identifies additional central and local government barriers to greater collaboration at the local level:

- no single agency at the centre with an overview
- no single agency at the regional level leading regional initiatives
- overall funding pressures limiting the funding allocated to collaboration
- differences between agencies' priorities and policies, making it difficult to identify common interests
- service boundaries within regions that are often different from each other and from iwi and local authority boundaries

- local managers lacking authority and flexibility to make decisions and use resources
- service contracting regimes that focus providers on outputs, and provide no obligation or incentive for providers to work collaboratively with other groups or services.
- competitive contract-letting systems, which create competition between provider organisations and undermine collaboration
- inflexible funding processes and annual planning cycles that drive short-term thinking and impede the ability of organisations to collaborate on strategic planning with a long-term focus.

After evaluating intersectoral working in Waitakere City, Craig and Courtney (2004) identify what they regard as ongoing 'bigger picture policy' barriers to the achievement of more successful 'joined up' working at the local level in New Zealand. These include:

- the manner in which elements of the Public Finance Act 1989 appear to limit greater cross-agency and government–community action in crucial areas
- the lack of a clear definition of which levels of government are responsible for wider wellbeing outcomes
- the lack of shared budgetary and planning frameworks and geographic boundaries between local agencies.

As already described in Chapter 2, more recent intersectoral initiatives for health in New Zealand have been modelled on elements of the 'Third Way'-style, place-based collaborative partnerships trialled in the UK, such as HAZs. These developments have been supported by the New Zealand government and by government agencies including the Ministry of Health (Craig 2003; Larner and Butler 2003).

The ICAH evaluations found evidence of increasing acceptance from central and local government departments of the need to 'work collaboratively these days' in order to 'make a difference':

> Working intersectorally has become the modus operandi for the public service. Government officials see themselves as now having the mandate to channel their resources into genuine intersectoral action. Support for intersectoral activities at the local government level is also now well developed and firmly established ... (Martin et al 2004: 160).

However, Craig and Courtney caution that:

> ... in this context it's all too easy for heavy expectations (and unreasonable responsibilities) to be heaped (or dumped) into partnerships. And heaping big problems into local partnerships usually means making local people responsible for things that really need addressing at central government level in Wellington (Craig and Courtney 2004: 11).

Larner (2004) observes that the new government emphasis on intersectoral collaboration is frequently interpreted as an acknowledgement that neo-liberal 'more market' approaches to the delivery of services have failed. However, she also states that certain commentators interpret the current focus on decentralised intersectoral projects as simply another form of cost-shifting by central government, with responsibility for providing services and activities passed down to

community groups.  In Larner's opinion these projects often rely on 'feminised and racialised labour of highly motivated, but over-worked "social entrepreneurs" and community representatives' (Larner 2004: 10).

**Legislation**

Legislative changes that free up opportunities for certain types of intersectoral working are also important.  For example, it may be prohibited by law for different agencies, working under different legislative frameworks, to contribute jointly to the cost of providing a new service (sharing budgets).  In the UK, the Health Act 1999 provided opportunities for all health and local authorities to share budgets in situations where 'joined up services' were expected to achieve health gains (Bauld et al 2001).

**Support for specific initiatives**

As well as a generally supportive political environment for collaborative working, support from central government for specific types of initiatives can be important.

Reflecting on the history of the Strengthening Families initiative in 1999, Angus recommended that national-level intersectoral initiatives should aim to get collective buy-in from, and accountability to, a team of Ministers.  If possible, common directives about the initiative should be given across agencies (e.g. in Cabinet minutes) and central government support should be formalised in priority-setting processes and accountability mechanisms (e.g. key result areas, purchasing agreements).

Lack of political support for the Healthy Cities concept at the central government level is cited as one important reason why several of these projects folded in New Zealand in the 1990s (Randle and Hutt 1997).

The HAZ initiatives also were destabilised by the introduction of a National Service Framework and continuing uncertainty from 2000 onwards about whether the UK Department of Health saw HAZs as a priority.  As a consequence of this instability, project timeframes were shortened, recruiting staff became difficult, and attention was increasingly given to newer types of local initiatives (Sullivan et al 2004).

**Government financial year**

Evaluations of the Community Renewal Project conclude that the July to June financial year of the Housing New Zealand Corporation (HNZC), as a government agency, did not fit well with local community processes and led to co-ordination difficulties and frustration.  HNZC's deadlines to achieve predetermined goals and objectives had 'the potential to negatively impact on the participation of community members in Community Renewal activities' (Nunns 2004: 17).  Flexible processes and timeframes are therefore recommended to encourage and respond to community participation (ibid.).

*The local government context*

At the local government level, political support from elected officials such as mayors and councillors can also be important.

Craig and Courtney (2004) note that in New Zealand local government is now mandated to promote wellbeing and community outcomes as part of its long-term planning processes through the Local Government Act 2002.

In Plymouth, UK, the commitment of local politicians to area-based initiatives is reported to have faded when a Conservative Party–dominated council was elected, replacing the previous Labour Party-dominated council (Office for Public Management 2001).

In the Manukau Healthy City project, the long-standing support from the city's mayor is recognised to be a key factor in its survival and success (Grey 1996). The same was found in other Healthy Cities, including Beijing (China) and Kuching (Malaysia), which are widely regarded as having two of the most successful Healthy Cities projects in the world (WHO 1997).

One factor contributing to the suspension of the Christchurch Healthy City project is that at the time no clear, formal mandate was given to the project from local health agencies or the city council (Grey 1996). This is in contrast, for example, to the mandate given by local agency partners to the Collaborative Case Management projects within the Strengthening Families initiative (Richardson 1999; Visser 2000b).

One reason why the Kawerau Community Injury Prevention initiative was found to be less successful is that the local council was not very supportive and was not generally using a community development model. By contrast, the more successful Rangiora initiative secured strong local council support (Simpson 1999). In the Waitakere Community Injury Prevention initiative, strong support from local government politicians resulted in safety issues being mainstreamed into the city council's activities, including planning and staff development processes (Coggan et al 1998c).

In the HAZ initiatives in the UK, choosing partners in 'simple' HAZ areas was found to be relatively straightforward, such as when a single local authority and a single health authority operated in the same geographic boundary. However, in more complex HAZ areas with multiple health and local authorities, it was less obvious who should be partners, and it was also much more difficult to bring them together (Matka et al 2002). Choosing partners was also found to be difficult in areas where competitive tendering processes had led community groups to see one another as rivals rather than potential partners (Matka et al 2002).

### *Limitations on freedom to act and make decisions*

The literature indicates that securing central or local government involvement or mandate for an initiative also can have its downsides. While high-level political and government support can confer several advantages, it can also be perceived by other participants in an initiative as limiting their freedom to act and make decisions.

Problems can occur, for instance, if Ministers or central government start trying to set priorities and agendas for community-based action, such as stipulating that certain health priorities are addressed. Other problems can occur if the funding agency 'changes the rules' midway through an initiative by, for instance, directing local initiatives to start following national agendas.

In the UK's Health Action Zones, for example, central government directives at times over-rode local processes. When HAZs were first set up, it was agreed that each HAZ would identify its

own priorities for action. However, all HAZs subsequently were instructed by central government to ensure they focused their work on four specific health issues (cardiovascular disease, cancer, mental health and waiting lists). This major shift in emphasis was considered to have undermined much of the commitment, confidence and trust that the HAZs had built up with local agencies (Bauld et al 2001).

At the start-up of the pilot Family Service Centres in New Zealand, some local provider groups were critical of the initiative because it had been implemented by government without consulting them (Kennedy 1994).

Many people involved in the ACC's ThinkSafe Community Projects commented that the injury-prevention areas that ACC had identified as priorities for the projects (road, work, community, sports and recreation) were not always the same as those of local communities. The way in which the priorities were chosen was also criticised for being 'top down' and not using a community development approach (Coggan et al 2003).

The Auckland Regional Community Action Project (ARCAP) on alcohol, which involved several Ministry of Health–funded organisations, agreed on five objectives to address alcohol-related problems among local young people. However, later in the project, the Ministry of Health advised that 70 percent of the work of these organisations should be directed towards these five objectives – a situation that some of the organisations had not understood. Some of the organisations were not keen to divert their efforts away from other priorities and towards regional rather than more local activities (Casswell et al 2003).

### *Limitations on ability to speak out*

Another risk of securing central or local government support or involvement for an initiative is that it may limit the capacity of lower-level workers in the initiative to fully voice their concerns or criticise various agencies, such as when community action goals conflict with corporate interests (Casswell 2000).

Difficulties may also arise if the individuals leading the work of an intersectoral initiative are employed by or based within a local city council or other local body agency. For example, an evaluation of the Manukau Healthy City project notes that 'there are undoubtedly difficulties in having advocates as Council officers' (Hutt and Scott 2000: 38). The report calls for more explicit internal discussion within the council about what the project co-ordinators can and cannot say as council employees.

(See also discussion on support from host and home organisations for decision-making in Section 3.)

## Other contextual features

The literature discusses other types of contextual factors that can influence the success of intersectoral working.

*Economic circumstances*

Features of the broader national or local economy can be important. In a situation where money is tight and resources are scarce, 'organisations often retreat to conducting their core business – they are less willing and able to address issues that fall outside their direct mandate' (Harris et al 1995: 60). However, in some instances scarcity can also encourage some organisations to try to work together more closely, with the aim of making better use of limited resources.

Other commentators note that securing political support for community-based intersectoral working is probably more likely in a period of economic growth or budget surplus, when governments are better able to afford to consider the health and social effects of policy decisions. An election year is also claimed to be a better year than most to seek political support, especially if voters are likely to be in a mood to support initiatives designed to improve the lot of the poor (FPTAC 1999).

More broadly, Crawshaw and Simpson (2002: paragraph 8.1) highlight the need to recognise that in most developed countries, including New Zealand, '[all] forms of social co-ordination mechanisms operate within a capitalist market. External factors stemming from the effects of the market influence local governance in whatever form'.

*Organisational pressures and change*

Another important element shaping the conditions for successful intersectoral action is the organisational context – the ways in which national-, regional- and local-level organisations operate and the pressures they experience (Harris et al 1995).

If an organisation is under extreme pressure, constantly reactive rather than proactive, or has a low organisational morale and history of failure, then it is unlikely to be in a position to participate effectively in the regular rounds of meetings and other relationship-building processes involved in intersectoral action. By contrast, organisations with a history of innovation and successful co-operative action are more likely to be a supportive partner in intersectoral action. Of course, these circumstances may be conditioned significantly by the various political and central government factors identified above.

In the Christchurch Healthy City project, the introduction of new public sector management systems involving inflexible deadlines, budgetary constraints and cutbacks was found to restrict the capacity of several organisations to participate effectively in new forms of intersectoral working (Grey 1996).

Similarly, the evaluators of the Waikato rural drink driving programme conclude that market-driven economic policies and retrenchments in public and private sectors had reduced the ability of local agencies to become involved in community action (Stewart and Conway 2000).

Evaluations of the four New Zealand ICAH projects conclude that restructuring of the health sector in New Zealand had contributed to delays in the development of these initiatives (Martin et al 2004).

During the HAZ initiative, major changes were made to the structure of the UK health system, including the demise of local health authorities and the development of Primary Care Groups

followed by Primary Care Trusts. These changes decreased the capacity of HAZ partners to work together in effective ways. The evaluators observe, 'Rapid change does not facilitate "joining up". Too much change too quickly can be counter-productive and at the very least amplifies the time taken for new collaborations to bear fruit' (Matka et al 2002: 100).

### *Timing and location*

Contextual factors related to the timing and location of a proposed intersectoral initiative can also be important.

Starting school-based projects at the wrong time of the school year, for example, can seriously undermine the effectiveness of projects.

The lack of success of the Christchurch Healthy City project is attributed partly to poor timing, with efforts to develop the initiative overlapping with a period of significant restructuring in the health and local government sectors (Grey 1996).

Research also indicates that intersectoral action can be problematic in locations where there is 'little organisational infrastructure or no sense of common responsibility for a particular population'. For example, intersectoral action may be easier to accomplish in rural or provincial centres rather than in larger metropolitan settings, because in the smaller population centres it can be easier to see the impacts of issues, such as drunk driving, and to identify the relevant stakeholders (Harris et al 1995). This seemed to be the case for the Safer Community Councils (SCC) initiatives, for which evaluation results suggest it was easier to publicise and build support for projects in smaller communities (Gray 1993).

Conversely, other research suggests rural centres with very small populations may not have enough local agencies to make certain kinds of intersectoral action viable, as the Collaborative Case Management projects within the Strengthening Families initiative experienced (Richardson 1999; Visser 2000b). A similar finding was made for small town Kawerau's community injury prevention initiative (Simpson 1999).

Travelling distances may also be an issue for workers or clients in rural initiatives. Some social workers in the Social Workers in Schools initiative found it hard to cover rural schools (Belgrave et al 2000), while transport was a problem for families from outlying rural areas in the Family Service Centre initiative (Ministry of Health 1997).

### *Beliefs and attitudes of the target community*

The values and beliefs of people in the communities where the intersectoral action is planned can also be important contextual influences. If a proposed initiative does not square with, or make sense to, at least a proportion of the community, then it is unlikely to get off the ground. On the other hand, if the core objectives of an intersectoral initiative in some way reflect the prevailing concerns or social movements in a community, this can be a positive step forward.

A key feature of the community nutrition initiatives was that their goals and ways of working dovetailed closely with the beliefs and philosophy of the Māori communities in which they were established (Pipi et al 1994; Moewaka Barnes et al 1998a, 1998b; Tunks et al 1998).

*Other factors*

Other related contextual barriers identified in the literature include: the presence of persistent 'turf wars' between local organisations and groups; a history of bad experiences with previous collaborative projects (which makes it harder to build or revive enthusiasm for intersectoral working); and the existence of so many different coalition projects in a community that it may be regarded as 'overcoalitioned' (Wolff 2001).

The context for intersectoral action can be shaped by other factors such as accidental or opportunistic events (e.g. forest fires or the death of a prominent person), new knowledge about an effective intervention, or the inspiration or commitment of a lone individual (Harris et al 1995).

For example, the deaths of several New Zealand children involving family violence, and the consequent growth in public concern, set the scene for Great Start Waitakere to be introduced in 2003 (Elizabeth 2004).

## (3)    Capacity exists to carry through the planned action

A consistent message in the literature is that successful intersectoral action is heavily dependent on the capacity of the participants and their host or home organisations to devote meaningful resources to the process (Harris et al 1995; FPTAC 1999; Kuhn et al 1999).  This includes resources to sustain the basic infrastructure for intersectoral working (e.g. meeting spaces, administrative support, employment of co-ordinating staff or project managers); and sufficient capacity in people's host or home organisations and in local community groups or other organisations (e.g. voluntary agencies, businesses, Mäori organisations) to contribute effectively to various kinds of intersectoral action or projects.

This section discusses these issues under two main headings:

- the capacity (infrastructure) of intersectoral groups – including: leadership; personnel (co-ordinators, volunteers and others); training; funding; time; accommodation and other physical facilities; support from host/home organisations; and other infrastructural resources
- the capacity of the community to participate – achieving community participation; who represents the community; failure to achieve community participation; building community capacity to participate; and participation by Mäori, Pacific peoples and young people.

## Capacity of intersectoral groups

The basic infrastructure for intersectoral working includes good leadership, suitable personnel, adequate funding, adequate time, suitable accommodation and other physical resources, and support from the host/home organisation.  These help to support the process of people from different organisations and groups meeting together to develop and sustain intersectoral action.

*Leadership*

The personal attributes of the people working at the front-line of community-based initiatives are recognised to be important factors shaping the chances of 'successful' intersectoral working (Mizrahi and Rosenthal 2001; Bourdages et al 2003).

The literature indicates that ideally the people leading the process of setting up and running an intersectoral group should have high-level verbal and written communication skills; a capacity to work well as team players in small and large group settings; an ability to build consensus; an ability to listen to and value the contributions of others; good negotiation and conflict resolution skills; and good management skills (accessing and packaging information, briefing appropriate people, handling publicity and media, etc) (Harris et al 1995). They should also understand the issues involved and the wider context in which they are working, and have good strategic and operational knowledge of existing community infrastructures (Harris et al 1995; Henderson 2001).

Another review observes that:

> ... special kinds of leadership and management are required to achieve the critical characteristics of a collaborative problem-solving process. This type of leadership and management is very different from what is needed to co-ordinate services or to run a program or organization. ...

> ... [T]he people who seem to be most successful do not function as traditional leaders and administrators, who tend to have a narrow range of expertise, are used to being in control, have their own vision of what should be done, and relate to the people they work with as subordinates rather than as peers. Instead, community collaborations appear to benefit from having leaders and staff who believe deeply in the capacity of diverse people and organizations to work together to identify, understand, and solve community problems. These kinds of individuals understand and appreciate different perspectives, are able to bridge diverse cultures, and are comfortable sharing ideas, resources, and power (Bourdages et al 2003: 30).

Desirable leadership attributes identified by Wolff (2001) include the ability to:

- share power rather than impose hierarchy
- look at things holistically in terms of the linkages between organisations and between people in the community
- be inclusive
- be proactive
- focus on both *process* and *product*
- take risks
- see the big picture
- demonstrate trustworthiness, patience, energy, hope
- resolve conflicts constructively
- communicate clearly and honestly
- nurture leadership in others
- foster commitment.

Alexander et al (2001) identify similar themes for good leadership in collaborative community health partnerships under five main headings: systems-thinking; vision-based leadership; collateral leadership; power sharing; process-based leadership.

The review of intersectoral working by Roussos and Fawcett (2000: 385) identifies various core competencies for effective 'partnership leaders' (i.e. the people responsible for organising and

managing partnership activities). These include: good communication, negotiation and networking skills; cultural competence; and the ability to facilitate meetings using democratic and consensus decision-making methods.

The review adds that in an intersectoral initiative, a variety of people can provide leadership or be part of a leadership team, depending on the stage of development of an intersectoral initiative, or other circumstances.

> Different leadership skills may be more useful during different stages of partnership development – in early stages of coalition development, leaders may require greater facilitation and listening skills to help engage a diverse and representative membership; later, when the partnership has built a strong identity and community presence, leadership skills may be needed in the area of negotiation and advocacy to bring about environmental changes (Roussos and Fawcett 2000: 385).

It is also noted by Roussos and Fawcett (2000) that initiatives organised around a leadership team or 'dispersed leadership' may be less vulnerable to 'manipulation, reduced efficacy, or dissolution' than initiatives organised around a single leader.

Personal skills and attributes of staff and/or governance members on the ICAH projects which key informants identified include:

- the 'right' individuals with the mandate to co-ordinate and develop the relationships
- extensive knowledge of the public sector and how to engage with them
- highly developed organisational skills
- 'good ideas' people and good at getting things done
- highly effective 'on the ground' at getting other sectors involved with 'what are essentially health issues'; for example, the NEW initiative
- flexibility and resilience
- an ability to engage with Māori and/or Pacific communities, or sincere in their efforts to consult with Māori and Pacific agency representatives
- good community links (including with iwi)
- very hardworking (Martin et al 2004: 162).

An evaluation of 25 USA partnerships for community health by Shortell et al (2002) found that good leadership skills were present in the five most successful partnerships. However, one of the least successful partnerships was made up of a coalition of 45 'prominent' leaders of the health care industry. The fact that this was an elite model with many individual leaders who were not working together as a whole group, and also the lack of more low-level community representation are thought to be reasons for the group's lack of success.

In the New Zealand context, an evaluation of partnership projects in Waitakere City observes that leading an intersectoral initiative is:

> ... a complex task, one that involves creative people management and the juggling of multiple agendas, accountabilities and tasks. It's a role that often is not recognised, nor appropriately resourced. We have coined a terms for these special people – 'strategic brokers' ... These brokers are special people, with enormous responsibilities in a

partnership context. They are nearly always overburdened and need to be better recognised (Craig and Courtney 2004: 14–15).

Evaluations suggest that members of the Moerewa Community Project team initiated, facilitated and provided leadership in the community, and that this leadership made an essential contribution to changing local alcohol and drug use (Greenaway et al 2004b).

The Christchurch Healthy City project's lack of success is partly attributed to the fact that it was run mainly by public servants who lacked some of the vital skills outlined above, including the ability to sell ideas (Grey 1996).

### *Personnel*

### Co-ordinators

Many intersectoral initiatives appoint a co-ordinator who assumes responsibility for much of the day-to-day management and administration of the initiative (Kuhn et al 1999). These functions include supporting and assisting interagency working by circulating information among partners (Ministry of Social Development 2003).

Having a dedicated co-ordinator is critical to the success of many intersectoral initiatives. Casswell (2000) observes that having at least one paid position in the community is essential for successful community action. Relying entirely on unpaid or voluntary labour is thought to make it hard to sustain continuity and a strategic focus.

The Waitakere Community Injury Prevention programme is considered to have been a success in part because it had co-ordinators assigned to the three parts of the project (Mäori, Pacific, general) (Coggan et al 1998c). Appointing co-ordinators from the local community is also judged to be a key element of the success of the Turanganui a Kiwa and Ngäti Porou community injury prevention programmes (Coggan and Simpson 1999).

The evaluators of the Huakina Mäori drink drive campaign partly attribute its success to the fact that it was well resourced financially, giving it scope to employ a co-ordinator (Moewaka Barnes et al 1996a).

A key success factor identified in the Turanganui a Kiwa community injury prevention programme is having a co-ordinator skilled in areas of community development and health promotion (Coggan and Simpson 1999).

Having co-ordinators and trainers skilled in nutrition and fluent in te reo also contributed to the success of community nutrition programmes for Mäori (Pipi et al 1994; Moewaka Barnes et al 1998a, 1998b; Tunks et al 1998).

Nearly all the community action projects included in SHORE/Whäriki's meta-analysis saw paid co-ordinators as essential to their success and the projects' sustainability. These co-ordinators were important in establishing 'continuity across the complex network of relationships' involved in the projects (Greenaway et al 2004a: 37). This network included relationships with project participants, community organisations, evaluators and funders. Co-ordinators were also responsible for administration and for giving projects a community profile. Where co-ordinator

positions were not filled, or when co-ordinators changed, it was difficult to keep volunteers, communication and processes working 'and the project suffered' (Greenaway et al 2004a: 38).

Compared with other SCAF sites, sites with a dedicated co-ordinator early on resulted in faster development of the project (Research and Evaluation Unit 2004).

The personal skills of the project co-ordinators are seen as critical to the success of the ICAH initiatives. 'Many of the projects have succeeded in attracting high-calibre staff that have stayed throughout the life of the project' (Martin et al 2004: 19).

However, the Waitomo Papakainga Tracker Programme covered in the SHORE/Whäriki meta-analysis did not have a paid co-ordinator as members of the whole whänau were contributing to the project, and having one paid worker was seen to be inappropriate (Greenaway et al 2004a).

The *Mosaics* review cautions that the co-ordinator's role should be clearly defined so he or she does not end up doing most of the work for the initiative (Ministry of Social Development 2003: 28).

Coggan and Simpson (1999) conclude that requiring co-ordinators of the Turanganui a Kiwa and Ngäti Porou community injury prevention programmes to do all their own administration as well as organise activities was detrimental to their performance.

Likewise, the evaluation of Safer Community Councils concludes that co-ordinators would have benefited from administrative assistance (Gray 1993). As well, project managers would have been useful for handling projects initiated by the local SCC itself (rather than those funded by the SCC but initiated by other agencies). Often co-ordinators did not have enough time to do this work themselves on top of their existing workloads (Gray 1993).

**Volunteers**

Many intersectoral initiatives for health rely on the work of volunteers to keep them running.

The ICAH projects were well-supported by the provision of a large number of hours on a voluntary basis by the ICAH groups themselves. This meant that the total costs of the projects were considerably more than was shown by the funding provided (Martin et al 2004).

Heartland Service Centre co-ordinators and intensive home visitor staff also ended up providing some of their work on a voluntary basis (CBG Health Research 2004; Family, Child, Youth and Community Research and Evaluation Unit 2004).

While volunteer work did contribute to the success of community nutrition programmes, some of those on the management group of Te Taro o Te Ora thought they should have been paid for their expenses and some of their time (Tunks et al 1998).

In the Take Ngakau Kaikohe Intersectoral Project, the project steering group was provided with a meal in comfortable accommodation during their regular meetings. The project team's purpose behind this action was to recognise the voluntary nature of the steering group members, provide networking time and encourage working. Many local people supported this approach; however, others thought it was extravagant and unnecessary (Henwood and Adams 2003).

**Other personnel**

Personnel other than project co-ordinators can also have an influence on the success of intersectoral initiatives.

Among the AIMHI schools, Full Service Education was more effective in schools where mature, experienced and confident people were employed as social workers, community liaison officers and student mentors.  Employment of registered nurses and support for professional development of school nurses are also seen as positive features (Thomas et al 2003).

In ACC's ThinkSafe Community Projects, the skills of ACC's injury prevention consultants were considered crucial to the success of the projects.  Stakeholders commented that the consultants needed the following skills: 'injury prevention content knowledge; effective and respectful communication skills; cultural awareness; ability to successfully negotiate with many stakeholders; and project management skills' (Coggan et al 2003: 133).  The skills of the existing consultants were highly regarded, with the stakeholders emphasising the importance of maintaining these skills.

In the Te Runanga o te Rarawa Community Action on Youth and Drugs (CAYAD) initiative, the CAYAD worker acted as a role model for young people through his drug-free lifestyle and strong involvement in various sports (Henwood et al 2001).

*Training*

Training opportunities, or management practices that encourage and reward expertise in working intersectorally, can be useful for fostering the various leadership and co-ordination skills described above.

Craig and Courtney (2004) identify the need to further develop the skills of the people leading partnership projects, including those based in local government, central government and the community sectors.  Setting up dedicated training courses is one option.

In the USA, the National Public Health Leadership Institute runs a team-based, collaborative public health leadership training programme (Umble et al 2005).  The central aims of the training programme are to develop collaborative leaders who convene or participate in partnerships, and to strengthen national networks of leaders who trust one another, share knowledge, and work together to improve public health.  The learning projects in the 12-month programme include leadership style assessments, personal feedback and coaching, assigned readings, interactive lectures/discussions, case studies, contact with expert practitioners, and team projects.

Because of funding restrictions, formal training in community development skills was not normally provided in the initiatives examined by SHORE/Whäriki's meta-analysis.  Only advisory support or supervision could be provided to the co-ordinators in most of the 10 community action projects..  Sometimes members of the evaluation team assumed an advisory and skills development role, while in other situations project co-ordinators simply learned through trial and error (Greenaway et al 2004a).

In the Take Ngakau Kaikohe Intersectoral Project, the project co-ordinator participated in a six-day community development training course and also enrolled in a block course in health promotion (Henwood and Adams 2003).

While feedback on the work of Heartland Service Centre co-ordinators was generally good, they received no training for their jobs. The evaluation of the initiative suggested this may have led to uneven services in different geographic locations and sometimes to difficulties for co-ordinators in identifying which services best met their clients' needs (Family, Child, Youth and Community Research and Evaluation Unit 2004).

In the Health Promoting Schools initiative, local co-ordinators were generally only experienced in health, education or social work and needed to be trained in a number of new skills relating to the Health Promoting Schools philosophy before they actually started working with schools (Dowden and Kalafatelis 1999; Wyllie et al 2000).

Evaluation results indicate some stakeholders had concerns about the level of training given to whänau/family workers employed in the Family Start programmes. Workers underwent an initial five days' training when they started with the programme, but this was considered to be of insufficient depth for their roles. In addition, in at least one Family Start site the skill levels of the staff who were recruited were questioned and were said to discourage referrals to the programme (Evaluation Management Group 2003).

### *Funding*

**Level of funding and workloads**

In general the literature indicates that intersectoral working and effective collaboration is more challenging and complex than working alone, and the level of funding provided by participating organisations should recognise this fact (Kuhn et al 1999; Miller and Ahmad 2000).

Shortell et al (2002) note that managing within limited resources is a characteristic feature of partnerships for community health.

The *Mosaics* review observes that:

> ... the fieldwork participants sent the clear message that collaboration can improve the use of existing resources, but cannot make up for a lack of sufficient resources. Nor can collaboration itself solve funding problems, legislative limitations, or a lack of skilled practitioners (Ministry of Social Development 2003: 3).

In the national Safer Community Councils initiative, funding was considered to have been spread too thinly across the 65 individual local SCCs, making it difficult for them to support local crime prevention programmes (Crime Prevention Unit 2003).

Due partly to unrealistic expectations on the part of the intersectoral group running the initiatives, nearly all the community action projects in SHORE/Whäriki's meta-analysis received less funding than they had hoped for. They also found it difficult to negotiate changes to contracts because of a lack of formal contract-renegotiation opportunities, and because of undeveloped negotiating skills (Greenaway et al 2004a).

The requirement to manage a large number of intersectoral relationships can considerably increase the workloads of organisations involved in case management initiatives. For example, organisations that provided social workers for the Social Workers in Schools initiative were unprepared for the 'level of support necessary to maintain the important networks required' (Belgrave et al 2002: 11). This sometimes led to a breakdown in relations between schools and their social workers (ibid.).

Organisations involved in the Christchurch Youth Drug Court pilot project, including government agencies and service providers, regarded the increased communication, co-ordination and teamwork with other sectors produced by the project to be a very positive development. However, they identified significant additional costs associated with achieving and maintaining this level of interaction, and indicated a need for additional funding if the project was extended (Carswell 2004).

Evaluations of the UK's Health Action Zones also showed that maintaining cohesiveness across differing agencies at the local level was reliant on staff putting considerable time into keeping other people in the loop, giving briefings, running planning sessions and generally communicating and sharing (Bauld et al 2001).

**Shared funding and budgets**

Larner and Butler (2003) observe that the whole of government approach that arose out of the Review of the Centre (Advisory Group on the Review of the Centre 2002) enabled single government contracts to be developed, where local partnerships are funded by several government agencies to generate multiple outcomes.

Shared budgets occurred in the ICAH initiatives for individual projects such as the AIMHI Healthy Community Schools Initiative and the GAPsproject in Counties Manukau.[3] The Tu Maia project in the Northland ICAH also budget-shared with Work and Income to support community workers in schools. In the Counties Manukau ICAH, some of the individual projects have been funded intersectorally. This joint, intersectoral funding of projects is seen to make financial sense especially if the projects are likely to produce a positive result for a range of sectors, such as health, welfare and education (Martin et al 2004).

**Funding instability**

As well as the level of funding, the short-term nature of funding for intersectoral initiatives for health has often been identified as a significant issue.

Larner and Butler (2003) observe that New Zealand is still in a period of innovation and experimentation with partnership projects, with a lot of local partnerships set up as one-off initiatives running on short-term or seed funding. This 'short-termism' and lack of stable, long-term funding can be detrimental in several ways.

One problem is that it can increase the pressure on project participants to concentrate on achieving shorter-term or perhaps more limited goals, in order to prove 'effectiveness' and

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[3]   The GAPS project was an element of the Youth Interagency Project. It aimed to 'reduce the number of young people with high needs 'falling through the gaps' of services' (Martin et al 2004: 112).

secure further funding (Bauld et al 2001). This can overwhelm the work aimed at achieving longer-term goals.

Funding uncertainties can also undermine the confidence of workers and other collaborating agencies. Staff can end up spending most of their time fundraising, rather than getting on with their core tasks (Bauld et al 2001).

In the United Kingdom, Bauld et al (2001) note that one destabilising feature of Health Action Zones was that they were persistently labelled as 'pilots' or 'trials' rather than being 'mainstreamed' and accepted as a core programme with a solid future.

One reason the South Auckland pilot Wraparound service had difficulty in attracting skilled case managers was that the service had a relatively short timeframe (2¼ years) (Centre for Research, Evaluation and Social Assessment [CRESA] 2000).

This lack of commitment to long-term investment in intersectoral projects has led to a degree of scepticism in some quarters about the motives underlying intersectoral action for health. *Working Together* notes, '... there are many examples of lack of ongoing support which has led to the perceived failure of projects, and to a consequent belief that the health sector is interested in intersectoral activity only as a means of cost shifting' (Harris et al 1995: 95).

### Time

Closely linked to funding themes is the issue of the length of time required to develop and implement effective intersectoral action. This includes developing relationships, developing activities and waiting for outcomes.

The literature indicates that effective intersectoral relationships and joint action usually take considerable time to develop (Harris et al 1995; Kuhn et al 1999; Casswell 2000). They cannot be expected to happen quickly, especially if the participants have not worked together before, or if there is a large number of disparate organisations and groups involved.

The *Mosaics* review notes that 'Building good relationships takes considerable time. Many successful regional coordination groups are the result of relationships built up over a number of years' (Ministry of Social Development 2003: 17). The review adds:

> Collaborative initiatives often face unrealistic demands or inadequate timeframes. Centrally-developed initiatives need enough time to be developed for local circumstances, and long-term performance measures to properly evaluate their success (Ministry of Social Development 2003: 37).

*Mosaics* further observes that 'Staff need sufficient time to build relationships. Local managers must enable their staff to be flexible and creative with the resources available, and manage workloads so staff have time to focus on relationship-building' (Ministry of Social Development 2003: 36).

This need for sufficient time to be given for intersectoral initiatives to evolve and mature has inevitable implications for organisational capacity and resourcing. It is repeatedly stated in the

literature that successful and effective intersectoral working relies on the commitment of stable resources over an extended period of time – typically several years, not just a few months.

As Angus observes, reflecting on his experiences with the Strengthening Families initiative, 'A serious foray into collaboration needs a long term commitment of resources, and is not to be undertaken lightly' (Angus 1999: 5).

In the case of Family Service Centres, fully establishing the six pilot centres initially had been estimated to take six months, but in reality took much longer (Ministry of Health 1997).

In the UK's Health Action Zones, relationship-building that initially was expected to take only two or three months to complete in many instances took a year or more to achieve (Bauld et al 2001).

In many schools, the Health Promoting Schools initiative tended to remain on the fringes for the first few years. Some schools took as many as three years to implement any concrete Health Promoting School activities (Dowden and Kalafatelis 1999; Wyllie et al 2000).

In the case of the SCAF sites, which were funded for four years, project progress was slow and some issues were still unresolved by the end of the funding period. However, evaluators commented that 'devolved models required a long lead time especially where there was little existing infrastructure and few community organisations' (Research and Evaluation Unit 2004: 12–13). Even when projects were relatively successful, some issues were still unresolved at the end of the four years. For instance, in Ranui conflicts remained over Māori participation, project leadership and maintaining community interest. These issues were being addressed through a mediation process, with working through and resolving these issues seen as a normal, necessary and time-consuming part of community development (Research and Evaluation Unit 2004).

Some of the objectives of the community renewal projects were able to be achieved in the initial three- to four-year timeframes for which they were funded. However, other objectives, particularly objectives relating to community development, leadership and capacity building, were assessed as needing 'substantially longer time frames and ongoing investment' (Nunns 2004: 14). 'Creating sustainable change at the community level takes time and sustained investment, particularly in communities that have experienced long term disadvantage' (Nunns 2004: 19).

The SHORE/Whāriki meta-analysis of 10 community action projects also emphasised the importance of adequate time for initiatives to build relationships and plan project structures and activities. According to the project teams in the SHORE/Whāriki meta-analysis, three years was not long enough for projects to bring about social change. Funding for five to 10 years was perceived as more realistic. One interviewee (a funder) said, 'I think in some ways some of the projects that have taken the longest amount of time have ended up being the best which might suggest that that is a key part of the development' (Greenaway et al 2004a: 36–37). Extra time was required especially in situations where groups had been working previously on a purely voluntary basis (ibid).

Of the three evaluated Family Start programmes, the programme run by a single, well-established iwi provider had the advantage of not having to commit energy and resources to establishing and maintaining a coalition board. By contrast, the other two sites had to build their

coalition partnerships at the same time as develop their Family Start organisations (Evaluation Management Group 2003). This led some of the participants in the latter two projects to feel insufficient time had been provided for them to get the service up and running.

### *Accommodation and other physical facilities*

Adequate accommodation and other physical resources also assist in the development of intersectoral initiatives for health.

The evaluation of the Full Service Education in AIMHI schools project concludes that services were more effective in situations where adequate accommodation space and other physical facilities were provided for social, community and nursing services. This encouraged good communication and collaboration between school support team members. However, it identifies a need for school nurses to have access to answerphone/voicemail facilities (Thomas et al 2003).

The evaluation of Heartland Service Centres suggests that a lack of prominently signposted premises may have contributed to the relatively low public profile of the service. Other accommodation features were also important, such as having buildings with an inviting outward appearance, easy access to people with mobility disabilities, private meeting spaces, separate telephone lines and access to the Internet. Several centres were located in Work and Income or Courts buildings – this was seen as deterring some people from using Heartland Services (Family, Child, Youth and Community Research and Evaluation Unit 2004).

The Mangakino SCAF project had difficulty in finding suitable accommodation, and participants experienced ongoing frustration in trying to establish a base. An attempt to purchase a SCAF project community house as a centre for a number of activities fell through and uncertainty remained about whether the SCAF project could be based in the town's new community hall complex and centre (Conway et al 2003b).

Other accommodation issues that may shape the effectiveness of intersectoral projects include the positioning of buildings where an initiative's front-line workers are located. In the Family Service Centre initiative, pilot projects with buildings located at the heart of communities were more successful at engaging people than those projects located at the periphery (Ministry of Health 1997).

### *Support from host/home organisations*

This section refers to the support given to individuals participating in an intersectoral group by their host or home organisation. The work of groups running intersectoral initiatives for health is helped if their host/home organisations:

- support the initiative throughout the whole organisation
- have clear decision-making processes
- allow local staff to make decisions.

### Support throughout organisations

Initially, engaging in intersectoral action for health may not be regarded as part of an organisation's core business, especially perhaps by middle and senior level managers in an organisation. They may perceive intersectoral working as risky, involving potentially a loss of a

degree of freedom to act independently or an investment of 'scarce resources and energy in developing and maintaining relationships with other organisations when the potential returns are often unclear and intangible' (Harris et al 1995: 56).

However, *Working Together* observes that 'the more levels of management that are involved in and support a project the more likely the project is to be successful and maintained' (Harris et al 1995: 67). This kind of support is important for protecting and strengthening the work being done by individuals within an organisation as part of an intersectoral initiative. If only part of a particular sector or organisation is committed, or if there is disagreement or conflict within a sector or organisation about the value of the intersectoral action (for example, if people lower down the hierarchy get little or no support for their work from their senior managers), then successful intersectoral action is less likely.

The World Health Organization identifies strengthened *intra*sectoral action within the health sector as a vital starting point for advancing a greater degree of *inter*sectoral action beyond the health sector (WHO 1997).

Evaluation results from Health Action Zones indicate that in some cases vertical linkages within a sector (say, between central and local agencies) had been compromised when the priorities and expectations of parent organisations or departments differed substantially from those of the local staff on the ground (Bauld et al 2001; Henderson 2001).

In the case of the unsuccessful Christchurch Healthy City project, where the initial stimulus for the project came from individual staff within a small number of organisations, one of the difficulties these people faced was that formal organisational support for their work was not expressed in job descriptions or within agency structures (Grey 1996).

Similar issues arose in the Waikato Rural Drink Drive initiative because some members of the initiative's co-ordinating group did not have a mandate in their job descriptions to contribute to the project (Stewart and Conway 2000).

A key ingredient in the success of the Strengthening Families project was identified as the good leadership shown by individuals at many levels of key agencies. They created a vision, built enthusiasm, legitimated the programme and 'sold the message' (Angus 1999).

The most successful Health Promoting Schools had an enthusiastic principal, a supportive Board of Trustees and a well-established health team (Dowden and Kalafatelis 1999; Wyllie et al 2000).

**Decision-making**

A further necessary element of organisational support is that each of the participating organisations has clear and easily understood decision-making processes. If these processes are too complex or opaque, or are in a state of flux (say, because of internal restructuring), it can be difficult to identify who has influence or responsibility in an organisation to support intersectoral work.

Hierarchical structures within organisations, where there are long chains-of-command involved in obtaining decisions, can also be detrimental to effective intersectoral action. Such structures

can make it difficult for lower-level staff to readily agree to proposals developed in conjunction with other agencies.

To enhance the scope for effective partnerships at the local level in New Zealand, Craig and Courtney (2004) call for the setting up of clearer local and regional accountability frameworks, better delineation of mandates for action at different levels of government, and the introduction of stronger incentives for agencies to engage in joint strategic planning with one another.

In general, the literature suggests that intersectoral working at the local level is enhanced when there is a degree of devolution of power from the centre to the periphery (for example, to the new local collaborative management groups established in Health Action Zones) (Bauld et al 2001).  The FPTAC (1999) notes that people within intersectoral partnerships should be as free as possible to act (and make decisions) as individuals.  Their participation and actions should not be tied too closely to the agenda of their own organisation.  They should also not be overly-constrained by rigid, impractical timeframes.  Realistic and flexible timelines are regarded as more compatible with managing the complexities of intersectoral working (Harris et al 1995).

The *Mosaics* review identifies that:

> Government at the centre needs to enable local managers to implement policy in a way that suits the local environment, and achieves broader policy outcomes.  This means developing greater trust in local representatives, and developing accountability systems that measure how well managers meet local needs as well as organisational accountabilities (Ministry of Social Development 2003: 34).

In an evaluation of the Manukau Healthy City project, some respondents note that the capacity of the signatories to the Charter to make decisions, and act in ways that supported the goals of the project, was often constrained by the fact that they were regional or local managers of agencies, with their budgets controlled from Wellington (Hutt and Scott 2000).

(See also discussion on limitations on freedom to act and make decisions, Section 2.)

### Other infrastructural resources

The Porirua and Kapiti ICAH projects received a considerable amount of 'in kind' resources from participating agencies and provider groups, including help with accounting (paying salaries and auditing) and rent-free accommodation (Martin et al 2004).

Evidence from the SHORE/Whāriki meta-analysis of 10 community action projects indicates that funders sometimes assumed an existing community group had sufficient infrastructure to run an intersectoral initiative, when in fact this was not so.  This situation was especially likely for groups that relied heavily on voluntary labour and donations (Greenaway et al 2004a).

Established intersectoral groups also need resources for the collection and dissemination of information (including research) indicating how and why a proposed form of action has the potential to be effective, and how the different partner organisations involved understand the issue (Harris et al 1995).  In addition, there must be facilities and processes in place for participating organisations to retain knowledge relating to an initiative, to guard against the loss of 'institutional memory' when key people move on.

## Capacity of the community to participate

The literature indicates that the capacity of community and volunteer groups, as well as 'grassroots' members of the community, to participate in the planning and implementation of intersectoral health action can be highly variable. While securing the participation of these kinds of groups in the development of intersectoral action is a desirable and in many cases vital goal, achieving it in practice can be difficult (Chavis 2001).

### *Achieving community participation*

In some New Zealand initiatives, a high degree of community participation has been achieved.

For example, in the Ranui SCAF site, increased community participation and community capacity occurred during the project. An increased understanding of community ownership of the SCAF project and increasing community pride and optimism were also recorded. Community engagement was fostered in Glen Innes and Whakatane by bringing together community groups to address shared objectives. Mangakino also reported the involvement of a diverse range of community networks in its implementation committee (Research and Evaluation Unit 2004).

The degree of community participation and sense of community developed in the Moerewa Community Project in Northland were so strong that eventually the project Trust group declared they were 'no longer prepared to compromise their control over community issues ... even if it means having to forgo funding opportunities' (Greenaway et al 2004b: 15). This meant they rated their accountability to the wider community very highly, ahead of the priorities and requirements of funders.

### Engaging existing organisations and groups

As discussed in Section 1 above, in general, New Zealand initiatives that have aimed to engage existing local organisations as partners (or funders) – including the voluntary sector, local businesses, Mäori organisations, and established interest groups – have worked well. This has been particularly so in localities with a history of and infrastructure for 'community' involvement.

For example, in New Zealand, community action, at least in the alcohol area, has tended to focus on working alongside existing community organisations, rather than relying on 'grassroots' development by ordinary community members (Casswell 2000). In fact, a key ingredient in the success of Mäori community alcohol action projects appears to be the decision to involve mainly existing organisations with high standing among Mäori, rather than attempting to create new groups made up of 'flaxroots' community members (Moewaka Barnes et al 1996a, 1996b).

Similarly, for community nutrition initiatives developed in partnership with Mäori communities, a critical 'success factor' was the presence of existing Mäori community networks (iwi organisations, marae and kōhanga reo) to help spread nutrition messages (Pipi et al 1994; Moewaka Barnes et al 1998a, 1998b; Tunks et al 1998).

The experience of Safer Community Councils appears to have been similar. They chiefly engaged representation from established community organisations, local businesses and agencies rather than 'grassroots' people, despite making efforts to include members of target groups (e.g. youth) on some committees (Gray 1993).

### Who represents the community?

Determining how community representatives will be selected and mandated by a community is an issue, especially in situations where the community sector is polarised or fragmented into competing factions or interest groups.

In their review of 25 'headline' local partnerships in New Zealand, Larner and Butler (2003) observe that the definitions of 'community' and who represents the community are becoming blurred. For example, local authorities sometimes claim to speak on behalf of their communities, whereas in other situations they try to encourage wider consultation and participation from others. This infers they do not adequately represent the community, at least with regard to certain issues.

Māori organisations such as iwi Trust Boards and/or runanga are often 'intermediate institutions' holding funds and employing initiative staff. That is, they are the providers of the initiative. At the same time they are representing and acting on behalf of their communities.

### Failure to achieve community participation

At the outset of an initiative, community and voluntary agencies cannot be expected to have the same degree of power as statutory organisations. They do not have the same resources, infrastructure, access to information or historical continuity, and need to be supported to gain capacity in these areas before they can participate on a more equal footing (Matka et al 2002).

Other impediments to community participation can be perceptions in the community that initiatives funded or led by government serve mainly bureaucratic or political ends, rather than being genuinely committed to improving the community's health and social problems in any significant way (Heenan 2004).

In New Zealand, initiatives that have tried to involve more loosely defined groups of 'flaxroots' community members or individuals (rather than existing community groups), particularly in strategic planning processes, have often failed to attract sufficient participation. The main reasons for this appear to be a lack of available time, resources and motivation of community members or citizens, especially if they are socially or economically disadvantaged and experiencing adversity in their lives (Ministry of Social Policy 2000).

Evaluations of the UK's Health Action Zones indicate that the capacity, ability and willingness of different community and voluntary agencies to participate in strategic planning varied a great deal (Centre for Urban and Community Research 2001).

A commentator on Health Action Zones reports that 'One of the most challenging aspects of partnership working is the development of meaningful working relationships with communities and service users. For many professionals this is more threatening than interprofessional working' (Amery 2000: 29).

The evaluation of Social Workers in Schools (SWIS) identifies a lack of community involvement in the management of these initiatives in some schools. There was no systematic way of including stakeholders and the community in the governance of SWISBelgrave et al 2002). Other schools had management groups that included the provider organisation, social worker and school representatives, and sometimes advisory groups to advise on specific issues (ibid).

The Take Ngakau Kaikohe Intersectoral Project produced a regular monthly newsletter to communicate with around 50 community groups and keep them informed. However, only a few of these groups contributed to the newsletter and the production ceased after six months due to a lack of return for the work involved. Instead a positive relationship was developed with the local print media, who reported project events in the free community newspaper (Henwood and Adams 2003).

Other evaluations suggest that generating community involvement takes time and generally is not well done by health agencies (Sullivan et al 1999). Also noted is the risk that community involvement processes will be hijacked by professionals or dominated by particularly vocal community groups (Randle and Hutt 1997).

**Consultation fatigue**

In some reports, lay people or community organisations complain of not being consulted enough, of having little influence over decisions, and of not being appreciated for their expertise and experience (Sullivan et al 1999). By contrast, other reports refer to 'consultation fatigue', where certain groups complain of being consulted by all and sundry, to the point of exhaustion.

Participation by community and voluntary groups in the UK's HAZ initiatives appears to have been limited in some cases by the very large number of organisations operating in some areas. In other areas with a relatively limited number of community and voluntary groups, members of these groups were often overworked in trying to meet the expectations of the different intersectoral initiatives running in their area. Sometimes local umbrella groups such as the Council for Voluntary Services or Community Health Councils took part in initiatives on behalf of their member organisations. However, the workloads for these umbrella groups tended to be very high, and their representativeness was sometimes questioned (Matka et al 2002).

In the New Zealand context, Craig and Courtney (2004) warn that, because of its complexity, one of the potential dangers of involvement in intersectoral working is that it can wear participants out, especially community people.

*Building community capacity to participate*

Some studies highlight the importance of carefully assessing existing community capacity before embarking on intersectoral action (Simpson 1999). It may then be necessary to build the community's capacity to participate in this action.

Suggested ways to encourage greater community participation in intersectoral action include building on existing mechanisms, maximising use of local authority and voluntary sector resources, identifying 'champions' within communities, and establishing new mechanisms to engender public-orientated perspectives (Sullivan et al 1999).

A New Zealand review of models for effective community–government partnerships concludes that community representatives should be properly supported and resourced, so they can play a full role in these partnerships (Ministry of Social Policy 2000).

The SHORE/Whäriki meta-analysis of 10 community action projects found that community participation was high in projects that operated with good accountability mechanisms. This meant project teams had to find ways of communicating with appropriate organisations and individuals about what they were doing and why. They also had to strategically involve these people in the development of the project (Greenaway et al 2004a: 34).

Early consultation with the wider public, for example through a needs assessment, can raise community awareness and encourage later community participation and buy-in.

For example, high levels of public consultation about the needs of their community resulted in high levels of public awareness of the project and inclusion of a 'community voice' in the SCAF pilot sites (Research and Evaluation Unit 2004).

The initial community meeting set up by the Take Ngakau Kaikohe Intersectoral Project involved about 60 people who indicated 'general support for the project and an interest in participating and strengthening the community by working together' (Henwood and Adams 2003: 28). They also spoke about a range of issues relevant to the health of people living in Kaikohe. People who were interviewed for the evaluation had no doubt that the project was needed in the area. Nevertheless, the timing of the meeting (several months after the project started) was criticised by some members of the community as being too late in the process. Setting up the contract with the Ministry of Health had taken a considerable length of time, and the community was frustrated and disappointed about not being involved in early decision-making at the proposal stage (Henwood and Adams 2003).

### Māori participation

The *Mosaics* report suggests:

> Iwi and Mäori groups identified that government agencies must support Mäori in building the infrastructure required for successful collaboration. They also need to understand the diverse needs of iwi and Mäori organisations, rather than taking a 'one size fits all' approach (Ministry of Social Development 2003: 8).

Iwi and Mäori groups also stressed that government agencies, individually or on a whole-of-government basis, need to work in partnership with mana whenua to:
- identify the aspirations and needs of Mäori, and identify where these needs are not being met
- build the capacity of government agencies and Mäori organisations to deliver responsive services
- ensure that resources are available to support Mäori communities
- create appropriate decision-making, governance, monitoring and evaluation processes
- make services accountable to Mäori as well as government

- address issues for Māori that affect collaboration, such as contested boundaries, different priorities, and different stages of Treaty of Waitangi settlement. (Ministry of Social Development 2003: 53).

The *Mosaics* report (Ministry of Social Development 2003) also identifies several factors impeding collaboration between mainstream agencies and iwi and Māori groups:

- agencies taking a 'one size fits all' approach to Māori, rather than recognising the diversity of Māori aspirations

- a lack of commitment and consistency in government agencies' approaches to Māori issues

- a lack of information related to the effectiveness of collaboration for Māori outcomes.

Duignan et al conclude that when working with Māori:

> Projects need explicitly to address how they are responding to the Treaty of Waitangi, provide for input from Māori in project development and implementation, create a culturally safe environment for Māori, monitor levels of Māori involvement, and attempt to assess impact for Māori (Duignan et al 2003: 7).

The evaluation of Manukau Healthy City also concludes that there were still issues to work through in terms of involving Māori of the area as joint partners in the initiative:

> It was generally considered that Māori in the community did not know or understand what Manukau the Healthy City – Te Ora o Manukau was about. It was expressed that this was due to the complexity of the message and the way it was delivered, which did not engender understanding or promote participation by members of the community (Hutt and Scott 2000: 30).

However, based on their experience of intersectoral working in Waitakere City, Craig and Courtney (2004: 12) conclude that '... Māori understandings of partnership differ to that of non-Māori. For many Māori, partnership is akin to the "Big P" partnership, i.e. the Treaty of Waitangi. Many Māori prefer to talk about relationships rather than partnerships'.

They add that there is debate among Māori about what should be the place of the Treaty of Waitangi in partnership contexts. 'In practice, local partnerships can be seen as either Treaty based (a comprehensive sharing of resources and responsibilities), Treaty influenced, or Treaty referenced (just mentioning the Treaty in documents)' (Craig and Courtney 2004).

Larner and Butler (2003) also note that the concept of 'partnership' is most commonly understood by Māori to mean the Partnership between Māori and the Crown under the Treaty of Waitangi. Other types of relationships are not described as partnerships.

Evaluation of the Mangakino SCAF site found there had been a high level of participation among Māori. Māori were positive about the representative nature of the project's management team and felt that Māori had the 'opportunity to be involved in decision-making from which they had previously been excluded' (Taylor 2004: 77).

The Glen Innes Health Project was also reported to have been particularly successful in achieving Mäori participation in its working group and in some of its initiatives such as Te Awhi Tangata (Scott and Conway 2005).

While the Ranui Action Project achieved considerable participation of Mäori members of the public in its activities on the ground, it had persistent challenges in regard to working under the Treaty of Waitangi at the governance level. These arose because there were different understandings and views on the Treaty within the project committee and between society members, leading to ongoing tensions (Conway et al 2003a; J Adams 2004).

A relatively large project committee of 16 was set up for the RAP so there could be adequate Mäori and Pacific representation. However, Mäori were not happy with the three committee positions they were allocated and it was difficult to maintain a high level of participation by all 16 committee members (Conway et al 2003a).

Mäori were expected to comprise a significant proportion of client families involved in Strengthening Families Collaborative Case Management. However, consultation with Mäori at the establishment phase of the initiative was assessed as 'minimal', as was iwi and other Mäori representation on local management groups. This lack of participation was attributed by several local co-ordinators to: time constraints affecting Mäori organisations; a perception that the initiative was a forum for (government) agencies only; the slowness of local management groups to recognise the importance of including Mäori; and local management groups' inability to engage with Mäori in a creative way. While Mäori expressed support for the concept of collaborative case management, they also pointed out that similar, parallel services were being provided by marae, rünanga and other Mäori providers (Te Puni Kökiri 2001).

In Tauranga Moana, a Mäori caucus was set up comprising local iwi, hapü, statutory agencies and Mäori community workers. Caucus members participated at an early stage of the initiative and developed programme protocols. However, later on the caucus withdrew its input due to a feeling that members were being constantly overlooked and ignored (Bennett 2002).

Mäori interviewed for the ICAH evaluation emphasised the importance of being able to choose their level and method of participation in a project. In practice, Mäori participated in all four ICAH initiatives, although the nature of this participation differed for each initiative and depended on the local situation (Martin et al 2004).

- Apart from in Northland, the ICAH initiatives found it difficult to retain Mäori participation in their governance groups.

- In Kapiti, iwi worked in partnership with the ICAH steering group (the Trust), rather than having positions on the group, to ensure that their aspirations were not diluted by inclusion within the group.

- In Porirua, a Mäori caucus formed part of the governance group. Mäori contributed to programme and project development at all levels, and processes were established for reviewing and improving relationships between Mäori and other participants.

- In both Kapiti and Porirua, the ICAH project regularly met with iwi rünanga and supported local Mäori health initiatives.

- In Counties Manukau, Māori participation in the ICAH occurred mainly through government agencies and to some extent the Tainui Māori Co-Purchasing Organisation (MAPO). However, Māori and Pacific peoples made considerable input to individual projects.

- In Northland, all three service providers participating in the ICAH project represented Māori and provided 'for Māori by Māori' services and projects (Martin et al 2004).

### *Pacific participation*

This literature review has identified only two intersectoral initiatives specifically for Pacific peoples living in New Zealand – Peaceful Waves/Matangi Malie and the Pasifika Healthcare Gardening Project. Other initiatives, like Great Start Waitakere, have contained Pacific sub-projects.

Greenaway et al (2004a) agree that 'by Pacific for Pacific' community action projects are relatively rare in New Zealand.

Pacific peoples consulted for the *Mosaics* report indicated that '... strengthening the responsiveness of government service delivery and building the capacity of Pacific groups to develop and deliver services to their communities is crucial to improving outcomes for Pacific groups' (Ministry of Social Development 2003: 8). These measures include ensuring the Ministry of Pacific Island Affairs has a much stronger role in co-ordinating collaboration among government agencies and Pacific peoples, including co-ordinating funding to make better use of existing resources, ensuring information reaches all relevant groups, and ensuring accountability for the way resources are used.

Further feedback from participants in the *Mosaics* study (Ministry of Social Development 2003: 68) suggests that government agencies should adhere to the following good practice principles when undertaking single or joint consultation with Pacific peoples:

- pay for participants' time and expenses

- support representatives to take feedback back to their communities

- involve the community in the design of consultation so issues are framed in a meaningful way, and attitudes and values of Pacific peoples are taken into account

- show what has changed as a result of consultation

- use culturally appropriate means of consultation (such as community venues and language assistance).

Craig and Courtney (2004) observe that, like Māori, different groups in Pacific communities have different needs and aspirations. Agencies need to understand and respond to these diverse needs, rather than try to adopt a 'one-size-fits all' approach for Pacific groups.

In the Pacific initiatives included in SHORE/Whāriki's meta-analysis, community participation was assumed to be accomplished because the project workers were Pacific peoples and saw themselves as part of their local community. However, finding people with the capacity and credentials to work across the various Pacific ethnic and cultural groups was found to be difficult; it was suggested that projects may need to employ workers from each of these groups. Nevertheless, the gardening competition that formed part of the Pasifika Healthcare Gardening

Project did attract different Pacific ethnic and cultural groups.  The community garden that was the other part of the project did not (Greenaway et al 2004a).

In the evaluation of the Manukau Healthy City project, participants noted difficulties associated with obtaining signatories and representations from Pacific Island peoples.  Consultation in this area was regarded as 'hard yards', with the project not seen as particularly 'well-known' amongst Pacific peoples (Hutt and Scott: 30).

The Porirua and Counties Manukau ICAH projects each made efforts to include Pacific peoples in their initiatives (Martin et al 2004).  However, both found it difficult to sustain the participation of Pacific peoples.  Reasons given for this included:

- the heavy time demands of participating
- high staff turnover in participating agencies
- competing demands for Pacific participants
- timing of meetings
- formality of the language used in meetings.

The Porirua project included a Pacific caucus and there was confidence that Pacific participation in the initiative was increasing (Martin et al 2004).

Of all the SCAF sites, the Porirua project had the most difficulty in getting established.  This was attributed to 'the significant differences between Pacific cultural frameworks and those underlying mainstream services and the needs they are designed to meet'.  Initially the project was trying to establish its own structure and processes at the same time as it was identifying the needs of its diverse community (consisting of seven Pacific cultural groups).  Eventually the Pacific Safer Community Trust was replaced by the Porirua District Council as the SCAF fund-holder, due to a loss of community confidence in the former group (Research and Evaluation Unit 2004).

Pacific peoples participated in the Glen Innes Health project through informal links between the project and their leaders, through collaboration on projects between the project and Pacific health providers, and by taking part in Te Awhi Tangata, the Healthy Homes project and the Healthy Lifestyles Initiative for Pacific Communities.  However, the level of involvement of Pacific communities in the project tended to fluctuate and relationships with local Pacific leaders and health providers still needed to be developed further (Scott and Conway 2005).

### *Participation of young people*

Young people do not always participate readily in intersectoral initiatives for health, although some initiatives have managed to overcome this.

For instance, the Ranui Action Project and SCAF site initially found it difficult to involve young people in the initiative.  However, they ran a 'Go Now' project which provided local students with coaching for School Certificate examinations.  This successfully engaged young people.  Then a talent quest was organised that attracted 600 community members.  From there, a Youth Focus Group was formed, which became active in organising several other events such as a youth holiday camp, a touch rugby tournament, a hip hop national event, a kids' fun day and another talent quest (Conway et al 2003a).

The Mangakino SCAF project found it difficult to retain youth on its committee, but young people (and their parents) engaged in project activities such as youth and kapa haka groups. Activities developed at the Whakatane SCAF site, such as the Whänau centre and Cyber Café, also achieved a high degree of youth participation (Research and Evaluation Unit 2004).

## (4)    Relationships enabling action are defined and developed

The fourth set of ingredients for running successful intersectoral initiatives for improving the health of local communities concerns the ways in which relationships between members of the intersectoral group are defined, planned, maintained and repaired if necessary.  Members of the intersectoral group include those involved in governance and those running initiatives 'on the ground'.  (See also Section 1 for a discussion about the initial setting up of intersectoral groups.)

The current section discusses these topics as follows:
- planning relationships
- defining and formalising relationships
- defining roles
- shared accountability
- power inequalities
- trust and respect
- maintaining partnerships
- conflict resolution
- recognising relationship life cycles.

## Planning relationships

Once an intersectoral initiative gets up and running and participants start meeting together on a regular basis, an important task is to clarify and define what will be the nature of the ongoing relationships.  These relationships include those between the participants themselves and also between the organisations or groups that the participants represent (Harris et al 1995; Kuhn et al 1999).

In practical terms, this task means working out matters such as what kinds of structures and processes the participants will use to interact with one another in 'joined up' ways.  These include timing of meetings, meeting facilitation, meeting rules, how agreement will be reached, conflict resolution, etc.  and what skills and resources each participant can be expected to contribute to the initiative.

Previous reviews highlight the importance of initiatives having a planning phase during which the partners or participants develop a consensus on issues that include leadership, operating processes, contribution of resources, methods of resolving conflicts, recognition and rewards (FPTAC 1999).

This kind of work on planning relationships is likely to be especially important if the participants in an intersectoral group come from organisations that work to different planning, budgeting and

accountability requirements, or do not serve clients in the same or similar geographic boundaries (Bauld and Judge 1999; FPTAC 1999; Office for Public Management 2001).

However, initiatives should aim to keep their co-ordinating structures and decision-making processes as simple as possible (FPTAC 1999).  A review of New Zealand's Healthy City projects notes that projects can be compromised if they are dependent on a 'myriad of planning cycles and bureaucratic processes' (Health Promotion Forum 1994).

Initial responsibility for facilitating this relationship planning and development work may be assumed by people from the promoting organisation, or by others.

### Defining and formalising relationships

*Working Together* notes that the more a group of people or organisations intends to share power to make decisions or allocate resources, the more clearly defined and formalised the nature of the relationships between the different people or organisations should be (Harris et al 1995).

The report also notes that the work of successfully defining and formalising relationships needs to be supported by sufficient resources and infrastructure for joint working, effective meeting procedures, efficient decision-making systems, and systems for ensuring people and organisations follow through on commitments (accountability mechanisms).  There should also be systems in place to enable reviews and revisions of relationships, especially if the goals of the intersectoral action change (Harris et al 1995).

There is scope for defining relationships between participants in terms of their degree of formality, intensity, duration of involvement and autonomy, with options ranging across a spectrum that includes information sharing, co-ordination, collaboration and formal partnerships (Harris et al 1995; Kuhn et al 1999).

In the *Mosaics* review, a distinction is made between *networking* relationships and *partnership* relationships (Ministry of Social Development 2003: 16).  A network is defined as:

> ... an informal, loosely structured group whose main purpose is relationship building and sharing information.  Its members don't have a mandate for specific action or change.  Its main purpose is for members to meet, talk, and develop the trust and familiarity necessary for collaboration to work.

A *partnership*, on the other hand, 'builds on the functions of a network, such as relationship-building and information-sharing, but also produces strategies, systems, and services'.

The *Mosaics* review adds that if the purpose of an intersectoral grouping is not clearly defined and agreed, this can create 'inconsistent expectations and lack of motivation among members. Members who expect a partnership model, for example, may feel that a network is simply a talking shop' (Ministry of Social Development 2003: 16).

The evaluation of the ICAH projects found that initiatives with formally-constituted governance groups provided an effective context for representation issues to be addressed (Martin et al 2004).

Community groups can sometimes be resistant to moves to set up formal governance systems (such as Trusts and Boards) for an initiative, regarding these systems as too bureaucratic. Although there was some initial resistance to setting up formal processes at the Glen Innes SCAF site, once these systems were put in place a high degree of collaboration was achieved. At the Porirua and Mangakino SCAF sites, the lack of clear governance and management structures, reporting systems and lines of accountability were regarded as key factors contributing to a lack of project development (Research and Evaluation Unit 2004).

### *Written agreements*

In New Zealand, various kinds of written agreements have been used to clarify and consolidate the relationships and workings of intersectoral initiatives. These include memoranda of understanding, terms of reference, project protocols, charters, statements of intent, and community action plans (Larner and Butler 2003).

Evaluations of the Health Promoting Schools initiative, for instance, found that having some kind of memorandum of understanding between partners (i.e. schools and local co-ordinators) was important for clarifying their respective roles and responsibilities (Dowden and Kalafatelis 1999; Wyllie et al 2000).

Evaluations of partnership working in Waitakere City indicate that:

> Some sort of documentation about how things will work will likely be necessary ... Relational agreements should be developed collectively by the partners and include aspects such as history, visions, values, how governance and decision-making will be shared, resourcing, roles and responsibilities of the partners both individually and collectively (Craig and Courtney 2004).

## Defining roles

### *Role of advisory or steering committees*

The organisational structures of some intersectoral initiatives include an advisory or steering committee. This committee is usually made up of people from a variety of organisations and tends to take responsibility for decisions about the overall governance and strategic direction of the work of the intersectoral initiative. Usually the initiative's co-ordinator or other staff and volunteers take responsibility for the day-to-day running of the initiative.

However, two of the five community action projects in SHORE/Whäriki's meta-analysis that had set up advisory or steering committees ended up removing these committees. This was because the roles and responsibilities of the committees had not been clear enough, with the committees trying to get involved in management issues, rather than in governance alone (Greenaway et al 2004a).

### *Role of umbrella or fund-holding organisations*

A common arrangement in many intersectoral projects is for one of the partner organisations to assume the role of 'fund-holder', meaning that it administers the funding provided for the initiative on behalf of the other participating agencies and people.

A review of partnership projects in Waitakere City observes that the role of fund-holder 'entails considerable yet necessary risks, and needs to be better understood' (Craig and Courtney 2004: 15).

Umbrella organisations can play an important leadership role in intersectoral initiatives. They can also be mentors and provide links to other organisations, improve the opportunities for achieving medium-term funding, and ensure clear structures for communication and accountability. One example is the gardening project that had Pasifika Healthcare as its umbrella organisation. Pasifika Healthcare provided resources and links to different Pacific communities (Greenaway et al 2004a).

### *Unclear roles*

For some of the initiatives included in this literature review, there was concern about the lack of clarity in the roles of different members of the intersectoral groups.

For example, in the ICAH initiatives, evaluations showed that the role of the Ministry of Health was not always well understood by other participants. While input and expertise from the Ministry were appreciated by the Porirua and Kapiti ICAH Trusts, there was some confusion among other organisations and concern from the DHB about the Ministry's participation (Martin et al 2004).

In the SCAF sites there was also some blurring of roles as some of the individuals participating in the initiatives had a history of moving between different sectors. Others had multiple roles or positions spanning different agencies or sectors. The three distinct SCAF partners were supposed to be Child, Youth and Family Services, a fund-holder and a group representing community interests. However, the latter two were the same organisation in Porirua (Pacific Safer Community Trust) and were closely related in Whakatane (Ngāti Awa Social and Health Services and Ngāti Awa) (Larner 2004; Research and Evaluation Unit 2004). While Larner sees this blurring of roles as helping other sectors understand one another as people can see things from more than one viewpoint, she also believes it confuses the categories of 'volunteers and bureaucrats, governance and management' (Larner 2004: 16).

## Shared accountability

An important issue is the accountability systems that should be used for intersectoral action. That is, the responsibilities of all partners should be defined. In general, the literature indicates that shared accountability frameworks are the most appropriate in these circumstances, rather than just one partner being accountable for the initiative. That is, accountability for achieving common objectives, as well as the recognition and rewards for success, should be shared among all the partners (FPTAC 1999).

However, one of the widely acknowledged risks of a shared accountability approach is that some participants may be less inclined to pull their weight. Findings from the Health Action Zone initiatives, for example, suggest that partners may need to devise some kind of system by which they can exert pressure on one another to ensure that collective decisions are honoured (Office for Public Management 2001). Including requirements to collaborate across sectors in job descriptions or programme descriptions is another suggestion that has been made to help overcome this problem (Bauld and Judge 1999).

Evaluations of the Strengthening Families Collaborative Case Management initiative indicate there was criticism of agencies, particularly CYF, for not turning up at case management meetings, and for not following through with actions they had agreed to (Te Puni Kōkiri 2001; Bennett 2002; Parsons c. 2002).

## Power inequalities

Some people and their organisations are likely to regard getting involved in joint action with the health sector as potentially challenging or threatening. They may worry that the extensive power and size of the health sector will be used to control what happens during an intersectoral initiative (Harris et al 1995).

SHORE/Whāriki's meta-analysis of 10 community action projects suggests that it is important to explicitly acknowledge the existence of power inequalities in partnership relationships (Greenaway et al 2004a). For example, most of the 10 projects identified difficulties in the relationship between funding agencies' representatives and other members of the project group. The Pacific projects were an exception to this, as funders and providers had a history of working together on projects and key individuals knew one another.

To try to minimise these types of difficulties, Greenaway et al (2004a) recommend using meetings, conversations and site visits to actively foster good relationships with funders from the very beginning of a project. However, they note that government officials do not always have time to attend meetings or can lose interest during meetings if issues relevant to them are not being discussed.

Larner and Butler (2003) report that it is the view of the Ministry of Pacific Island Affairs that relationships between the government and Pacific peoples cannot be called 'partnerships' because of the unequal power between the two parties.

Another review observes, '... the collaborative process needs to be designed and run by its diverse participants rather than by any single stakeholder ... together, the participants need to determine how their collective work gets done.' This approach responds to '... numerous concerns raised in the literature about the control of community collaborations by experts and specialists and the domination of such endeavors by the agenda of powerful stakeholders' (Bourdages et al 2003: 28).

## Trust and respect

The presence of mutual trust and respect between partners is widely acknowledged as one of the most important ingredients for achieving successful intersectoral working relationships (Blaiklock 1997; WHO 1997; Angus 1999; FPTAC 1999; Kuhn et al 1999; Nelson et al 2001). Trust and respect need to be developed and consolidated as initiatives progress. As part of this, consensus-orientated decision-making processes should be used (FPTAC 1999). Discussions should proceed in an atmosphere where 'the experience and perspective of each organisation/ sector is valued and acknowledged' (Harris et al 1995: 80), irrespective of whether the power of the participating organisations is equal (Murphy and Thomas 1999).

For example, mutual respect was seen as an indicator of the presence of positive working relationships within the AIMHI schools where Full Service Education was being evaluated (Thomas et al 2003).

However, there is the potential for wider sociocultural factors to impede the development of trusting and respectful relations. For example, in the USA, commentators point to elements which together appear to be contributing to an erosion of traditional concepts of community:

> Confrontational politics and the growing diversity of the American population have both been cited as contributing to the polarization of people and organizations. In addition, the new business orientation of government, which sees citizens as customers, encourages people to focus on their own self-interest rather than the public good. The net result of this diminished sense of connectedness is a frayed social fabric in which ties within groups may be strong, but people from different backgrounds, organizations, sectors, and jurisdictions do not know each other and trust each other enough to work together to solve problems (Lasker and Weiss 2003: 20).

Evaluations of the ICAH initiatives indicate there was a noticeable lack of trust among participants in the Porirua project. The evaluators recommend that future project planning acknowledge the considerable time, effort and commitment that may be needed to develop trusting relationships between intersectoral partners (Martin et al 2004).

### Competitive environment

The capacity of local community organisations to trust one another other has been eroded in some cases by the competitive contracting environment (CBG Health Research 2004).

For example, in the Wraparound initiative, hostility from other providers (particularly unsuccessful bidders) in a competitive environment meant that Te Whanau of Waipareira Trust found it difficult to collaborate with and gain the trust of other agencies in South Auckland (CRESA 2000).
Walker (2004: 8) concludes, 'It is questionable whether sufficient levels of trust can ever be achieved while so much of the new public management framework, which was a direct causal factor in the breakdown of interagency trust in the first place, remains relatively unaltered.' Nonetheless, the author adds:

> Initiatives such as the Strengthening Families Strategy show that positive outcomes can be achieved when government and community agencies manage to overcome institutional and administrative barriers and work together by establishing norms of trust and collaboration (Walker 2004: 12).

### Past experiences and familiarity

Larner and Butler (2003: 30) observe that in New Zealand 'the historic antagonism and disapproval between government and community organisations has not necessarily abated' and 'there continues to be considerable scepticism in communities about the motivation for local partnerships'.

Some organisations that lost community trust in the past have found this difficult to regain. Housing New Zealand (the predecessor of HNZC), for example, had previously sold off a great

deal of state housing and this made relationship-building difficult for the community renewal teams (Nunns 2004).

An evaluation of 10 ThinkSafe Community Projects found that many of the stakeholders were initially reluctant to engage with ACC on the projects because of their past experiences of working with the organisation. They were particularly concerned about the sustainability of such projects (Coggan et al 2003).

In the community renewal projects, the degree of trust between project participants tended to vary. Organisations or individuals that were well known locally, and had a good name (like Plunket), were more likely to be accepted by community renewal residents. Organisations from outside the community found things more difficult. For example, one community was suspicious of the Māori organisation from outside its area that was helping to introduce a self-harm prevention programme. The community had not previously known the organisation and did not receive the programme well, despite efforts by the community renewal team 'to ease their entry' (Nunns 2004: 16).

## Maintaining partnerships

Retaining the interest of all partners in an initiative may become more challenging as time goes on. For example, it appears that among Safer Community Councils, partnership relations with central and local government weakened over time. Maintaining the participation of central and local government staff with adequate seniority and authority was also difficult (Crime Prevention Unit 2003).

The regular Glen Innes Health Project Working Group meetings provided a useful opportunity for social service workers to network, exchange information, identify community needs and develop collaborative initiatives. However, meetings were not always attended by groups with an interest in the topic being discussed. This lack of attendance was due to time pressures, a lack of scope in social service workers' roles for engaging in wider health and wellbeing issues, different organisational approaches, and the competitive funding environment in the health sector (Scott and Conway 2005).

Co-ordinators of the community action projects included in SHORE/Whāriki's meta-analysis often found it difficult to balance the need for ongoing networking and relationship building and the need to get on with the 'tasks at hand' (Greenaway et al 2004a: 30).

Maintaining partnerships where participants have different understandings and philosophies can be particularly difficult, as illustrated by Great Start Waitakere: Te Korowai Manaaki.

The early stages of this initiative appeared to be going very well and shaping up to maximise the 'collaborative advantage' of agencies working together on local family violence issues (Elizabeth 2004). However, as the project progressed, relationships between the partners became strained. These difficulties were attributed to differences related to ethnicity, organisational cultures and philosophies concerning family violence prevention and treatment.

Ethnic differences emerged over the design of billboards that had been organised by the 'importance of the first five years' team. This team consisted of a group of five Pākehā women who were working so effectively together that they were 'first off the mark' with the initiative's

activities. The billboards were designed to convey a strong message, but were criticised by Māori and Pacific members of the interim steering group for being 'blunt, brutal and heavily reliant on verbal communication' which they felt was culturally inappropriate for their communities (Elizabeth 2004).

Differences also emerged over what 'working collaboratively' and 'accountability' meant. For some partners (especially those working in large institutions), working collaboratively meant getting a job done together and being accountable for completing the task. For others (particularly those from smaller community groups), working collaboratively meant consulting widely and being accountable for getting the process right (Elizabeth 2004).

All of the partners in Great Start Waitakere: Te Korowai Manaaki had a strong commitment to reducing family violence. However, they had different philosophies on how to address this problem, and were also likely to have had different personal experiences of family violence. Those who came from a background of working with partner violence tended to have a feminist philosophy in which responsibility for family violence primarily rests with men. On the other hand, those working in child-centred organisations and Māori and Pacific groups tended to place more responsibility for child welfare with their mothers (Elizabeth 2004).

The project's evaluators observe that the status of Māori and Pacific peoples as a minority from the start, as signified by the existence of their own separate projects, did not provide an adequate mechanism for resolving conflict; neither did bringing in third parties to adjudicate, as occurred later on in the initiative (Elizabeth 2004). The evaluation concludes that a better outcome might have been achieved if, at the very beginning of the project, the partners had engaged in much more dialogue about their core assumptions regarding the philosophies, content and processes of the initiative.

## Conflict resolution

Overseas studies that have looked at the place of conflict in intersectoral working, agree that it is not always possible 'to remain within the comfort zone of mutual and pleasantly supportive exchanges' (Baillie et al 2004: 223). Nonetheless, it is also recognised that it can be the 'difficult, open, frank discussions' that can 'engender the jarring shift in thinking' that can result in real change (ibid.).

Shortell et al report that the more successful of the 25 USA community health partnerships they evaluated:

> ... were able to use a number of strategies to manage and channel conflict in more positive directions than those that were less successful. Specifically, highly successful partnerships did a better job of anticipating problems and likely trouble spots ...; worked to create interdependencies among partnership members...; worked on continually maintaining a high degree of trust ...; created a process of decision making that was perceived to be fair and open to all; and provided updated information to participants to keep everyone informed and to 'nip problems in the bud' (Shortell et al 2002: 75).

In the New Zealand context, evaluators of the SCAF pilots conclude that conflict between partners (and with others in the community) is by and large an inevitable and necessary part of partnerships that are based on devolved funding and decision-making. Mediation processes can

be useful for helping to deal with these tensions, although some conflicts may take time to resolve and therefore impact significantly on project operation (J Adams 2004; Research and Evaluation Unit 2004).

At the Glen Innes SCAF site, where several ethnic groups had been brought together for the first time, issues were resolved at hui and kōrero.  Initial conflict at Mangakino lessened as partners improved their meeting skills.  In South Hokianga, transparent and constructive policies and procedures to resolve conflict were established very early in the life of the project (Research and Evaluation Unit 2004).

### Recognising relationship life cycles

Finally, it is important for intersectoral initiative teams to recognise the natural life cycle of group relationships.  Shortell et al found that the most successful of the 25 USA health partnerships they evaluated were more likely to recognise:

> ... where they were at in each stage of evolution as a partnership than those making less progress ... For example, groups that were more successful recognized that they were entering a period of maturity in which some of the early problems within the partnership had been addressed and, indeed, some of the earlier initiatives [activities] had been completed.  They recognised they were now at the stage of addressing more complex issues that might require changes in the organization, structure, composition, and leadership (Shortell et al 2002: 77).

That is, intersectoral groups need to acknowledge that relationships change as initiatives progress, know what stage they are at, and plan for further change.

### (5) Agreed actions are planned and implemented

Once relationships, structures and processes are developed, enabling participants in a community-based intersectoral health initiative to communicate and interact effectively with one another, the next steps are for the participants to develop a joint plan of action, and then to implement the plan (Harris et al 1995).

This section describes the planning and implementation of intersectoral initiatives' activities under the following headings:
- initial planning
- programme logic and clear goals
- needs assessments
- prioritising action
- activities/actions
- balancing action and planning
- renegotiating plans
- planning for sustainability.

### Initial planning

This process is likely to include preparing a formal action plan or clear statement of agreed actions. This plan would indicate why all the participating people and organisations regard it as important to work together, how they understand the nature of the health issues they are addressing, and the various actions they intend to take together in an effort to help solve these issues (Bourdages et al 2003). Actions or goals specified in the plan should be achievable within a given time period and level of resources. A plan can also indicate the level and kinds of resources each of the participating organisations will commit to support the various actions.

In discussing the kinds of actions that partners could plan to undertake, the *Mosaics* review notes that:

> Activities need to fit with the priorities of the agencies and organisations involved. This helps to maintain the commitment and motivation of members, and allows them to achieve their own outcomes as well as the group's. Organisations will only continue to be involved when they see that the group adds value to the work they do and that they can make a contribution (Ministry of Social Development 2003: 16).

### Programme logic and clear goals

The literature suggests it is important that participants are clear about the logical connections between the actions they have chosen and the outcomes they are wishing to address – sometimes referred to as 'programme logic' or 'intervention logic' (Lal and Mercier 2002; Martin et al 2004). This is considered to be more likely to motivate and sustain intersectoral action than attempts to 'meet laudable but vague goals' (FPTAC 1999: 19). 'If goals are not explicit, problems can arise later when organisations do not see their own goals being adequately reflected in action, or when others undertake actions that had not been articulated in the original agreement' (Harris et al 1995: 92).

Having a clear philosophical basis and/or kaupapa for making planning decisions was an important feature of effective initiatives in SHORE/Whāriki's meta-analysis of community action projects. Formalising the project culture by developing policies and protocols was useful. Also, documenting planning processes and having written strategic plans helped projects communicate with funders, raise their profile and access additional funding (Greenaway et al 2004a).

The degree to which different HAZs identified their rationales for including certain activities in their initiatives varied greatly. Rationales ranged from intuitive, common-sense statements to much more extensive, evidence-based ideas drawing on programmes that had been run elsewhere (Sullivan et al 2004).

### Needs assessments

In some initiatives, work towards the development of a formal action plan can include undertaking a detailed analysis of the health status and health needs of the local community, a process commonly known as a 'needs assessment'. This information is used as a framework and resource for assisting future decisions about which health issues the intersectoral group should focus on, and what strategies might be used to address these issues. Usually a needs assessment is done quite early in the life of an intersectoral initiative, although this is not always the case.

In the SCAF sites, a number of techniques were used to try to better identify the needs of the community. These included: surveys; public meetings; workshops (public and ethnic-specific); and the creation of groups of residents and organisational representatives for consultation purposes. Engaging in public consultation about needs was also seen as useful for raising public awareness about the SCAF project and for developing a 'community voice' (Research and Evaluation Unit 2004).

Efforts to systematically identify community needs were most successful at SCAF sites such as Glen Innes, Ranui and Whakatane. All three of these sites had a strong community identity, a history of engaging in community development projects, and existing organisational structures and processes to support intersectoral working.

Attempts to identify community needs were less successful in Porirua, where the SCAF project was trying to establish its own structure and processes at the same time as identify the needs of its diverse community (which included people from at least seven different Pacific ethnic communities or nationalities) (Research and Evaluation Unit 2004).

All four ICAH projects undertook needs assessments. The needs assessments conducted in Porirua and Kapiti were valued for their high degree of detail and succeeded in securing widespread community ownership and support. The needs assessment for the Counties Manukau ICAH was described as very thorough and highly valued by the intersectoral partners. The needs assessment done for the Northland ICAH was used in project planning (Martin et al 2004).

In the Community Renewal projects, local residents were surveyed to identify the issues they regarded as important, and how they thought the issues might be solved (Nunns 2004).

In SHORE/Whāriki's meta-analysis of 10 community action projects, needs assessments were found to be beneficial for developing common understandings and descriptions of issues; identifying political, historical and resource constraints; promoting awareness of other local community projects; and predicting the implications of project actions for other groups in the community. Baseline information about the health status or health-related beliefs and practices of community members can also be collected in readiness for subsequent evaluation or monitoring of changes over time as the initiative proceeds (Greenaway et al 2004a).

The evaluation of the Finlayson Park School HAZ found there was a lack of clarity and conflicting expectations about what should be the role of the Hauora facilitator. It was suggested that carrying out an independent needs assessment prior to the appointment of the facilitator might have helped to clarify the role of the facilitator at an early stage (Voyle 2002).

### Prioritising action

While doing needs assessments and using programme logic can be helpful in identifying and prioritising possible activities, the literature emphasises that this process of prioritisation is not always easy.

The Ranui Action Project developed the Ranui Action Plan in consultation with a wide range of community members. This plan was ambitious and extensive but did not prioritise projects or activities. The later prioritisation process proved challenging, and tensions around this delayed

decision-making for a while. However, eight priority projects were chosen for the 2004 project plan (Conway et al 2003a; J Adams 2004).

Evaluation findings indicated that all four ICAH groups found it very difficult to prioritise their project activities and workloads, even after a good needs assessment had been carried out (Martin et al 2004).

These findings are consistent with the observations in the *Mosaics* review that 'Trying to tackle too many issues will create unmanageable demands on time and resources. The group needs to define what issues it will address, and what activities it will undertake' (Ministry of Social Development 2003: 16).

Tackling small, achievable projects, at least at the start of an initiative, is seen as an effective strategy. The experience from the UK's Health Action Zones indicates that initiatives should try to avoid setting too broad an agenda or excessively high expectations at the beginning (Bauld et al 2001). Securing short-term quick wins is described as being helpful for 'gaining legitimacy and support for more complex, long-term goals during the early stages of partnership development' (Mitchell and Shortell 2000: 261).

Evaluators gave similar advice to the Manukau Healthy City initiative at an early stage in its development. They recommended that the efforts of the initiative's working party should 'focus on very specific projects which had limited but achievable aims' (Jaffe 1991: 15). Meeting these small, achievable targets can demonstrate to participating organisations and groups that the initiative is able to produce results and is working. In addition, it can help build trust and understanding between participants before tackling larger ventures that perhaps involve greater interdependency and risk.

Starting on small, manageable projects was one way that some of the SCAF sites managed to gain a degree of public trust for the project partnerships (Research and Evaluation Unit 2004).

Similarly, in the community renewal initiatives, completing small, visible projects that were chosen by local residents, like the 'One Thing' project, really helped to build trust and credibility (Nunns 2004). Having a manageable number of projects was also felt to be an essential ingredient in the success of the East Coast community injury prevention programmes (Coggan and Simpson 1999).

On the other hand, too much emphasis on short-term projects for too long can mean that intersectoral groups do not get around to undertaking longer-term projects with more substantial outcomes.

Unlike many initiatives, the Glen Innes Health Project deliberately planned long-term, sustainable programmes, rather than one-off or short-term projects (Scott and Conway 2005).

## Activities/actions

In practical terms, activities depending on the type of intersectoral initiative that is being undertaken, and the programme logic for achieving particular outcomes.

However, initiatives can include a range of sub-projects such as:

- use of electronic media to raise the initiative's profile in the community (e.g. advertising, radio programmes, websites)

- production of pamphlets, services directories and newsletters to give the public information about health issues and health services

- special events for the local population (e.g. health days, sponsored concerts, competitions, mural painting)

- establishment of a centre for the initiative in publicly-accessible accommodation

- lifestyle-related prevention activities for individuals at risk (e.g. nutrition and exercise classes, smoking cessation programmes)

- changing the local environment (e.g. improve roads, transport, housing, education, local employment opportunities; ensure adequate incomes; improve access to existing services; change legislation and regulations)

- setting up new health and other services such as home visiting services, outreach services, one-stop shops

- encouraging health and other services to increase their working together and to integrate their services for local clients with problems that directly or indirectly affect their health (e.g. case management).

An example of a set of activities planned by a New Zealand initiative is the Ranui Action Project which funded a number of small community-initiated projects, as part of its strategy to encourage greater community participation and ownership. These 'Go Now' projects included a very wide variety of topics such as oral history, flax planting, School Certificate coaching, massage training, Market Day, Health Information Centre, anti-violence programme, Pacific literacy tutors, access to computers, mural, and a Welcome to Ranui information pack.

The *Mosaics* review lists the following examples of possible actions that could be undertaken by an intersectoral group (Ministry of Social Development 2003: 13). Note that these actions relate chiefly to the co-ordination of existing services, as this was a key focus of the *Mosaics* study.

- Jointly map service provision, to ensure that clients and other agencies are aware of and can access appropriate services.

- Highlight gaps in current service provision, and identify opportunities to develop collaboration to address problems and needs.

- Identify duplication of services, to align resources and activities.

- Provide opportunities to build capacity within organisations to improve service delivery.

- Build capacity within communities to identify their own needs and play an active role in developing solutions.

### Balancing action and planning

The SHORE/Whāriki meta-analysis of 10 community action projects found that often projects found it challenging to balance planning with actual action. Some of the project teams noted 'how important it was to plan tangible outputs relatively quickly, alongside the slower, more

long-term strategies, so that people could gain some sense of achievement early in the project' (Greenaway et al 2004a: 41).

In the Take Ngakau Kaikohe Intersectoral Project, there was tension between taking time to plan a sustainable project framework and achieving some short-term projects with tangible outcomes. Many local key informants felt that not enough action had taken place, although others thought this was a natural situation and the pace of the project had increased more recently (Henwood and Adams 2003).

An evaluation of the Nelson Healthy City project concludes that the 'talking heads' group of mayors and managers from local agencies had a lot of successful discussions and the group was a very useful forum, but there was a need to convert talk into action (Hutt 1998).

## Renegotiating plans

There should also be clearly defined times when organisations can renegotiate the actions they have agreed to and the terms of their involvement in an initiative (Harris et al 1995; Murphy and Thomas 1999).

Shortell et al (2002) found that initiatives making the most progress had the ability to 'patch' the nature of their activities by repositioning their assets, competencies, and resources to address changing needs and priorities. Examples of patching include 'the ability to blend funds from multiple sources to focus on local community needs, the ability to spin off smaller projects in order to move on to larger projects, and the ability to adjust initiatives to be more realistic given the amount of work to be done'.

## Planning for sustainability

The SHORE/Whãriki meta-analysis of New Zealand community action projects found it was important that project planning include a consideration of what should happen once current funding ceased. In three of the 10 projects, funding stopped during the implementation phase of the project. This resulted in projects having to find further funding from the original funder or from other sources when the original funding term was over. Where this was not possible, projects either stopped completely until more funding was found, or staff reverted to working on a voluntary basis (Greenaway et al 2004a).

An evaluation of the HAZ initiatives in the UK also notes that there is a 'huge issue' in regard to what happens when funding runs out. It comments:

> Once people's energies and hopes have been engaged there is a danger of achieving less than nothing if the support cannot be sustained, as they are likely to become disillusioned and cynical about any opportunities that might be offered in the future. In the words of one HAZ-funded community development worker 'it will be worse than if we had not been there at all' (Matka et al 2002: 103).

The Ranui Action Project purchased a centrally-located house for its own activities and also to gain revenue through rent. It also established the 'Swanui' Business Association. Both of these strategies were designed to increase the sustainability of the project (Conway et al 2003a).

*Mainstreaming*

Planning for mainstreaming was very important in the HAZ initiatives in the UK, although this was found to be difficult because of financial uncertainty. Mainstreaming HAZ activities into Primary Care Trusts and Local Strategic Partnerships structures was one way of sustaining these activities. Mainstreaming at the various levels of projects, practice and policy was also recommended by evaluators (Mackenzie et al 2003).

Sustainability of community action projects involved in SHORE/Whäriki's meta-analysis was enhanced by incorporating 'the work of the project into the strategic plans of the stakeholder organisations' – in other words, mainstreaming (Greenaway et al 2004a: 58). Involving multiple stakeholders also enhanced sustainability through sharing resources. Changing environments rather than changing individual behaviour was also seen as encouraging sustainability (ibid).

## (6)    Outcomes are monitored and evaluated

Monitoring and evaluating how well a community-based intersectoral initiative is working, and its impact, are other key ingredients for successful intersectoral action. Setting up suitable evaluation systems to chart an initiative's activities and their impact can yield important information for thinking about how the initiative could be improved or developed in future.

This section discusses monitoring and evaluation issues under two main headings:

- monitoring and reporting
- evaluation – including: evaluation themes and tools; formative and process evaluations; evaluating intermediate outcomes; evaluating final health-related outcomes; controlled studies; cost-benefit analyses; choosing an appropriate evaluation strategy; other evaluation issues.

## Monitoring and reporting

As part of meeting their obligations for receiving funding or their accountability to the community, often intersectoral groups must have their activities monitored. This is usually done through a system of regular reporting to the funder or community, usually by the group itself or sometimes by an external monitor. Reports include information such as what activities have been undertaken, and how many and what types of people and organisations have participated in the activities.

*Monitoring and reporting requirements*

A reasonably common finding of overseas and New Zealand evaluations is that intersectoral groups perceived the monitoring and reporting processes required by funders as unduly onerous.

The reporting requirements for the Hauora facilitator at Finlayson Park School were assessed as being 'hugely disproportionate ... especially considering the limited size and short duration of the project'. During the one-year project, the Ministry of Health (the funder) required the facilitator to make quarterly reports. In addition, the District Health Board, which provided the Kidz First Public Health Nursing Service to which the facilitator belonged, required quantitative and qualitative key performance indicator reports to be provided each month, as well as a detailed outcome report and a detailed 'wrap up' report. A considerable amount of time was spent selecting key performance indicators (Voyle 2002: iii).

Staff in the UK's HAZs often questioned the usefulness of monitoring data they were required to collect for central government. While some HAZ personnel found the data useful for their own internal monitoring, others found it 'clashed with their own local structures' (Mackenzie et al 2003). The evaluators suggest that it is important to work out what the data are for and how they will be used. They state:

> The collection of data centrally is only meaningful if it is seen to feed into decision-making processes in a transparent fashion. Locally more thought needs to be given to how routine monitoring might be more meaningfully tied into the process of pulling together the overall case study picture (Mackenzie et al 2003: iv).

Each of the ICAH initiatives was required to provide quarterly reports to the Ministry of Health. ICAH staff found that the amount of paid worker time required to prepare these reports was high compared to the amount of funding provided. As well, it was not always clear what sort of information was required to be included in the reports. DHB staff responsible for monitoring and supporting the ICAH projects reported that this work could be quite onerous and included various hidden or unexpected costs. For its part, the Ministry of Health commented that sometimes an insufficient amount of detail was provided in the reports (Martin et al 2004).

The ICAH evaluators believed that it would have helped if they, the funder and the ICAH groups had together developed a model of intervention logic at the establishment stage of the initiative. This would have helped in the design of monitoring and reporting templates and evaluation outcome measures that were useful to the ICAH groups themselves, the funder and the researchers (Martin et al 2004).

While some might regard these various auditing, monitoring and evaluation requirements as excessive managerialism, others may regard them as necessary accountability mechanisms and part of a move towards greater transparency and democracy (Larner 2004).

## Evaluation

Formal evaluation attempts to document the progress and assess the effectiveness of projects and initiatives. It is often conducted by outside evaluators and, like monitoring, it may be a condition of funding. Pilot projects are particularly likely to be evaluated as their purpose is to trial new approaches and share the results with others.

Evaluation feedback provided by stakeholders at different stages in the life cycle of an initiative can play an important part in identifying and resolving obstacles to the initiative's future development and effectiveness. Evidence that an initiative is running well and achieving meaningful results can also influence decisions by participating organisations about their future commitment to the initiative, including funding and other resourcing issues.

Many of the general methodological issues that need to be considered when designing an evaluation of a community-based intersectoral health initiative are the same as for evaluations of other kinds of programmes, and are well-documented by various authors (e.g. Patton 1981; Waa et al 1998). However, community-based intersectoral health initiatives also tend to have some relatively distinctive features that can complicate evaluation design. These include:

- their diversity, which means that comparing initiatives can be difficult

- the complexity of partner relationships

- the extra time, resources, infrastructure, activities and 'transparency' that agencies need to develop and support collaborative partnerships, meaning that evaluations also may take longer to do than first expected

- the large number and wide scope of different activities often undertaken as part of an intersectoral initiative

- the need to consider the possible influence of many aspects of the community context

- the large number of different types of 'outcomes' or 'impacts' that may need to be considered, including: health status indicators; personal health knowledge, attitudes and behaviour; aspects of the physical, economic, social and policy/legislative environments; and levels and quality of contact with service clients and other members of the community

- the difficulty in attributing longer-term outcomes to the interventions themselves

- the cost, technical difficulties and burden of collecting suitable data

- the long time lag between the interventions (the initiatives) and some outcomes.

These issues and some examples are discussed in more detail below.

One issue to bear in mind is that the broader health outcomes resulting from certain kinds of community-based intersectoral initiatives, such as injury prevention programmes (which address acute, not chronic, health events) and heart health programmes, may be easier to measure than others (meaning that the effectiveness of the former programmes may also be easier to demonstrate).

Evaluations of intersectoral initiatives focusing on broader downstream health status outcomes are reasonably common in the USA, but much less so in New Zealand. There are several reasons for this, but perhaps the most significant is the substantial resource costs usually required to undertake this kind of detailed, in-depth study.

Another is the length of time an initiative and its associated evaluation may need to run before this kind of health outcome can be expected to be detected.

For example, all groups involved in the ICAH initiatives thought it was unreasonable to expect measurable outcomes in the three-year period of the evaluation. This was especially applicable in the case of initiatives that had experienced delays in getting underway (Martin et al 2004).

Similarly, the evaluation of the SCAF sites concluded that it was not possible to assess any medium- or long-term outcomes as it had taken the partnerships around three years to develop governance structures and processes, identify needs and priorities, and then implement activities (Research and Evaluation Unit 2004).

Other barriers to undertaking outcome evaluations of this kind include technical difficulties such as the non-availability of suitable research data or tools, and the disruption to the day-to-day work of an intersectoral initiative that may be caused by requirements to compile data on health-related outcomes.

In the Family Service Centre pilot projects, a major effort went into attempting to get centre staff to collect detailed quantitative data directly from participating families, to try to gauge some impressions of the impact of the pilot projects. However, in the end the data proved to be incomplete in many ways and therefore not particularly useful for answering some of the more significant outcome questions set for the evaluation (Ministry of Health 1997).

Likewise, in the Social Workers in Schools programme, data collection was abandoned because social workers found the task too onerous (Belgrave et al 2000).

Evaluators of the Waitakere Community Injury Prevention programme tried to set up an injury monitoring system using data from a variety of sources (e.g. emergency departments, New Zealand Health Information Service hospitalisation data) but were largely unsuccessful because data were not accessible, not robust enough or not up-to-date. A focus on intermediate outcomes was more fruitful, identifying increases in the use of car restraints for children, installation of home safety equipment (fireguards, swimming pool fences etc), and purchase of protective equipment for sports (Coggan et al 1998c).

Evaluators of the Northern Region Health Promoting Schools initiative decided that measuring long-term health status outcomes was inappropriate. Instead they believed it would be more feasible and meaningful to monitor shorter-term impacts such as liaison with other schools, agencies and communities, and whether schools had put in place strategies and plans for delivering policies and actions (Wyllie et al 2000).

Commentators also observe that even when this kind of outcome evaluation identifies particular improvements in health status or service use, it may still be a matter of judgement as to whether the improvements can be attributed to the work of an intersectoral initiative. It is quite possible that other factors, both recognised and unrecognised, may have had a significant impact as well (Berkowitz 2001; El Ansari et al 2001).

In the case of the UK's Health Action Zones, evaluators note the difficulty of identifying whether positive outcomes were being achieved by a new initiative when the initiative had been integrated or 'mainstreamed' into an agency's normal working (Sullivan et al 1999). Even where improved health outcomes were detected, it was hard, if not impossible, to 'disentangle' changes due to the HAZ initiative from changes due to other factors (Office for Public Management 2001). In this regard, Amery (2000) recommends that future evaluations of HAZ type initiatives aim to identify measurable outcomes but not become obsessed with attribution.

Randle and Hutt (1997: 8) refer to the 'very context-specific, complex and process-orientated nature' of the various New Zealand Healthy Cities initiatives and the difficulties of using standardised indicators to evaluate them, especially when local interpretations of the Healthy Cities concept varied so much. They also note that 'establishing causality using controls and evaluations of outcomes over time is difficult' (ibid.) and question whether it is possible to use quantitative indicators to capture evidence of broader achievements such as co-operation and networking.

Others experienced in setting up intersectoral projects in a New Zealand context acknowledge the methodological difficulties of linking action to long-term impacts.

One should not over promise what evaluations of collaborative initiatives might provide, in particular in terms of impact.  The problems in making causal links and attributing change to an intervention are considerable in social policy evaluation.  Unpicking what was the result of a collaborative approach will be even more difficult (Angus 1999: 9–10).

Similarly, the *Mosaics* review observes:

According to New Zealand and international literature, there is little or no research evidence proving that collaboration in itself improves outcomes for individuals or for their families/whanau.  This is partly because many of the expected benefits of collaboration, such as improved relationships, are difficult to measure.  In addition, evaluation is often limited, too focused on process, and conducted over too short a time to pick up long-term changes in outcomes (Ministry of Social Development 2003: 2).

### *Evaluation themes and tools*

The evaluation literature includes various guides to the kinds of issues and themes it may be useful to focus on when evaluating the different stages that an intersectoral initiative goes through in its development (e.g. Funnell et al 1995).  An example is the paper by Granner and Sharpe (2004), which lists the following 'array of concepts that have been empirically associated, or are expected to be associated, with coalition functioning and/or success'.

**(1)  Member characteristics and perceptions**

- Member benefits
- Member participation
- Member satisfaction and commitment
- Member skills and training
- Representativeness of members
- Member recruitment
- Member expectations
- Ownership

**(2)  Organisational or group characteristics**

- Conflict resolution
- Decision making
- Clear mission
- Quality of action plan
- Formalised roles and procedures
- Technical assistance
- Resources available

**(3)  Organisational or group characteristics and climate**

- Community context and readiness
- Group relationships/collaboration
- Communication

- Strong leadership

**(4)   Impacts and outcomes**

- Linkages to other groups/community
- Policy advocacy/change
- Empowerment/social capital
- Community capacity
- Institutionalisation

Techniques for evaluating complex, community-based intersectoral health initiatives are discussed in several publications (e.g. Bauld and Judge 1999; Judge et al 1999; Meyrick and Sinkler c. 1999; Judge and Bauld 2001).  These and other more recent studies make it plain that, while certain authors may argue for the superiority of one kind of evaluation approach over another, the reality is that there is no single best method for evaluating intersectoral working. Rather, there is potential to select one or more of several different approaches.

Various toolkits for evaluations and self-assessment tools for intersectoral groups have been developed overseas that may be of assistance to evaluators of intersectoral initiatives for health. These include toolkits for modelling or benchmarking successful intersectoral action (Aaro et al 2000; Bertinato 2000; Hagard 2000; Health Canada 2000; Perry and Markwell 2000; Watson et al 2000; Weech-Maldonado et al 2003; Department of Health, Health Inequalities Unit, Local Government Association, et al 2004; LGNTO and Educe Ltd n.d.; Centre for the Advancement of Collaborative Strategies in Health website) and tools for assessing community involvement (Hausman et al 2005; Fairfax et al n.d.).

In New Zealand, Duignan et al (2003) have developed the Community Project Indicators Framework, which can also be applied to intersectoral initiatives for improving the health of local communities.  This framework comprises two parts:

(1)   **a list of project activities** – which describes what the initiative is planning to complete within a certain timeframe, and reports on what was achieved

(2)   **a description of intended results and impacts** – which describes what processes and outcomes are planned and reports on what was achieved under 11 headings: project planning and regular reassessment; project infrastructure and sustainability; community participation; enhanced community voices; leadership/key players upskilled; collaboration; conflict managed; resources increased; changed organisations; Treaty of Waitangi obligations; Pacific people's involvement.

### *Formative and process evaluations*

Most New Zealand evaluations of community-based intersectoral health initiatives have been so-called *formative* or *process* evaluations.  This kind of evaluation chiefly focuses on the processes involved in setting up and running an initiative.  This focus includes examining issues such as the extent to which the partners in an initiative have developed appropriate working relationships with one another, and the factors important in shaping the emergence of these new relationships. How activities are planned and implemented and how the community responds to these can also be included in this type of evaluation.  The levels of intersectoral collaboration and community participation are often a focus of the evaluations.

Commonly in the formative evaluation phase, participants in the intersectoral initiative and evaluation specialists work together to carefully define the intended objectives and processes of the intersectoral project.

Formative and process evaluations are mainly built around evidence collected from face-to-face discussions or surveys, reviews of project documents, or direct observations in the field or at meetings.  The advantage of using these techniques is that they enable details of the often complex processes involved in implementing an initiative to be thoroughly documented, analysed and, where appropriate, critiqued.

For the 10 community action projects included in SHORE/Whāriki's meta-analysis, it was difficult to find ways of measuring their success.  In particular, it was hard to develop indicators that were useful to both project providers and project funders (Greenaway et al 2004a).

Techniques that were used in this study included:
- assessing project performance against objectives
- assessing the achievements, risks, and positive and negative impacts of the project
- documenting the activities and issues addressed by the project
- identifying the strengths, weaknesses, opportunities and threats of the project
- assessing the changes people had witnessed or experienced as a result of the project (Greenaway et al 2004a: 55).

Mainly qualitative information was used; this was collected from project records, interviews, focus groups, written questionnaires, observations and media coverage.  Quantitative data were mainly statistics on project participants and project activities (Greenaway et al 2004a).

**Results of formative and process evaluations**

The following summarises results from the formative and process evaluations of some of the intersectoral initiatives covered by this literature review.  These examples illustrate the types of information that can be collected and issues that may arise during its collection.

In an evaluation of eight of the 26 HAZ initiatives in the UK, some aspects of the initiatives were easier to assess than others.  A number of specific service-related activities were evaluated and were assessed as being successful.  Observation of processes relating to the HAZ partnerships and building capacity for collaboration also led to the conclusion that the initiatives had achieved a great deal of success.  For example, stakeholder feedback from an evaluation of eight UK HAZs indicated that the initiatives had been successful in the following ways:
- introducing non-medical perspective to health
- encouraging closer working between health and social services
- helping in change to or introduction of mainstream services
- preparing for sustainable real partnership working by providing an infrastructure
- encouraging public participation as citizens and service users
- raising the profile of specific health issues
- encouraging a change in attitudes and introducing a 'HAZ way of working'

- allowing shared learning (e.g. through the evaluations)
- enabling initiatives to experiment (Sullivan et al 2004).

However, demonstrating that HAZ activities had increased community participation and reduced inequalities was much more difficult, due to a lack of suitable instruments to measure this type of outcome, the difficulty of establishing causality, and the time available for the evaluations (Sullivan et al 2004).

In evaluation feedback, families of Mäori children who participated in the Strengthening Families Collaborative Case Management project were generally happy with the process and indicated they would recommend it to others (Te Puni Kōkiri 2001).

There was a similar response from client families of Strengthening Families Collaborative Case Management in Dunedin. In this evaluation, families said the process had resulted in significant improvements in parenting, family relationships, support and service co-ordination (McKenzie et al 2001).

Another evaluation at six sites where the initiative was operating also identifies a high degree of satisfaction with the idea of Collaborative Case Management, as it gave hope to families that problems would be identified, solutions would be found and agencies would co-operate with one another and become accountable. On the other hand, families were not always clear about the purpose and boundaries of the process, initial meetings were not always facilitated in the best way, and agencies did not always follow up on their agreements (Oliver and Graham 2001).

The evaluation of the Healthy Housing pilot programme found that the programme had established collaborative relationships, many of them formal, with 46 different health and social agencies. There were a large number of referrals between these agencies, which was taken as indicative of effective intersectoral working. However, the evaluation adds that in future it would be useful if families were allocated a single support person, such as an advocate or social worker, to improve communication and reduce the potential for confusion during the referral process (Auckland UniServices 2003; Martin et al 2004).

Evaluations of the Ranui SCAF initiative found evidence of increasing community participation and community capacity, an increased sense of ownership of the SCAF project by community members, and increasing community pride and optimism. In Glen Innes and Whakatane, bringing community groups together to address shared objectives was considered to have fostered greater community engagement. Evaluations of the Mangakino SCAF indicated that the initiative's implementation committee had built links to a diverse range of community networks (Research and Evaluation Unit 2004).

Increased community participation (particularly among Mäori), the creation of new networks and associations, and greater proactivity were observed at the Mangakino SCAF site (Taylor 2004).

In the Take Ngakau Kaikohe Intersectoral Project, stakeholders interviewed for the evaluation observed that the project had led to improvements in relationships between people and brought together groups that had not been linked previously (Henwood and Adams 2003).

Safer Community Council stakeholders indicated that SCCs could contribute significantly to local crime prevention by leading community safety strategies within local authorities. The skills and expertise of SCC co-ordinators were also acknowledged to assist with a range of local authority activities. The relationship between the Police and local authorities was also improved, and other government initiatives, such as District Truancy Services and Strengthening Families, had benefited from SCC involvement (Crime Prevention Unit 2003).

Stakeholder feedback on ACC's ThinkSafe Community Projects indicated that the multi-sectoral collaboration was regarded as a key factor in enabling the establishment and sustainability of the projects (Coggan et al 2003).

### *Evaluating intermediate outcomes*

Other evaluation strategies aim to identify *intermediate* outcomes attributable to the work of an intersectoral initiative. It is assumed these intermediate outcomes will be followed by changes in final health-related outcomes (see the next subsection).

Examples of intermediate outcomes include: changes in people's health-related knowledge, attitudes and behaviour; changes in organisational policies, structures and processes related to the delivery of health services; and changes in the built environment that affect people's health. More specific examples include the increased provision of free school-lunches for children in disadvantaged areas, and an increase in awareness in the community about drink drive enforcement campaigns.

In most cases, evaluations aim to establish with a reasonable degree of confidence that these intermediate outcomes are visibly and directly connected to the work of the intersectoral partners and probably would not have occurred without it. Relevant evidence may be gathered using face-to-face interviews or surveys, reviews of project documentation, or direct observation in the field or at meetings. In some cases, too, before-and-after type research methodologies may be able to be used to track changes in dimensions such as community awareness or knowledge, or self-reported alcohol consumption.

### Results of evaluations of intermediate outcomes

Examples of the various types of intermediate outcomes identified in evaluations of New Zealand initiatives include:

- improved nutrition-related knowledge and provision of healthier food (*community nutrition programmes for Mäori*)
- improved road safety behaviour (e.g. using car seats for children, not speeding) (*injury prevention programmes*)
- improved student attitudes to health education (*Health Promoting Schools*)
- improved behaviour and family relations of young people (*Wraparound*)
- improved help-seeking behaviour for depression among mothers (*Early Start*)
- increased awareness and knowledge about the relationship between housing and health (*Otara Health and Housing Campaign*)
- physical environment – provision of shade trees (*Health Promoting Schools*)

- installation of smoke alarms (*Otara health and housing campaign; Turanganui a Kiwa community injury prevention project*)

- economic environment – local employment schemes (*HAZs*)

- social environment – provision of education and leisure activities for young people at risk of crime (*Safer Community Councils, Wraparound*)

- policy/legislative environment – influencing child hunger policy (*Manukau Healthy City*), including safety requirements in local authority policy and plans (*Waitakere Community Injury Prevention Programme*) (Ministry of Health 2001d).

More recently, evaluations of the Healthy Housing project have identified an increased awareness of infectious diseases, particularly meningococcal meningitis, among the local population (Martin et al 2004).

A pseudo-patron survey was run as a collaborative project by the Auckland Regional Community Action Project on alcohol initiative. The survey found that, between 2002 and 2003, there was a significant drop from 61 percent to 46 percent in the number of off-licence visits for young people without age verification. There was also a considerable amount of coverage of the survey by the media (Casswell et al 2003).

Researchers note that it was difficult to assess outcomes at the four Family Start sites participating in an outcome/impact evaluation. This was in part because it had not been possible to implement a randomised controlled evaluation design which meant that interpretation of causality was difficult. There was no evidence that Family Start had improved intermediate child health outcomes such as breastfeeding and immunisation rates or parent/caregiver smoking rates. However, over the period of the evaluation (about seven months) a high proportion (43 percent) of parents/caregivers had participated in education or training course, had become employed (an increase from 13 percent to 40 percent) and had bought a car (Centre for Child and Family Policy Research 2005).

### *Evaluating final health-related outcomes*

In some cases there may be scope for an evaluation to investigate if an intersectoral initiative has contributed to health status improvements. These improvements include reductions in the incidence or prevalence of certain health conditions as measured by indicators such as self-perceived health status, mortality rates or health service utilisation rates for certain conditions.

This approach is most feasible in communities where relevant and robust statistical information is collectable, available and easily accessible. However, even where data are available, attributing this type of outcome to interventions related to intersectoral initiatives is generally more difficult than attributing intermediate outcomes to these interventions.

### Results of evaluations of health outcomes

Nevertheless, some recent New Zealand evaluations have managed to include valuable data on final health outcomes that may be attributable to intersectoral working. (They also included data on intermediate outcomes.)

Evaluations of the Healthy Housing Programme, for example, identified the following changes among the intervention households (Auckland UniServices 2003; Martin et al 2004):

- a 9 percent increase in visits to GPs over 12 months (and a 6 percent increase for selected infectious conditions related to overcrowding)

- a 55 percent increase in GP visits for immunisations over 12 months

- a 55 percent increase in GP visits for diabetes

- a 39 percent success rate for referring people who wished to join smoking cessation programmes

- a 56 percent increasein the use of emergency departments, a 10 percent increase in the use of outpatient clinics

- a 21 percent drop in hospital admissions over 12 months, which equated to a 33 percent drop (statistically significant) compared to a matched control group

- a 9 percent drop over 12 months in potentially avoidable hospital admissions for selected infectious diseases (such as rheumatic fever, respiratory infections, tuberculosis, meningococcal disease, cellulitis, gastroenteritis)

- a reduction in the overcrowding ratio (number of people in each bedroom), with the caveat that new space was not always used in the intended way.

In the Finlayson Park School HAZ initiative, a 98 percent return rate of measles, mumps and rubella (MMR) immunisation forms for students was achieved under the encouragement of the Hauora facilitator, although there were no comparative data available from similar schools (Voyle 2002).

There was a significant increase in the awareness of injury prevention among people living in the Ngäti Porou Community Injury Prevention Project area (25 percent post-intervention compared with 17 percent pre-intervention). From 1997 to 1999, injury morbidity statistics also showed a significant decline relative to a comparison community (Brewin and Coggan 2004).

Over the time the intensive home visiting initiative ran in Tokoroa/Mangakino and Mangere, there were increases in the annual frequency of GP attendances among the project's clients who consented to their medical records being examined (from 1.04 to 1.96 in Mangere and from 3.96 to 5.46 in Tokoroa). There were also significant decreases in hospital admissions (55 percent in Tokoroa/Mangakino and 24 percent in Mangere). As well, there was a small decrease in emergency department use in Mangere, and a small increase in outpatient visits at both sites. Outpatient non-attendance rates increased slightly in Tokoroa/Mangakino and decreased slightly in Mangere. Most of these changes were in the direction expected if the home visiting service was being effective (CBG Health Research 2004).

*Controlled studies*

Another possible evaluation strategy to gather health outcome evidence is to identify a quasi-control community – a community very similar to the community in which the intersectoral initiative is being established (Parry and Judge 2005). Selected indicators of health and wellbeing (including intermediate and final health-related outcomes) are then tracked over time in both the intervention and control communities, and compared. The idea of this approach is to control (allow) for the effects of influences unrelated to the initiatives themselves.

Qualitative research could be undertaken at the same time to compile information suitable for making a judgement about the extent to which actions generated by the intersectoral initiative may have contributed to any health improvements seen in the intervention community compared with the control community.

Controlled studies may produce credible and useful information, but are relatively expensive and difficult to set up, and have not often been used to evaluate intersectoral initiatives in New Zealand.

**Results of controlled studies**

A review by Ontario's Community Health Research Unit identifies several large-scale community-based intersectoral initiatives that included a strong focus on measuring health outcomes (including health status outcomes) using control or comparison communities (Kuhn et al 1999). Of the 20 projects, six injury prevention projects and three heart health projects demonstrated statistically significant changes in health status (e.g. lower rates of head injuries in children; lower drowning rates; lower rates of fatal road crashes; reduced fracture rates among older people; improvements in the proportion of HDL-cholesterol to total cholesterol; decreases in hospitalisation through improved blood pressure control).

Some of these projects, plus others in the group, also demonstrated statistically significant positive impacts on health risk behaviours (e.g. use of bicycle helmets among children, increases in seat belt use,increases in self-reported regular physical activity, reductions in smoking prevalence) and on health-related knowledge and attitudes (e.g. changes in attitudes towards smoking).

These findings led the reviewers to conclude that community-based public health coalitions 'can be effective' in changing outcomes related to health status or health risk behaviour, and knowledge and attitudes. This seemed to be particularly so for initiatives focusing on neighbourhoods or specific target groups, rather than on whole communities. However, the reviewers' endorsement of the effectiveness of community-based intersectoral action remains, in the end, somewhat guarded.

> Overall, the studies in this review suggested that community-based coalitions can produce good results some of the time, but that too few are achieving the improvements in health status, health risk behaviours, policies or environmental conditions that one might expect given the arguments for collaborative work (Kuhn et al 1999: 30).

The reviewers add that 'the majority of studies reviewed were supported with special research or project funding leading to uncertainty about the generalizability of these results to the day-to-day activities of public health units' (Kuhn et al 1999: 3).

As discussed in the previous subsection, evaluations of the Healthy Housing Programme and the Ngäti Porou Community Injury Prevention Programme included components that consisted of comparisons between the intervention group and a control group.

Early Start is one of the few New Zealand intersectoral initiatives that has used a randomised controlled trial design for the whole evaluation. The three-year evaluation included 220 children and their families who were receiving Early Start services and 220 children and their families who were not (Fergusson 2003).

After one year, there were few differences between these groups in the areas of well child care, home safety, maternal mental health and family economic circumstances. However, some (statistically) significant results were:

- children in the Early Start group were more likely to be attending preschool education and they attended for longer hours

- children in the Early Start group were less likely to have had contact with welfare agencies because of abuse or neglect (Fergusson 2003).

After two years (for 60 percent of the sample), there were increasingly significant differences between the groups:

- children in the Early Start group were still more likely to be attending preschool education
- Early Start children's homes had a higher average number of safety features
- a higher proportion of Early Start mothers with depression had consulted a doctor for this and were taking medication (Fergusson 2003).

After three years, Early Start children had 'better health care; greater utilisation of family doctors; increased attendance at preschool education; more positive parenting; reduced child abuse risks; and improved behavioural outcomes' (David Fergusson, personal communication, 13 April 2005). These results are also consistent with the suggestion that outcomes of intersectoral initiatives for health may take a number of years to change (Centre for Child and Family Policy Research 2005).

### *Cost-benefit analyses*

Kuhn et al (1999) note the relative shortage of studies estimating the overall costs and benefits (human and financial) of forming or maintaining an intersectoral initiative.

At least one New Zealand study, the evaluation of the intensive home visiting service operating in Tokoroa/Mangakino and Mangere, includes an economic analysis. This concludes that dollar costs were $570 per home visit and $2000–$4000 per household. These costs were not offset by reductions in hospital admissions, although the evaluators suggest that savings for each client may accumulate over a longer timeframe (CBG Health Research 2004).

*Choosing an appropriate evaluation strategy*

When all is said and done, decisions about which kinds of evaluation strategy to use for any given initiative are likely to be shaped by a variety of factors (El Ansari et al 2001; Coote et al 2004). These include what the participants in the initiative regard as the central purposes of the evaluation, its main audience, and the quantity and quality of evaluation resources available (e.g. personnel, time, funding).

Some participants in an initiative may also be concerned that the health sector's emphasis on scientific evidence, often narrowly defined, may be used during an evaluation to 'devalue the basis on which many organisations work' (Harris et al 1995: 70). Community members may also be resistant to certain forms of research approaches, which they may regard as intrusions into their lives and as a 'subtle form of control' (Labonte 1999: 7).

Decisions may also be shaped by discussions between initiative partners about what is meant by 'effectiveness' in the context of intersectoral action. How is effectiveness to be defined? Ontario's Community Health Research Unit calls for more comprehensive, shared definitions of effectiveness to be developed for community-based intersectoral initiatives. These definitions should cover 'process as well as quantitative outcomes and measures at the community level as well as individual results' (Kuhn et al 1999: 32).

Above all, as various reviews of intersectoral working observe, whatever kind of evaluation strategy is used, its research methods and the quantity and quality of evidence it seeks to provide should be *acceptable* to all the people and organisations participating in the initiative (Harris et al 1995).

It is also important to ensure that the evaluation does not overpower the actual initiative or become the dominant driver of the intersectoral process.

*Other evaluation issues*

**Intellectual property**

In some of the community action projects included in SHORE/Whäriki's meta-analysis, there was tension because of the assumption that evaluations would be the property of the evaluation funder, rather than of the project itself. Community organisations expected to have some control over the resources they had developed and the way in which information about these was shared with others (Greenaway et al 2004a).

**Trust in evaluators**

Project teams are sometimes suspicious of evaluators and perceive them as funders' watchdogs. This suspicion can be reduced if, from early on in projects, evaluators help in relationship-building processes. Trust can also be gained if evaluators are able to show that the evaluation will help the project itself, as well as helping funders (Greenaway et al 2004a).

**Critical reflection**

Apart from formal evaluation methods, projects can critically reflect on their progress in other ways. For instance, telling the story of the project to other groups, for example in meetings and workshops, and keeping journals of project activities can be of great value (Greenaway et al 2004a).

# Appendix 1: Examples of Intersectoral Initiatives for Improving the Health of Local Communities

## Introduction

Since the first literature review in 2001 (Ministry of Health 2001d), a large number of evaluation documents on intersectoral initiatives for improving the health and wellbeing of local communities has been published in New Zealand. This appendix contains short descriptions of 33 New Zealand initiatives for which evaluation reports were available and able to be accessed.[4] As well, as in the 2001 review, it describes Health Action Zones in the UK, which were models for Intersectoral Community Action for Health initiatives in New Zealand.

The descriptions of each initiative cover features such as: when the initiative started; who funded and ran it; what it aimed to achieve; and what activities it undertook. Selected results from evaluations of the initiatives have been used in Chapter 3 to illustrate success factors. Readers wanting more detailed evaluation results for individual initiatives should refer to the full evaluation documents cited in the reference list at the end of each description.

As in the 2001 literature review, the intersectoral initiatives are grouped into three categories:
- overarching area- or settings-based initiatives
- issues-based initiatives
- case-management services and one-stop shops.

Table A1 shows which category each initiative is allocated to, and the distinctive features of the initiatives in each category.

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[4] This literature review could not cover all the New Zealand intersectoral initiatives for improving the health of local communities. This is because of the very large number of initiatives that exist, many of which have not been evaluated or publicly documented in a useful way for the purposes of this review. Also, it is difficult to identify some documents as they are produced in-house for organisations such as funders, or for initiatives themselves, and are not listed in standard bibliographic databases.

**Table A1: Examples and characteristics of the three types of intersectoral initiatives for improving community health**

| | Overarching area- or settings-based initiatives | Issues-based initiatives | Case-management services and one-stop shops |
|---|---|---|---|
| Initiatives included in this report (and described in Appendix 1) | • Health Action Zones (HAZ)<br>• Healthy Cities<br>• Intersectoral Community Action for Health (ICAH)<br>• Take Ngakau Kaikohe Intersectoral Project<br>• Glen Innes Health Project<br>• Ranui Action Project (RAP)<br>• Stronger Communities Action Fund (SCAF)<br>• Community renewal projects<br>• Health Promoting Schools / Healthy Schools<br>• Finlayson Park School Health Action Zone<br>• Full Service Education in AIMHI schools | • Community alcohol action programmes<br>• Community Action on Youth and Drugs (CAYAD)<br>• Moerewa Community Project<br>• Safer Community Councils<br>• Safe Communities/ Community Injury Prevention Projects<br>• ACC ThinkSafe Community Projects<br>• Great Start Waitakere: Te Korowai Manaaki<br>• Peaceful Waves/ Matangi Malie<br>• Community nutrition programmes<br>• Pasifika Healthcare Gardening Project<br>• Housing and health initiatives<br>• TAIERI project | • Intensive home visiting<br>• Strengthening Families Collaborative Case Management<br>• Early Start/Family Start<br>• Social Workers in Schools<br>• Wraparound services<br>• Waitomo Papakainga Tracker Programme<br>• Rough Cut Youth Development Project<br>• Otago GP Link Project<br>• Christchurch Youth Drug Court<br>• Heartland Services<br>• Family Service Centres |
| Target population | Whole population of the area or setting and/or demographic subgroups based on age, sex, ethnicity, neighbourhood) | Whole population of the area or setting and/or demographic subgroups based on age, sex, ethnicity, neighbourhood) | People who require personal services across different agencies or sectors – often at-risk, disadvantaged individuals and their families or those with poor access to services |
| Target issues | A wide range of issues, e.g.<br>• health<br>• welfare<br>• economic situation<br>• employment<br>• education<br>• physical environment | One health (or other sector) issue, e.g.<br>• alcohol and/or drugs<br>• safety/injury<br>• family violence<br>• crime<br>• nutrition<br>• housing | A wide range of issue, e.g.<br>• health<br>• welfare<br>• economic situation<br>• employment<br>• education<br>• physical environment |

| | Overarching area- or settings-based initiatives | Issues-based initiatives | Case-management services and one-stop shops |
|---|---|---|---|
| Population-based health promotion/public health/ prevention programmes | • Yes | • Yes | • Occasionally |
| Personal health and welfare services | • Often (but not always) | • Occasionally | • Yes |
| Community consultation in planning and/or governance | • Yes, usually | • Variable | • Not usually |

Source: Compiled by authors

## Overarching area- or settings-based initiatives

An overarching area- or settings-based initiative is targeted to the whole population of a local community or setting, or to a demographic subgroup of that population.  This type of initiative generally addresses the health of local communities in a very inclusive, broad way.  Such initiatives look at many different health and wellbeing outcomes and many health determinants.  This means they often attempt to improve the social, economic and physical environments of their local populations as well as, or even instead of, more specifically health-related strategies.  These health-related strategies often include health promotion activities such as educating the public on preventing specific health problems and achieving a healthy lifestyle.  Some of them also attempt to improve the quality of health services and/or people's access to them.

Overarching area- and settings-based initiatives often use a community development approach to improve health and other outcomes in their local area.  This involves increasing the community's capacity to work collaboratively across different sectors and improving social capital.  The initiatives usually involve a high level of community participation in their establishment, ongoing planning and activities.

In New Zealand, evaluated initiatives have targeted the entire population of specific geographic communities (regions, cities or towns), a subgroup of the local population (children and young people) and school-based settings.  They are discussed in the following order.

### Whole population

- Health Action Zones (UK)
- Healthy Cities
- Intersectoral Community Action for Health
- Take Ngakau Kaikohe Intersectoral Project
- Ranui Action Project
- Glen Innes Health Project
- Community renewal projects

**Children and young people**

- Stronger Communities Action Fund

**School-based settings**

- Health Promoting Schools/Healthy Schools
- Finlayson Park School Health Action Zone
- Full Service Education in AIMHI schools

**Health Action Zones**

As part of its policy of establishing new Area-Based Initiatives in 1997, the UK government invited health authorities, in conjunction with local authorities and other agencies, to submit bids to establish Health Action Zones. In 1998, 11 areas in the UK were granted HAZ status ('first wave' HAZs), followed by a further 15 areas in 1999 ('second wave' HAZs).

The 26 HAZs were set up in areas of relative social deprivation and poor health status – primarily urban, industrialised regions, such as parts of London, the Midlands and the north of England.

HAZs were expected to adopt the following seven 'underpinning principles':

- achieving equity
- engaging communities
- working in partnership
- engaging frontline staff
- taking an evidence-based approach
- developing a person-centred approach to service delivery
- taking a whole systems approach.

There were two main strategic objectives for HAZs: 'identifying and addressing the public health needs of the local area, in particular trailblazing new ways of tackling health inequalities'; and 'modernising services by increasing their effectiveness, efficiency and responsiveness'.

HAZ programmes were also considered to 'represent a new approach to public health – linking health, regeneration, employment, education, housing and anti-poverty initiatives to respond to the needs of vulnerable groups and deprived communities'. That is, they were using an explicitly intersectoral approach.

Another strategic objective of HAZs was to 'develop partnerships for improving people's health and relevant services, adding value through creating synergy between the work of different agencies'. Interagency relationships involved in the establishment and ongoing management of HAZs included those between different health and social agencies, local authorities, statutory agencies, voluntary organisations, private businesses, with the public (to enlist their support and involvement), and different HAZs.

It could be said that HAZs were among the most complex, largest-scale community-based intersectoral initiatives for health.  They worked with large populations, addressing many different health and social issues, using community development and health promotion strategies, as well as providing health and social services for individual clients' treatment and care.  Usually there was a large number of partners involved in these initiatives and many also interacted with other area-based intersectoral initiatives that were working in their region.

Another feature of HAZs that made them different from many other community-based intersectoral initiatives for health was that, from the start, they were only minimally funded.  This was because it was intended to 'mainstream' HAZ activities into those of other agencies, with the ultimate aim of making HAZs themselves unnecessary.

This mainstreaming has now taken place, with all HAZs ceasing to operate as separate entities.  Functions of the HAZs have been taken over by original partners such as local authorities and health agencies and/or by more general community development initiatives such as community renewal projects or local strategic partnerships.

HAZs were evaluated extensively, both nationally and locally.  The reference list below covers just a selection of the evaluation documents produced.

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## Healthy Cities

Healthy Cities (including Healthy Communities) is an international movement developed by the World Health Organization as part of its Health For All by the Year 2000 strategy, with stimulus coming from the 1986 Ottawa Charter on Health Promotion.

Starting with pilot sites in 11 European cities, the movement has grown to now include about 1800 cities or communities worldwide. At the heart of the Healthy Cities movement is the concept of using intersectoral action and community development strategies to build a strong lobby for public health and health promotion activities within a city or rural area. The Healthy Cities model therefore essentially represents a *process* for generating local action on public health issues, rather than prescribing the kinds of health issues that should be the focus of action in a city or community.

Enthusiasm for the Healthy Cities model developed in New Zealand not long after the European pilot sites were established. It was particularly spurred by the visit of John Ashton, the co-ordinator for the Liverpool Healthy City project.

The first New Zealand Healthy City project was established in Manukau (1988), closely followed by projects in Lower Hutt (1988), Otago (1988), Christchurch (1989) and Wellington (1990). Other projects were subsequently begun in Nelson/Tasman (1991), Southland (1992),

North Shore (1992), Masterton (1993), Wanganui (1993), Porirua (1993), Gisborne (1996) and Merivale (a suburb of Tauranga) (1997).

By 1997, the Southland, Christchurch, Wellington and North Shore projects were classified as 'inactive' (Hutt and Bowers 1997). By 2000, only Manukau, Masterton and Nelson/Tasman had significant ongoing activities. The Healthy City movement does not seem to have expanded significantly in New Zealand since the 2001 literature review. In 2003, Healthy Cities still existed in Manukau, Lower Hutt, Otago, Christchurch and Wellington.

Projects in places such as Manukau, Otago and Nelson/Tasman typically involved the appointment of a full- or part-time Healthy City or Healthy Community co-ordinator, employed by either the local health authority or the local city council. These workers were responsible for promoting the Healthy Cities model in their area and building coalitions between local agencies and citizens to encourage them to identify and undertake actions to improve health.

In the case of 'Healthy Manukau', there are now 49 signatories to Te Ora o Manukau – Manukau the Healthy City Charter, including central and local government agencies, community organisations and local businesses. Recent activities have included a collaborative action plan on child poverty.

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## Intersectoral Community Action for Health

In 2000 and 2001 four Intersectoral Community Action for Health initiatives were established in Porirua, Kapiti, Northland and Counties Manukau. These initiatives were funded by the Ministry of Health and began as local community responses to health issues.

The projects, modelled on the UK's Health Action Zones, aimed to improve the health of local communities by pursuing a number of objectives, the focus of which was on working intersectorally. The objectives were to:

- improve health and disability outcomes in the community, particularly for Mäori, for Pacific peoples, and for population groups who have worse outcomes
- develop initiatives that address health outcomes, broadly understood
- harness the support and involvement of local authorities, iwi and agencies responsible for health, housing, transport and education
- harness the wisdom and expertise of local communities, including providers, alongside that of policy makers, planners and funders
- develop intersectoral capacity for successful joint community action across sectors
- pilot and evaluate the current initiatives so the lessons learned can be included in guidance to DHBs (Martin et al 2004: 1).

Geographic communities were prioritised for project funding using several criteria. These criteria included having a population greater than 10,000 with a high relative deprivation score of 8–10 on the NZDep96 scale. Mäori were to comprise over 20 percent of the population and there were to be significant differences in health status among Mäori, Pacific and other populations. The projects were to use community engagement and development principles and were to tackle wider determinants of health, as well as improving access to health and disability services. The community also needed to be willing and able to work using an intersectoral approach.

The four ICAH projects differed significantly from one another in the demographic characteristics of their communities, in their governance structures and participants, in the degree of community participation, and in the ways in which they were operating. They also differed in the types of activities they were undertaking, with some focusing more on health services and others more on health determinants.

### Northland

There were three projects in Northland, each one run by one of the three ICAH partners:
- Whakawhiti Ora Pai co-ordinated the Hei Oranga i te Whenua gardening and nutrition project
- Te Hauora o Te Hiku o Te Ika ran the Ahipara Youth Intersectoral Project (youth camps)
- Te Runanga o Te Rarawa ran the Tu Mai youth support project, helped by the Ministry of Education and Work and Income.

### Counties–Manukau

Counties–Manukau partners included: the Counties–Manukau District Health Board (which employed an intersectoral project manager); Housing New Zealand Corporation; Ministry of Social Development; Work and Income; NEW ZEALAND Police; Child, Youth and Family Services; Te Puni Kökiri; Ministry of Pacific Island Affairs; and Strengthening Families. Projects included:

- Youth Interagency Project, which generated several youth-focused intersectoral projects including AIMHI (see subsection below on Full Service Education in AIMHI schools)

- Healthy Housing pilot programme (see subsection below on housing and health initiatives).

### *Kapiti*

The Kapiti Community Health Group Trust managed the funding of this ICAH. The Trust consisted of representatives from smaller geographic communities within the region, Kapiti District Council and other members with expertise in health, community matters and technical issues. 'Partner organisations' listed by the initiative's annual plan were Ngäti Raukawa, Te Ati Awa ki Whakarongotai Inc, Ngäti Toa Rangatira, Kapiti and Coast District Council, Ministry of Health, Capital & Coast District Health Board, MidCentral District Health Board and Kapiti PHO. One of the ICAH's main projects was the Otaki Community Health Worker service which aimed to increase access to primary health care. It also did advocacy work on health issues such as access to services, communication with the community and with service providers, and providing a health and disability information service. Additionally, the ICAH had a significant role in developing the Kapiti PHO, including ensuring that community representatives were elected to the PHO Board.

### *Porirua*

The Porirua Healthlinks Trust (PHLT) consisted of two committees – the PHLT Trustees group and the PHLT committee. The PHLT Trustees group comprised nine trustees responsible for legal, administrative and policy matters. The PHLT committee had representatives from community groups such as Pacific peoples, Ngäti Toa, Porirua City Council, and Porirua Safer City Trust. Some of the high-priority projects of the ICAH were: participating in the redesign of Kenepuru Hospital; PHO development; improving access to primary care (the Improving Access to Primary Care in Porirua initiative); development of a Health Cluster working on local health issues; an electronic newsletter (Allpoints); community health forums; and a diabetes project.

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## Take Ngakau Kaikohe Intersectoral Project

In 2001, the Take Ngakau Kaikohe Intersectoral Project in Northland was established through funding from the Ministry of Health. The initiative served a rural area with a 70 percent Mäori population. The initiative's partners were Ngäti Hine Health Trust, Northland Health Ltd Community Health Services and Te Hau Ora o Kaikohe.

The objectives of the initiative were 'to improve the health and wellbeing of the community by addressing the broad determinants of health through a sector-wide approach to health' (Henwood and Adams 2003: 8). This was done by:

- addressing the determinants of health that affected the wellbeing of Kaikohe people
- initiating actions to reduce health and other inequalities
- taking a sector-wide approach to public health through improved networking and planning across the community, health and social services and local and government agencies.

A project co-ordinator was appointed at the end of 2001, and an office base was established in a central Kaikohe location where other community service organisations were also working. Later several more staff were employed. A project steering group was also set up.

Project activities included considerable networking with other groups and the media, developing a community development action plan, liaising with the media, producing a regular newsletter/pänui, developing the Kaikohe Community Trust website, developing a directory of local services and organisations, and contributing to the establishment of a local PHO. The initiative also ran an activity week that included an alternative health expo, a PHO community forum, Tai Tokerau Organic Producers Inc. Society event, Pioneer Village open day and a visit to the sulphur and mercury mines at Ngawha. Community feedback on the project was also gathered during the activity week.

### *Reference*

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## Ranui Action Project

The Ranui Action Project was established in Ranui (West Auckland) in 2000 in response to the Waitakere Health Plan that called for a Health Action Zone in the area. It was funded by the Ministry of Health and Child, Youth and Family Services (the latter through SCAF) with the Waitakere City Council as fund-holder and project co-ordinator.

A steering group (later known as the RAP Society) was set up and in early 2001 RAP was publicly launched at the Ranui Fun Festival. It was then decided to set up RAP as an incorporated society, and 16 committee members were elected. Subcommittees on human resources and funding were established, as well as focus groups for Mäori, Pacific peoples, and youth. There were also working parties and interest groups. A paid manager and administrative staff were employed by the project.

RAP had four broad goals:

(1)    improve local health and wellbeing

(2)    expand community capacity

(3)    increase access to services

(4)    revitalise the Ranui community.

RAP had a particularly strong emphasis on community engagement.  Its activities included: producing the Ranui Action Plan, with input from local people; holding a Futures Creation Festival; running or funding a range of small-scale projects (such as ClicIT, Books for Keeps, Trash to Fashion), some of which were initiated by members of the community (Go Now projects); developing partnerships with other community organisations to deliver programmes such as a road safety project; producing a newsletter (RAP RAVE); creating a website; setting up a radio station; running a School Certificate coaching project; and buying a house to use for RAP activities and to generate income.

In 2004, eight priority projects were chosen:

(1)    health information centre

(2)    early childhood development

(3)    business forum development

(4)    community garden

(5)    community information and communication technologies

(6)    Violence Free Ranui

(7)    Ranui youth leaders collaboration

(8)    Radio Ranui scoping.

### References

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Conway K, Adams J, Witten K.  2003a.  *Evaluation of the Ranui Action Project: Final Report.*  Centre for Social and Health Outcomes Research and Evaluation and Te Röpü Whäriki, Massey University.

## Glen Innes Health Project

The Ministry of Health funded the Glen Innes Health Project in 2002 to develop a stocktake of existing home visiting by social service workers and to support them in this work.  Auckland City Council was the fund-holder and administrator for the project.  Later, in response to concerns expressed by community workers, the scope of the project was expanded to include facilitating intersectoral and interagency collaboration to promote community health and wellbeing.  It was also to develop new action concerning the local social determinants of health.

The project facilitator who was employed worked first in an office shared by SCAF staff, and then in an office in the Glen Innes Community Centre.  A working group was set up which met regularly to discuss local health priorities and collaborative ways of addressing health determinants.  The working group meetings were topic-based so members with interests in

certain topics – such as smoking, housing, inorganic rubbish collection, meningococcal disease, preschool children – could attend appropriate meetings.

Extensive community networks and relationships with local social service workers and community leaders were built.  Strategic, action and implementation plans were also developed.  Project activities included a youth day, children's health days, a gardening training day and a clean-up campaign.  The project also collaborated on several initiatives with other local groups including Te Awhi Tangata (a physical activity, nutrition and lifestyle programme), the Healthy Homes initiative, the Healthy Lifestyles Initiative for Pacific Communities and the GI Lynx (a project newsletter).  A services database was developed, and a gambling initiative and a programme for young parents were planned.

*Reference*

Scott K, Conway K.  2005.  *Evaluation of Glen Innes Health Project: Final Report.*  Auckland: Centre for Social and Health Outcomes, Research and Evaluation, Massey University.

## Community renewal projects

From 2001 to 2002, Housing New Zealand Corporation funded five community renewal projects for a period of three to four years.  This funding was in recognition of the role of housing improvement in the renewal of communities and social change (i.e. housing's contribution to the wellbeing of communities).

The objectives of the community renewal initiative and projects were:

1.  improve and enhance physical environment and amenities

2.  use the principles of community development to build community leadership and implement sustainable community-led solutions

3.  provide targeted needs-based tenancy and property management services

4.  create links to programmes that enhance resident employment and business growth

5.  provide access to affordable and appropriate community services that respond to changing community needs

6.  improve neighbourhood safety and reduce crime

7.  build social networks to facilitate residents supporting each other (Nunns 2004: 3).

The five projects were sited in areas with high proportions of state housing and each involved the participation of several groups:

• **Aranui** (Christchurch) – Aranui Community Trust Incorporated Society, Christchurch City Council

• **Fordlands** (Rotorua) – Rotorua District Council, Fordlands Community Association, Sunset Junior High and Primary Schools, Fordlands Residents and Landlords Association, Rotorua Pacific Islands Development Charitable Trust

• **Clendon** (South Auckland) – Clendon Residents Group, Habitat for Humanity, New Zealand Housing Foundation, Manukau City Council, Clendon Community Support Group

- **Talbot Park** (Glen Innes, Auckland) – Auckland City Council, Ka Mau te Wero, Glen Innes Collaboration Group
- **Eastern Porirua** (Wellington) – Porirua City Council, Housing Action Porirua, Tokelau Association, Wellington School of Medicine.

The five projects were evaluated.  Subsequently, a sixth community renewal project was established at Northcote Central (North Shore), but was not evaluated.

The projects included a range of large- and small-scale activities such as:

- an extensive redevelopment and replacement of HNZC properties at Talbot Park

- changing the appearance of HNZC properties at Porirua and Aranui

- a 'One Choice' project where tenants could choose one thing they most wanted to change in their house

- energy retrofits of existing houses

- activities to foster community identity and pride, community consultation, community participation (including by youth, Māori, Pacific peoples), establishing and strengthening community structures, building leadership and skills

- Intensive Tenancy Management at two sites where tenants were assisted with housing issues and referred to social agencies and service networks where they had other needs

- lobbying of local private landlords to improve maintenance of their rental houses

- facilitating training and employment opportunities for local people in relation to maintenance and improvement of HNZC's own properties

- linking with other agencies and providers associated with training, employment and business opportunities for local people

- one-stop shops where other agencies work alongside community renewal teams in a community house – this includes Under One Roof which is a joint venture of HNZC, Work and Income and the Community Services Card; and sharing of community houses by health workers such as public health nurses and Plunket nurses

- meetings with other government agencies and community groups

- partnerships with and lobbying of local business to improve the rundown appearance of local shopping centres

- using crime prevention through environmental design principles in housing redevelopment areas

- security upgrades of HNZC properties

- establishing neighbourhood support groups

- building carparking areas and driveways on HNZC properties

- improving lighting

- sponsoring youth drug and alcohol prevention programmes

- improving road safety

- establishing a volunteer security patrol

- running events that bring neighbours together such as street barbecues, graffiti 'wipe-out' days, family fun days and gardening workshops.

### References

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Nunns H. 2004. *Community Renewal Project Evaluations: Synthesis and Discussion of Findings*. Wellington: Research and Evaluation Team, Housing New Zealand Corporation. (A summary of a series of evaluation reports by SHORE.)

## Stronger Communities Action Fund

The Stronger Communities Action Fund was based on the United Kingdom's New Deal for Communities initiative that addressed the problems of disadvantaged neighbourhoods through devolvement. The fund was established as a pilot project for four years until June 2004, with the purpose of improving the wellbeing of children and young people by:

- encouraging communities to identify their needs
- supporting innovative ideas from within communities to address those needs
- testing this new approach to decision making
- increasing the strength and capacity of communities in need (Research and Evaluation Unit 2004: 6).

Sites were chosen for funding on the basis of economic need, and comprised small disadvantaged communities within wealthier areas. They represented a range of rural, urban, provincial and kin-based settings throughout New Zealand. The first seven sites established under the 2000/2001 budget were: South Hokianga; Glen Innes (Auckland); Ranui (Waitakere); Whakatane; Mangakino; Porirua; and Awarua (Bluff). These seven sites were evaluated. Two years later Wairoa and Aranui (Christchurch) were added to the scheme.

SCAF initiatives were three-way partnerships of Child, Youth and Family Services, a representative community group and a local organisation acting as fund-holder. There was a part-time national SCAF advisor, located in the national office of CYF, and some sites also had a local funding advisor. Full-time local co-ordinators were appointed in five sites and a part-time co-ordinator worked at another. New organisations were established at two sites to run the initiatives, whereas three others formed committees or used existing organisations.

Activities at the various sites related to health, youth engagement, violence prevention, services to the community, assistance to Mäori, assistance to new residents, employment, safer families, assistance to women, and community governance. They included:

- **Aranui** – needs analysis, progress towards an action plan, and partnerships with Housing New Zealand Corporation, Christchurch City Council and CYF

- **Awarua** – a range of initiatives to improve the wellbeing of young people including holiday programmes, remedial reading programmes and young achievers' awards

- **Glen Innes** – a range of projects including Whänau Development Programme and World Café as part of wider locally-developed strategy

- **Mangakino** – several initiatives that benefited young people and the marae
- **Porirua** – support of 25 local initiatives and development of an action plan
- **Ranui** – establishment of an incorporated society and training of local residents to run this, support of local initiatives, and relationships established with other funders and agencies
- **South Hokianga** – establishment of a Trust, identification of local needs and organised events, establishment of a Cyber Centre for kaumatua, and assistance to other local initiatives
- **Wairoa** – needs analysis, development of a draft plan, planning of work within Wairoa Development Strategy
- **Whakatane** – Cyber Café, Taiohi 98.4 FM youth radio station, Whänau Centre at Te Teko.

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## Health Promoting Schools/Healthy Schools

Health Promoting Schools (also known as Healthy Schools) were developed under the principles of the Ottawa Charter for Health Promotion. The emphasis was on joint working between the health and education sectors so that individual schools develop 'an organized set of policies, procedures, activities and structures, designed to protect and promote the health and wellbeing of students, staff, and the wider school community members' (Rissel and Rowling 2000).

Health Promoting Schools were expected to promote health within their general operations, health curricula, teaching processes, social policy and physical environments. They were also

expected to promote health through their links with students' families, the local community and other agencies.

In New Zealand, the Public Health Commission defined Health Promoting Schools as working in five main areas:

- Building on policies to promote the health and wellbeing of students and staff.

- Creating school environments which promote the health and wellbeing of students and staff.

- Strengthening local community involvement.

- Developing personal skills to promote health and wellbeing of students and staff.

- Co-ordinating school health activities aimed at promoting the health and wellbeing of students and staff (Dowden and Kalafatelis 1999: B-1).

Health Promoting Schools were introduced into New Zealand through pilot schemes started in 1997. Evaluations have assessed how successful these pilot schemes were in the Northern Health Funding Authority region and in the Midland, Central and Southern Health Funding Authority regions.

In Northland/Auckland, the Northern Health Funding Authority contracted four Crown Health Enterprises, one city council and one school to establish Health Promoting School initiatives. Two regional co-ordinators and 10 local co-ordinators were employed to support the 59 initiatives established. Forty of these initiatives took part in an evaluation.

In the Midland, Central and Southern Health Funding Authority regions, 30 Health Promoting Schools were evaluated.

Each school identified its own priority health areas to address, often through some kind of needs analysis (for example, a survey). Some of the main issues for Health Promoting Schools and examples of their activities were:

- mental health issues – Eliminating Violence programme, laughter weeks, Positive Pupil awards, a grief policy

- the school's physical environment – Sunsafe activities (hats, planting trees for shade, providing sunscreen), litter, improving toilets

- injury prevention – road and playground safety, back care, safe area for parents to drop off and pick up children, improving accident reporting systems

- nutrition – healthier food in tuck shops, subsidised breakfasts or lunches, Pacific Heartbeat, water cooler system

- staff health and wellbeing – reducing stress, improving communication, Smokefree policy.

### References

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Wyllie A, Postlethwaite J, Casey E. 2000. *Health Promoting Schools in Northern Region: Overview of Evaluation Findings of Pilot Project.* Auckland: Phoenix Research (for the Health Funding Authority, Northern Office).

## Finlayson Park School Health Action Zone

This New Zealand Health Action Zone project, located at Finlayson Park Primary School, was funded for one year by the Ministry of Health in an attempt to encourage collaboration across local Crown and community agencies. Finlayson Park School was a decile one school in Manurewa, South Auckland, whose roll had a high proportion of Māori and Pacific students. In 2001, two new positions were created at the school as part of the Kidz First Public Health Nursing Service. The first position was a full-time health facilitator/co-ordinator, known as the Hauora (Health) facilitator. The second position was a part-time public health nurse to provide personal care to students.

The aim of providing these two positions was to reduce barriers to health and welfare services to the school students and their families. In turn, it was hoped that this would directly and indirectly improve students' health and educational outcomes. To do this, the project workers were expected to:

- map the health and wellbeing services that were available at the school
- inform students and their families of how to access these services
- identify health and social barriers to educational achievement and school attendance, including special needs issues
- facilitate a co-ordinated, client-centred approach through a multi-disciplinary team
- achieve a comprehensive service meeting the school community's health and social needs
- optimise selected health and social wellbeing programmes within the school
- detect and treat hearing loss and ear disease.

*Reference*

Voyle J. 2002. *An Evaluation of the Health Action Zone Pilot at Finlayson Park School, South Auckland*. Auckland: Community Research and Evaluation Services (for Kidz First South Auckland Health).

## Full Service Education in AIMHI schools

Full Service Education (also known as Healthy Community Schools) was an initiative that co-located a range of community services, such as health and social services, in school settings. It aimed to 'strongly connect community aspirations/goals with school aspirations/goals to maximise the potential for interventions to respond to student needs both within and beyond school' (Thomas et al 2003:4).

The goals of the project were to improve health and social outcomes for students so they were able to achieve better educational outcomes. This improvement would be possible because they would face fewer barriers to learning; and students' health and wellbeing issues would not distract teachers.

A pilot programme of FSE was announced in 2001, with all nine schools in the Achievement in Multicultural High Schools Initiative participating. There were eight AIMHI schools in South Auckland and one in Porirua. All were in decile one urban areas with a high proportion of Māori and Pacific students. In Counties Manukau, the AIMHI schools were part of the Youth Intersectoral Project, which was linked to the local ICAH initiative. Intersectoral collaboration was considered an essential part of the FSE programme.

As well as providing personal health and social services to students and staff, these initiatives engaged in wider health promotion activities in their school setting, and addressed wider health and wellbeing issues in the whole school community. Activities of FSE have included:

- a social worker or community worker in each school
- an operational health centre in each school with a registered nurse and visiting doctors, physiotherapists and dentists
- a co-ordinated student support service
- the Keeping Schools Safe Programme
- participation in evaluation.

*References*

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## Issues-based initiatives

Issues-based initiatives mainly aim to address *one* particular type of health outcome rather than dealing with a whole range of health issues. They target either the entire population of a specific geographic community or a subgroup of that population, such as young people or Māori.

Some of these initiatives have been established as smaller projects under overarching area- or settings-based initiatives, whereas others have been stand-alone.

Like the overarching area- or settings-based initiatives, issues-based initiatives engage in a variety of activities targeted at local communities. This usually includes prevention of health problems through health promotion activities such as public education and changing the environment (including physical, social, economic, health services and legal factors). Less commonly, they may also contain elements of case-management of at-risk individuals. Evaluated issues-based initiatives in New Zealand have often used a community development approach to their work. However, the degree of community participation has varied.

Many issues-based initiatives can be classified as 'community action projects'. Community action projects 'work by engaging organisations and selected members from a local community to focus on the particular topic' (Duignan et al 2003: vi). The projects often address an issue specified by national health policy. They also use strategies based on research-based knowledge from previous projects (Casswell 2000; Duignan et al 2003).

Topics that have been covered by New Zealand issues-based initiatives include alcohol and drug use, injury prevention, violence, nutrition, housing and water resources. The initiatives are discussed below in the following order.

### Alcohol and drugs

- Community alcohol action programmes
- Community Action on Youth and Drugs
- Moerewa Community Project

### Safety/injury

- Safer Community Councils
- Safe communities/community injury prevention projects
- ACC ThinkSafe Community Projects

### Family violence

- Great Start Waitakere: Te Korowai Manaaki
- Peaceful Waves/Matangi Malie

### Nutrition

- Community nutrition programmes
- Pasifika Healthcare Gardening Project

**Housing**

- Housing and health initiatives

**Water resources**

- TAIERI Project

## Community alcohol action programmes

A range of community alcohol action programmes have been run in New Zealand since the 1980s.

### Community alcohol project

The first New Zealand community alcohol project (CAP) ran from 1982 to 1985 and consisted of a large-scale, relatively resource-intensive, quasi-experimental 'research-initiated demonstration project' involving six New Zealand cities. The interventions for the project consisted of a mass media campaign in two of the six cities, and a mass media campaign and community organisation process in another two cities. The remaining two cities served as 'reference' cities, having no interventions. The overall objective was to change attitudes to alcohol use and increase support for alcohol control policies. The project did not include interventions organised around enforcement such as compulsory breath testing.

### Drink driving initiatives

Building on the lessons learned from CAP, community alcohol action projects were subsequently initiated in a number of New Zealand cities, towns and regions. These included Hamilton (Drink Drive Campaign 1986), Wanganui (Drink Drive Die 1987), Dannevirke (Drink Drive Die, and How Much is Enough 1987–1989), Christchurch (Lifesaver 1992), Hawkes Bay, Gisborne, Bay of Plenty, North Shore City (Community Alcohol Responsibility Scheme), Wellington (We've Had Enough End Liquor Smashes, or WHEELS), Tokoroa (Drinkwise), Auckland (Community Alcohol Action Programme 1995–1996), Otago, and rural Waikato (Waikato Rural Drink Drive Project 1996–1998).

Most of these projects included a major focus on drink-drive traffic-crash prevention through stepped-up enforcement campaigns. Several were funded in part by the Land Transport Safety Division, with Police also contributing extra staff and resources.

Projects typically were based on collaborative working between relevant local agencies such as Police, local authorities and health agencies. Three examples with significant evaluation components are the Wanganui Community Alcohol Action Programme (Drink Drive Die), the Christchurch Lifesaver project and the Waikato Rural Drink Drive Project.

**Wanganui Community Alcohol Action Programme**

The Wanganui Community Alcohol Action Programme (Drink Drive Die) mobilised local resources and organisations in Wanganui to join forces to promote responsible attitudes to alcohol consumption and driving after drinking. This was the first time in New Zealand that

actions related to enforcement were combined with community-action type efforts (education and publicity) in a single programme.

**Christchurch Lifesaver project**

The Christchurch Lifesaver project aimed to integrate resources and expertise from various organisations, institutions and communities. The project was initiated and run by the Christchurch City Council's Traffic Safety Co-ordinating Committee, which included representatives of various locally-based organisations with an interest in traffic safety, such as the Automobile Association, Canterbury Regional Council, Police, Transit NEW ZEALAND, ACC, and the Canterbury Area Health Board's Road Safety Unit. A co-ordinator was employed to run the project.

**Waikato Rural Drink Drive Project**

The Waikato Rural Drink Drive Project was a pilot community alcohol action project in the Te Awamutu Police District. A project co-ordinating group took responsibility for running the project; the group included representatives from national bodies such as the Alcohol Advisory Council (ALAC), the Police and the Alcohol and Public Health Research Unit, as well as staff from regional- and local-level agencies such as liquor licensing inspectors, health promotion advisors and Land Transport Safety Authority (LTSA) regional staff. While initially the project put a major emphasis on community mobilisation, subsequently the project was refocused towards the 'preservation and enhancement' of existing efforts to influence drinking environments and police activities.

### *Whiriwhiri te Ora or Choose Life programme*

Two Mäori-focused community alcohol action projects have included a significant degree of intersectoral working. The Whiriwhiri te Ora or Choose Life programme was a marae-based programme developed by the Huakina Development Trust Board, based in Pukekohe. Kaumatua were closely involved in the campaign, as were Mäori wardens, who, along with kaimahi, gave addresses to many groups and organisations. A key feature of the campaign was the development of a co-operative relationship between Whiriwhiri te Ora representatives and the local Police in Pukekohe, which resulted in Whiriwhiri te Ora giving more active support to Compulsory Breath Testing strategies.

### *WHANAU and Tu BADD (Brothers Against Drink Driving)*

The WHANAU and Tu BADD (Brothers Against Drink Driving) project was developed by the Te Whänau o Waipareira Trust Board and aimed to encourage young men to take responsibility for issues surrounding drinking and driving. The project targeted 20–30-year-old Mäori males and campaign messages centred on Mäori notions of manhood. Collaborative action involved a range of groups including community, Police, councils, marae, education, justice and sports organisations.

*Auckland Regional Community Action Project*

A more recently-developed initiative was the Auckland Regional Community Action Project on alcohol. This was developed in response to local stakeholders' concerns about the lack of collaboration and co-ordination of alcohol health promotion activities in the region. The Ministry of Health and MAPO brought together Ministry-funded alcohol health promotion service providers to discuss worsening trends in alcohol consumption among young people living in Auckland. These organisations included the Auckland Regional Public Health Service, Alcohol Healthwatch, Safe Waitakere Alcohol Project and Hapai Te Hauora Tapui. The project aimed to 'engage organisations across the Auckland region in collaborative evidence-based activity to reduce alcohol-related harm' (Casswell et al 2003: 10).

ARCAP had no new funding for extra staff, and therefore had to redirect existing resources in order to achieve the project's objectives, which were to:
- reduce the social supply of alcohol to under 18s
- reduce the access to off-licence purchases of alcohol for under 18s
- reduce on-licensed premise intoxication of under 25s
- reduce drinking and intoxication in public places
- influence and challenge existing social norms (e.g. the marketing and promotion of alcohol).

The main activity of the initiative was the pseudo-patron survey which monitored the age-verification practices of alcohol retailers. This project was complemented by a range of other activities undertaken by individual ARCAP member organisations.

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## Community Action on Youth and Drugs

This initiative, developed in 1997, originally ran in six city and rural areas with relatively large Mäori youth populations and/or high youth unemployment (Hokianga, Whangaruru, Kaitaia, West Auckland, Opotiki and Nelson). Funding for the initiative was originally from the Ministry of Education and then from the Ministry of Health. By 2003, a further 16 communities had joined CAYAD.

The five main objectives of CAYAD were to:
- increase informed debate on drug issues and their impact on the community
- promote, implement and support policies and safe behaviours concerning drugs
- identify best practice programmes to address school and student needs
- develop alliances between organisations and sectors
- develop local resources to raise awareness, and support youth 'voice' and discussion on decreasing drug-related harm.

A community action worker employed in each location was responsible for developing local resources and alliances between organisations and agencies, as well as for encouraging young people to develop their own drug and alcohol harm reduction strategies.

### He Rangihou New Day Project

The He Rangihou New Day Project began in Opotiki in 1998. Its umbrella organisation was the Safer Community Council (funded by Opotiki District Council and the Crime Prevention Unit of the Ministry of Justice). The target group of the programme was youth (particularly Mäori) aged 10–25 years. It worked from a holistic perspective and recognised alcohol and drug misuse and abuse as symptomatic of deeper, more complex social and personal issues. Out of this came the development of various strategies aimed at encouraging everyone in the local community to take responsibility for the wellbeing of young people. There has been a move away from the project's original focus on schools to young people's homes and the wider community.

### Te Runanga o te Rarawa, Hokianga and Whangaruru

These three CAYAD projects used a range of different approaches to reduce the drug- and alcohol-related harm among local young people. Activities, which often employed an emphasis on sport, included:
- **Te Runanga o te Rarawa** (based in Kaitaia) – involvement in health promoting schools; a smokefree and drug-free initiative; publicity through the media; employing a Mäori co-ordinator in He Oranga Poutama in the Far North; introducing a team approach to health services; sports activities such as basketball; an inter-school debate; production of a video; 'Nip it in the Bud' project; health expos; school holiday programmes

- **Hokianga** – Peer Sexuality Support Team/Hokianga Youth Council; coaching, supporting and participating in various sports; youth beach camps; school and marae events; 'Pa Wars' annual sporting and cultural event; school programmes; and CAYAD worker as a role model for young people

- **Whangaruru** – smoke-, cannabis- and alcohol-free sports club; creation of employment opportunities in the seafood industry; submission to select committee; public debate about cannabis and the local economy; and CAPOW youth programmes (rugby/sports, waka ama, billboards, exchanges with Canada, enhancing employment and income opportunities).

By 2001, both the Te Runanga o te Rarawa and Whangaruru CAYADs had moved towards an approach looking at the wider social and economic determinants of health in their areas, whereas the Hokianga CAYAD remained more focused on education and clinical services.

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## Moerewa Community Project

The Moerewa Community Project was established in 1995. It was funded by ALAC and then the Community Employment Group, and addressed alcohol and drug use among community members in Moerewa, Northland. A broad community development approach was taken which was consistent with the project team's understanding that problems related to drugs and alcohol were symptoms, rather than causes, of local issues. An understanding of historical issues was also considered to be important.

Working through issues as whänau, and drawing on tikanga Mäori approaches, activities have been designed to inspire community spirit and vision. Activities have included: developing the phrase 'Moerewa on the Move'; running a well-attended three-day festival; building a new public toilet in a collaborative way; supporting a mural; making over a local building; and purchasing a block of local shops to help businesses to be established.

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## Safer Community Councils

In 1990, four pilot Safer Community Councils were launched in Ashburton District, Christchurch City (Sydenham electorate), Manukau City and the Wairoa District. The pilot scheme was initiated by the Prime Ministerial Safer Communities Council, comprising Ministers of the Crown whose portfolios covered social services and policy, the Commissioner of Police, the Deputy Secretary for Justice and the mayors of the four local authorities. The role of the Prime Ministerial Safer Communities Council was to set policy guidelines for SCCs and promote public interest and discussion on crime prevention.

Each local SCC received $40,000 for a co-ordinator for two years and a project fund of $15,000. The Crime Prevention Administrative Unit was also available to give advice, information and guidance. The main focus of each SCC was local crime prevention and promoting safer communities. All four pilot projects were evaluated.

Once launched, the SCCs operated in different ways and ran a wide range of different (mainly short-term) projects. Some of the projects were initiated by SCCs themselves. For others, SCCs funded existing initiatives run by other community groups. Most local initiatives targeted wider social issues by promoting activities that addressed issues such as parenting skills, after-school activities, reading support, budget advice, involvement in sports teams, and smoke detectors.

Each SCC included representation from the local authority, Police, the Departments of Justice and Social Welfare, and the NEW ZEALAND Employment Service. Other SCC members included staff from the Department of Internal Affairs, Te Puni Kökiri, and Housing, as well as representatives from the education and health sectors.

By 2003, 65 SCCs were operating in New Zealand, with a total funding of approximately $1 million each year.

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## Safe Communities/community injury prevention projects

The WHO's Safe Communities concept was developed out of Swedish injury prevention programmes run in the 1980s. Intersectoral collaboration, community involvement/development, and targeting of programmes towards at-risk groups were the bases for the approach. Worldwide there are now 80 formally-designated WHO Safe Communities members, including Waimakariri (formerly Safe Rangiora) and Waitakere in New Zealand. Formally-designated Safe Communities must have:

- an infrastructure based on partnership and collaboration, governed by a cross-sectional group that is responsible for safety promotion in their community

- long-term, sustainable programmes covering both genders and all ages, environments and situations

- programmes that target high-risk groups and environments, and programmes that promote safety for vulnerable groups

- programmes that document the frequency and causes of injury

- evaluation measures to assess their programmes, processes and the effects of change

- ongoing participation in national and international Safe Communities networks.

Safe Communities/community injury prevention projects in New Zealand that have been evaluated include those in Rangiora/Waimakariri, Kawerau, Waitakere and Tairawhiti (Gisborne/East Coast area). Other similar projects exist in Manukau, Whangarei and Auckland City.

### Rangiora and Kawerau

Both the Rangiora and Kawerau projects were originally established in 1993 and were funded by the Public Health Commission and managed by the Plunket Society. However, in 1996 management of the Rangiora project was taken over by the Waimakariri District Council and management of the Kawerau project was taken over by the Eastern Bay of Plenty Rural Education Activities Programme (REAP). At the same time the Regional Health Authorities took over the Public Health Commission's funding role.[5]

The two projects primarily addressed injury prevention among children aged under 15 and ran activities such as Keep Kids Safe Near Water, Fun in the Sun, Poisons Awareness, playground safety, and use of car restraints. Many of these activities were local promotions of national campaigns, rather than being locally-developed.

### Waitakere

In 1994, Waitakere City Council set up another community injury prevention programme in response to funding being available from the Public Health Commission for pilot projects. The Waitakere City Council saw such a programme as being consistent with its principles of partnership and intersectoral development and persuaded Safekids and the Henderson branch of ACC to join in its bid.

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[5] By 2003, community injury prevention projects were being funded by the Ministry of Health.

The aims of the Waitakere initiative were to:

- increase awareness of ways to prevent injury
- ensure sustainability beyond three years
- advocate for policies and programmes to develop a safety culture
- create safe places by reducing risk factors and hazards for specific types of injury.

Seven priority areas were identified (Māori, Pacific, children, young people, older people, alcohol, and road-related injuries). Early in the initiative, three sub-projects were formed – a Māori project (Puriri), a Pacific project and a general population project – each with a co-ordinator. Activities included a car restraint campaign, a home safety equipment project, hui, a mural, initiatives for kaumātua, tamariki safety day, marae safety checklist, education kits on burns, displays, education sessions, injury prevention brochures, rap song and art competitions, and a community survey of falls among preschool children.

### *Turanganui a Kiwa and Ngāti Porou*

In 1995, two further community injury prevention pilot projects were set up by Tairawhiti Healthcare in conjunction with the two Māori organisations of Turanganui a Kiwa (based in Gisborne) and Ngāti Porou (based in Ruatoria). These projects were funded for three years, first by the Public Health Commission, then by the Regional Health Authority, and they shared a management team.

The Turanganui a Kiwa project in Gisborne city identified the following as priorities: road traffic safety for children (tamariki); family violence; alcohol-related harm; and environmental hazards such as fires and road safety. Promotional activities included using various media and holding hui at schools, marae and sports clubs. There was one project co-ordinator.

The Ngāti Porou project in the large rural area north of Gisborne identified similar priorities: road traffic safety, family violence, alcohol and drug-related harm, environmental hazards such as those related to playgrounds and forestry roads. Activities were focused on marae using a tikanga Māori approach and included hui, education campaigns and other activities relating to the priorities. Three co-ordinators were employed by the project.

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## ACC ThinkSafe Community Projects

In 2002, ACC established ThinkSafe Community Projects in 23 New Zealand locations. These initiatives aimed to prevent injuries in local populations. They provided for: 'strategic partnerships; the building of community coalitions; strategic targeting; profiling, analysis and planning; and the implementation of prioritised interventions' (Coggan et al 2003: 34). Building community capacity, involving employers, using the media, monitoring project performance and considering the Treaty of Waitangi were also integral to the projects.

While similar to Safe Communities/community injury prevention projects (see above) in that they covered all population groups and environments, ACC's ThinkSafe Community Projects included a focus on occupational injury prevention and involved employers as partners and stakeholders in the projects. ACC also provided strategic, technical and financial support directly to communities through the injury prevention skills and resources of its staff. The aim of this approach was to encourage a safety culture and create safe environments to reduce the severity and frequency of injuries.

As part of this strategy, ACC injury prevention consultants worked in partnership with local community organisations on short- and medium-term projects covering issues such as safety on roads, at work, in the community and in sport and recreation. Local ACC data were also used to identify local priority areas for injury prevention.

A formative evaluation of the ThinkSafe Community Projects included 10 of the 23 project sites: Whangarei; Auckland; Hamilton/Waikato; Tauranga; New Plymouth; Gisborne; Porirua; Wellington; Nelson; and Christchurch.

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## Great Start Waitakere: Te Korowai Manaaki

Great Start Waitakere: Te Korowai Manaaki was a primary family violence prevention initiative targeting children aged under five who were living in Waitakere City. It was established in 2003 in the context of:

- several high-profile cases of fatal child abuse in New Zealand

- the introduction of the national *Te Rito* family violence strategy

- the release of The Agenda for Children

- the status of multi-agency collaborations as a 'fashionable response to the problem of domestic violence' internationally (Elizabeth 2004: 2)

- a long history of local interagency collaboration in the family violence field including a network of agencies called Waitakere Anti-violence Essential Services (WAVES), which had been running since 1993

- citywide safety plans organised by Safe Waitakere (which comprised Safe Waitakere Injury Prevention, Waitakere City Safer Community Council Trust, Road Safety Waitakere and Safe Waitakere Alcohol Project).

In 2002, Safe Waitakere Injury Prevention and Waitakere City Safer Community Council co-funded an exploratory research project which aimed to identify what types of work they might undertake in the area of family violence. It was concluded quickly that a wide range of agencies would need to be involved for effective primary prevention work in the region.

A collaborative partnership was established comprising organisations from sectors such as early childhood welfare services, injury prevention, family violence services, health, criminal justice, Mäori services and Pacific groups. The organisations represented local and central government and community organisations. All except one of these group representatives were women.

An action plan was developed, identifying seven mainstream priority projects. These projects included early identification of warning signs of family violence by home visitors, promoting awareness of children's developmental needs, and enhancing local values concerning children. In addition, a separate Mäori project aimed to develop a Mäori service providers network, and a separate Pasifika project aimed to run a radio campaign and a day of activities celebrating children.

Later in 2003, Great Start Waitakere was integrated into the Waitakere Wellbeing Collaboration Project which enabled government departments, the Waitakere City Council and the community sector to work collaboratively. This move was seen as 'the best way to ensure a cohesive and coordinated long term programme of action – both for family violence prevention and the wellbeing of under 5s in Waitakere' (Great Start Waitakere: Te Korowai Manaaki booklet, cited by Elizabeth 2004: 9).

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## Peaceful Waves/Matangi Malie

Peaceful Waves/Matangi Malie was an initiative funded by the Ministry of Health and run by Group Special Education (formerly Special Education Services). It aimed to prevent violence among Tongan and Samoan families living in Auckland by providing information to community groups about anger and its management.

The programme was set up in 1995 by a resource teacher of learning and behaviour who was concerned about the effects of violence among children she had contact with. Several other people joined her team, including her brother and a church minister (who had trained as a psychiatric nurse). The team met in the evenings or weekends to plan their activities and discuss how the service could be improved. They also reported their progress to a community reference group.

At first the initiative worked with families mainly across churches of different denominations, as churches are central to many Pacific families' lives. 'The Church remains the pivot of different Pacific communities because of its role in spirituality, social interaction, maintenance and development of ethnic language and culture, social support, education and disseminating information' (Greenaway et al 2004b: 20).

Following an unsuccessful trial of the initiative in schools, some of the focus then shifted to Pacific providers, radio programmes and responding to requests to present workshops at one-off events. Funding was available for training and development of presenters, including attendance at short courses and conferences.

*Reference*

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## Community nutrition programmes

At different times between 1993 and 1995, four community nutrition programmes for Mäori were set up to 'improve nutrition at a community level by training community workers in basic food and nutrition' (Moewaka Barnes et al 1998a: 4). Various health agencies collaborated with different Mäori organisations to implement the programmes.

All the programmes were based on strong community development perspectives and achieved a great deal of Mäori community involvement, empowerment and sense of local 'ownership'.

### Te Kai o Te Hauora

The original programme – Te Kai o Te Hauora – was initiated by Te Hotu Manawa Māori in conjunction with Tairawhiti Healthcare. It ran for 14 months during 1993–1994 in five communities on the East Coast of the North Island. Marae committees and other community organisations nominated five kaiawhina (nutrition community health workers) to work for eight hours per week in their own communities. The kaiawhina were trained and supported by the project co-ordinator (a qualified dietician). Activities included site visits by the co-ordinator, kaiawhina networking with community members, running hui that included kōrero (discussion), cooking demonstrations, preparing special meals and visual displays.

### Te Taro o Te Ora

Following the above programme, a joint initiative – Te Taro o Te Ora – was established by Te Runanga o Ngāti Porou, Te Runanga o Turanganui-a-Kiwa and Tairawhiti Healthcare Ltd. It operated from 1994 onwards on the East Coast of the North Island. This programme also consisted of training kaiawhina who were nominated by their communities. In turn, the kaiawhina trained marae workers from 11 marae on topics such as healthy food menus, food preparation and food safety. Altogether around 50 people were trained during the programme.

### Kai Oranga Tinana Mo Waipareira

Another community nutrition programme for Māori was established in 1994 at Wai Health in West Auckland – Kai Oranga Tinana Mo Waipareira. It was originally funded by North Health as a collaborative initiative between Te Whanau o Waipareira Trust Board and Auckland Healthcare Ltd. At the beginning of the initiative, a joint venture management group was set up consisting of Te Whanau o Waipareira Trust, Auckland Healthcare, the National Heart Foundation, and the Department of Community Health (University of Auckland). In 1997, Te Whanau o Waipareira Trust took over as sole provider and the joint management group was established.

An extensive community consultation process and needs assessment were completed before the programme began. It was developed as a certified training programme in kai and nutrition for community workers.[6] Later on there was also an emphasis on providing community nutrition activities as well as training. Two programme co-ordinators were appointed at first, but later there were one full-time and two part-time co-ordinators.

### Te Pataka o Te Tai Tokerau

Te Pataka o Te Tai Tokerau was established at the beginning of 1995 in Northland. This programme was funded by North Health and was originally run by Northland Health, and then in 1998 jointly by Te Hau Ora te Tai Tokerau and Ringa Atawhai (a marae-based health promotion network). The programme aimed to provide a training programme in basic nutrition in order to produce Māori 'community nutrition advisors'. A programme co-ordinator, belonging to Ringa Atawhai and from Tai Tokerau, was appointed from the beginning of 1995, along with a (Pākehā) dietician to help with programme development and the training of the community advisors. By 1997, no dieticians were linked to the programme. Each iwi area had a

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6    The course was certified by the Auckland Institute of Technology (now Auckland University of Technology).

co-ordinator, appropriate teaching resources were developed and dental health issues were addressed. Marae-based education sessions on topics such as budgeting, cooking, diet and meal planning were also run.

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## Pasifika Healthcare Gardening Project

In 1998, Pasifika Healthcare set up a gardening initiative for Pacific peoples living in West Auckland. The project was funded and supported by Waitakere Health Link, Waitakere Hospital, well child promotion services and mental health community support work contracts.

The initiative aimed to promote wellbeing by providing good nutrition through encouraging Pacific peoples to eat more fruit and vegetables and to participate in outdoor physical activity. This was seen as improving lifestyle and preventing chronic diseases such as diabetes.

The initiative began as a gardening project in some West Auckland preschools where children planted, harvested and ate their own vegetables.

Then in 2001/2002, 89 local families participated in a Backyard Garden Competition that involved growing at least five types of vegetables and five types of flowers. As well as the nutrition-related outcomes, people got to know their neighbours through exchanging produce.

Following the success of the gardening competition, in 2002 a community garden was set up on land owned by the Waitemata District Health Board located behind Waitakere Hospital. Volunteers (particularly from the Tongan community) cultivated fruit and vegetables, which were given to disadvantaged families.

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## Housing and health initiatives

Two intersectoral housing and health initiatives in South Auckland are described here: the Otara Health and Housing campaign, and the more recent Healthy Housing Programme.

### *Otara Health and Housing campaign*

This was a joint housing and health initiative of the Manukau City Council, Housing New Zealand, and Work and Income.  The initiative involved a six-month campaign to 'provide Otara residents with clear information about housing matters which affect their health and wellbeing' (Haigh 2000: 1).  The campaign was co-ordinated and supported by Otara Health Inc.

Two teams of mature (previously unemployed) Otara residents from mixed ethnic backgrounds, who were bilingual, were trained as Health and Housing Ambassadors.  They undertook a door-to-door campaign in the older part of Otara – a socioeconomically deprived area of 1960s and 1970s state housing.  Ambassadors talked about health and housing issues with residents, and provided them with information.  They also made referrals to other agencies including Housing New Zealand, the Fire Service (for installation of smoke alarms) and Work and Income, and provided a large number of rodent traps.

### *Healthy Housing Programme*

This was a joint programme of Housing New Zealand Corporation, Counties–Manukau District Health Board and Auckland District Health Board, and was one of the Counties–Manukau ICAH projects.  The programme targeted nearly 1000 homes in disadvantaged areas of Onehunga, Mangere and Otara in South Auckland.

The Healthy Housing Programme aimed to decrease overcrowding and improve health by a combination of interventions.  These interventions were preceded by joint housing, health and social needs assessments and included: modification of houses; referrals of household members to appropriate health and social services (such as GPs, secondary health care, preventive health services, Work and Income); and intensive follow-up of those who had been referred.  During the programme, intersectoral links with 46 different agencies were established, many with formal memoranda of understanding.

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## TAIERI Trust River Catchment project

The Taieri Alliance for Information Exchange and River Improvement (TAIERI) project was developed in 2001 from an earlier project linked to PhD research on health and ecology in the Taieri River catchment area. This PhD research (known as the Taieri Catchment and Community Health Project) included a health survey and was funded by the Health Research Council. The TAIERI project was funded by the Sustainable Management Fund.

The TAIERI project was a partnership of the Taieri community, Otago University and New Zealand Landcare Trust (NZLCT). The TAIERI Trust, comprising community representatives from four different geographic areas and one representative from the University of Otago, ran the initiative. There was also a wider management group comprising additional community representatives, Fish and Game, Otago Regional Council, and the Health Sciences, Sciences and Humanities divisions of the University of Otago. The NZLCT employed a project co-ordinator, whose role was to network, facilitate and mediate and to interpret scientific information for the public. The NZLCT also provided professional support for the co-ordinator, along with office furniture, computers and accountancy services.

The initiative used an extensive community networking and participatory approach that covered scientific, health, environmental, farming and industry sectors. There was also ongoing consultation with and participation by local Māori.

The initiative sought to identify and mobilise local community and scientific knowledge and strengthen the community's capacity to deal with water resource and related health issues in an integrated way. It aimed to:

- enhance existing relationships and partnerships among the community, researchers and agencies
- establish an effective communication system to convey information
- improve the environment through various activities including catchment classification, practical enhancement projects and education
- design an action reflection model and use evaluation to review and disseminate what had been learnt from using a catchment approach.

The initiative's activities included public meetings, tree planting, running field days, publishing newsletters, developing a website, providing environmental education in schools, and various activities for volunteers. Public health issues that were addressed included waterborne diseases and the relationships among rural development, ecological sustainability and community wellbeing.

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## Case management services and one-stop shops

This final category of initiatives focuses on the needs of individuals (and sometimes their families) who require specific services or who are considered to be at risk. That means these initiatives are generally improving the health of local communities, in a slightly more indirect way, by targeting individuals within those communities.

This type of initiative may be a component of an overarching area- or settings-based initiative, or of an issues-based initiative, or it may be stand-alone.

A large number of local organisations are often involved in the service delivery aspect of case-management and one-stop shop initiatives. However, unlike the situation for the other two types of intersectoral initiatives for improving the health of local communities, community organisations and other community representatives do not usually participate in the establishment and ongoing planning of case-management initiatives or one-stop shops, especially if they are stand-alone services.[7]

However, the initiatives do have a strong emphasis on improving collaboration between services across different sectors in order to improve health and other outcomes for their clients. This is done through 'wraparound service provision', 'co-ordinated case management', and one-stop shops (concepts included under the term 'integrated service delivery' – Gray 2002). This may involve increasing referrals to and from other organisations, co-locating different agencies in one place, and using cross-sectoral teams.

These initiatives will now be discussed in two main groups – case-management initiatives and one-stop shops.

### Case management initiatives

- Intensive home visiting
- Strengthening Families Collaborative Case Management
- Early Start/Family Start
- Social Workers in Schools
- Wraparound services
- Waitomo Papakainga Tracker Programme
- Rough Cut Youth Development Project
- Otago GP Link Project
- Christchurch Youth Drug Court

### One-stop shops

- Heartland Services
- Family Service Centres

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[7]   This is also the case for some community action projects, particularly alcohol-related projects in New Zealand.

## Intensive home visiting

In 2002, the Ministry of Health funded two one-off intensive home visiting service initiatives. Both initiatives had Mäori and Pacific organisations as project partners. One home visiting initiative was located in the Tokoroa/Mangakino region and was run by the Raukawa Trust Board and the South Waikato Pacific Committee, who had a memorandum of understanding with one another. The other initiative was located in Mangere and was run by Turuki Healthcare and South Seas under a joint venture named Hawaiiki.

Both projects were community-based home visiting services that aimed to 'improve collaboration between health and social services, develop community information and education about services available and improve integration and access to existing services' (CBG Health Research 2004: 5). So, while their main focus was to provide integrated services to at-risk individuals of all ages (and their families), an additional aim was to educate the whole community.

Before the initiatives had been set up, an extensive consultation process had taken place in both communities. Both projects recruited 15 staff with a range of skills. These staff included nurses, social workers and community health workers who underwent special training on home visiting at the start of the initiative. Relationships were built with local agencies and service providers to encourage them to refer clients to the intensive home visiting services (and vice versa). These referrals most commonly came from the Police, clients themselves, friends and neighbours. General practitioners, schools, Work and Income, hospital community liaison units and ambulance services also made referrals. Contact with clients involved assessing them and then following them up, sometimes at home, sometimes at the Intensive Home Visiting centres. Once needs had been met, clients were discharged from the service.

In Tokoroa/Mangakino, home visiting services were delivered to 9 percent of the catchment population (13 percent local households) with an average of 8.1 contacts with each client (80 percent face-to-face). Home help and transport were common needs that were addressed.

In Mangere, home visiting services were delivered to 19 percent of the catchment population (33 percent of households) with an average of 9.5 contacts per client (half of which were home visits). Drug and violence issues were common in this area.

Activities aimed at the wider community included door knocking, leaflet drops, exercise programmes, and support of health expos.

### *Reference*

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**Strengthening Families Collaborative Case Management**

*Strengthening Families*

Strengthening Families was an intersectoral policy initiative introduced by the government in 1997 to improve the overall wellbeing of families considered to be at risk. At the beginning the initiative involved the Ministries of Health and Education and the Department of Social Welfare (now the Ministry of Social Development). However, it currently includes Child, Youth and Family (on a compulsory basis) as well as a large number of other government and non-government agencies (on a voluntary basis).

Through national- and local-level co-ordination, Strengthening Families aims to achieve better outcomes and opportunities for children by helping families meet their care, control and support relationships and improve families' ability to resolve difficulties and problems. Central to achieving these aims is the promotion of clearer definitions and better collaboration among the health, education and welfare sectors, both locally and nationally, and better use of existing resources.

A variety of intersectoral projects and programmes have been developed and implemented under the Strengthening Families banner. They include Collaborative Case Management (discussed below), Family Start (see next subsection) and Social Workers in Schools (see subsection after Family Start).

*Collaborative case management*

This initiative aimed to formalise and enhance intersectoral collaboration in order to provide a seamless service, thus improving outcomes for families.

Local management groups were responsible for bringing together government agencies, non-governmental organisations, and sometimes local authority and Mäori organisations to help to co-ordinate local services. Most regions employed local co-ordinators who had a range of roles, primarily in the collaborative case-management process. This process involved the following steps:

- services already dealing with families (e.g. teachers, social workers, public health nurses) identified a need for collaborative case-management meetings with other agencies

- relevant agencies were identified

- families gave informed consent and identified other family members, support people and agencies they wished to include in the process

- a meeting took place with a facilitator (who usually could be Mäori if the client chose) – this meeting included development of an action plan, goal setting, allocation of tasks and completion dates, choice of a lead agent, and setting a review date

- review meetings were held to assess progress and, once goals were achieved, the case was closed

- data were collected systematically throughout the process.

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## Early Start/Family Start

Both Early Start and Family Start are early-intervention, home-visiting programmes for young children and their families.

### Early Start

In 1995 Early Start was introduced as a pilot project in Christchurch. It was based on Hawaii's Healthy Start initiative.

Early Start was a home-based, family support system aiming to meet the needs of high-risk families and their children. It was set up by an intersectoral consortium including the Family Help Trust, the Christchurch Health and Development Study, the Plunket Society, Pegasus Medical Group, and Māori representatives.

The programme used an approach that included recognising the range of problems that the participating families faced, as well as helping them to develop strengths and skills to overcome these difficulties.

The main objectives of Early Start were to:

- ensure that children received adequate well child care and timely visits for morbidity

- ensure that children were not exposed to neglectful or abusive home environments

- assist, advise and empower parents in addressing mental health and other issues that affected their family's wellbeing

- provide families with advice and support in addressing family budgeting and related issues.

Families were recruited to the programme by a three-step process: (1) identification of at-risk families by Plunket nurses; (2) a one-month probationary period; and (3) an in-depth needs assessment and informed consent procedure.

Participating families were assigned a Family Support worker with a nursing or social work background and five weeks of specialist training. The Family Support worker contacted families through home visits and telephone calls in a mentor/advocate role. Family Support workers developed systematic family support plans and helped with many referrals to other agencies. Some families had contact with as many as 20 different agencies.

Consultation with and participation of Mäori were part of the initiative from the start. In 2003 half of the Board and 20 percent of the Family Support workers were Mäori.

Following ongoing evaluation during the early stages of the initiative, a three-year randomised controlled trial of the initiative is now almost complete (and scheduled to be published by the Ministry of Social Development later in 2005) (David Fergusson, personal communication, 13 April 2005).

### Family Start

The Family Start initiative was developed from the Christchurch Early Start initiative as part of the Strengthening Families policy. It was established first in three locations in 1998, then in a further 13 in 1999–2000. Family Start was a partnership of: the Ministry of Education; Child, Youth and Family; the Ministry of Social Development; and the Ministry of Health.

Family Start delivered integrated services for up to five years, starting at a time around the birth of a child (six months before to six months after), to the 15 percent of families considered most at-risk. It used collaboration and co-ordination across government and community organisations, and local Family Start services provided their services in ways that reflected the situations of their local communities. It also used a 'strengths-based' model.

The goals of the programmes were to:
- improve children's wellbeing and development and enhance their life outcomes
- improve parents' parenting capability and practice
- improve parents' personal and family circumstances.

Families were referred to Family Start services by an approved agency such as lead maternity services, hospital maternity services, or well child providers. An assessment was made, and participating families were assigned to one of three levels of service delivery according to their needs. In the first year of the programme, high-intensity families received up to 240 hours of assistance, medium-intensity families up to 150 hours, and low-intensity families 60 hours. These hours decreased during the time families participated in the programme.

Individualised Family Plans were designed with the family. Family/whänau workers then helped families to access any services and resources they needed including transport to appointments, food preparation, advice on parenting skills and so on. Families themselves were asked to take responsibility for the safety of their children.

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## Social Workers in Schools

Social Workers in Schools was a Strengthening Families initiative led by Child, Youth and Family that provided social workers in low-decile schools. It was established in 1999 in partnership with the Ministry of Education, the Ministry of Health, Te Puni Kökiri, the Ministry of Pacific Island Affairs, the Health Funding Authority, school principals, social workers and other support agencies. As well as contributing to the overall goals of Strengthening Families by integrating education, health and social services for school students and their families, the initiative aimed to address inequalities between Mäori and non-Mäori. The service used a strengths-based social work approach that aimed to help families overcome problems themselves through their own strengths and resources.

Originally located in 56 primary and intermediate schools in Northland, the East Coast and Porirua–Upper Hutt, by 2003 Social Workers in Schools had expanded its coverage to about 220 decile 1–5 schools throughout the country.  The 2004 Budget increased the allocated funding further so that 115.5 full-time equivalent social workers would be working in 330 schools.

Mainly external, experienced social service organisations provided the social workers who worked in the schools.  The intention was that having social workers in schools would allow easy, voluntary access to services so that issues could be dealt with confidentially at an early stage to prevent more serious problems later on.  Social workers were expected to establish strong partnerships with schools, particularly school principals, and with other local community providers of education, health and social services.  Social workers were given the discretion to work flexibly, in their own style and to provide services suited to the needs of children and their families.  While they did not have to have formal qualifications, there was an emphasis on working in a professional way, under supervision.

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Larner W, Butler M.  2003.  *'Headline' Local Partnerships in Aotearoa/New Zealand*.  Auckland: Local Partnerships and Governance Research Group, University of Auckland.

## Wraparound services

Wraparound services were case-management programmes for 'children and young people experiencing emotional, mental and/or behavioural disturbances and/or for children with multiple difficulties and needs' (McClellan 1997: 2).  These services were based on the Vermont model of individualised care which provided clients with:

- unconditional care
- flexible, individualised treatment plans based on their own strengths and the strengths of their families
- participation and empowerment in their own treatment and care
- service delivery in a non-restrictive, normal environment
- a comprehensive service integrated with other community support agencies
- a culturally-appropriate service
- 24-hour crisis back-up.

The Wraparound service model is 'intersectoral' in that it addresses all the clients' social and health needs in a holistic way, and engages other service sectors to help deal with these needs. Two Wraparound programmes that were run in New Zealand were a Health Camps pilot programme in Northland and Auckland and a larger pilot programme in South Auckland.

*Health camps pilot Wraparound programme*

The first Wraparound service was piloted in 1996 in two children's health camps in Northland (Maunu Health Camp) and Auckland (Pakuranga Health Camp). While the health camps originally called their programmes Wraparound, they later changed the name to the Co-ordinated Family Care and Support Programme/Tui Tui Nga Teaki Whānau, Me Te Awhina. They differed from the Vermont model in significant respects (for example, they were run as short-term, remedial, residential services, and they had no 24-hour crisis service).

The health camps pilot Wraparound programme catered for children aged 5–12 years, who lived in the two health camps' catchment areas, and who had multiple emotional and behavioural problems, often needing long-term and external agency support.

Services provided included developing a 'Care Plan', co-ordinating with families and other agencies, activities at the camp such as educational and behaviour modification programmes, and monitoring/ongoing support.

*South Auckland pilot Wraparound service*

Subsequently, in May 1998, a larger-scale pilot Wraparound service was established in South Auckland, more in line with the Vermont model described above. The service was one of seven developed by an intersectoral group led by the Crime Prevention Unit of the Prime Minister and Cabinet. Other sectors included in the group were Youth Affairs, Justice, Education, Social Welfare, Te Puni Kōkiri, Police, Health, Courts and Internal Affairs.

The pilot programme was run by Te Whānau o Waipareira Trust and was initially funded for just over two years. The main aim of the programme was to reduce youth offending by case management of local[8] young people aged 13–17 years who had at least three of the following risk factors:
- criminal behaviour
- truancy/at risk of suspension from school
- at risk of being placed outside their families/whānau
- physical or mental health problems (including unplanned pregnancies, drug and alcohol problems, suicide attempts)
- risk behaviours such as dangerous driving
- conduct disorders.

This Wraparound service employed one programme manager, eight case managers and one administrative assistant. Referral and selection processes were guided by a Wraparound Advisory Group. Case managers' roles were as therapists, brokers and advocates, and they spent several hours with clients and their families each week. They also provided 24-hour crisis management support.

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[8]  Enrolled, or eligible to be enrolled, at six local secondary schools in Otara and Mangere.

Wraparound was perceived as a 'co-ordinated blend of services for each person that cuts across health, justice, education, social welfare and community support social support sectors' (CRESA 2000: 79). It provided some in-house services, such as assessment and therapy, where these were not available elsewhere, but was able to use funding 'attached' to clients to pay for outside services such as: accommodation; counselling; drug and alcohol assessment; home tutoring; driver licence training; anger management; exercise programmes; outdoor pursuits courses; health services; legal advice; motivation and self-esteem courses.

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## Waitomo Papakainga Tracker Programme

In 1998 the Crime Prevention Unit and Child, Youth and Family funded the Waitomo Papakainga Development Society to manage a Tracker Programme for at-risk youth in Kaitaia. The Papakainga Development Society consisted of the Rawiri whänau and whänauanga which ran a number of initiatives using tikanga Mäori and whänau/hapü development approaches.

While there was a focus on stopping youth offending (presumably because of the type of funding provided), the whänau saw the programme as addressing the wellbeing of young people in a much more holistic way. 'The initial Tracker Programme idea emerged from the whänau "just doing what they needed to do" to address the issues they could see in the young people around them' (Greenaway et al 2004b: 6). The programme had already been operating informally for several years on a voluntary basis before the Tracker funding was secured, and afterwards continued to use a considerable amount of voluntary labour from the whänau.

The whänau met monthly to discuss the programme, and consulted widely with government agencies and other local organisations.

The Tracker programme's activities consisted of local at-risk youth living and working with mentors for three weeks in an isolated, natural, beach setting – 'it was initiated as a kaitiaki structure focused on their whenua' (Greenaway et al 2004b: 6). This was designed to give the young people an alternative experience to their usual daily life, using the whänau's resources. They then worked with the whänau until their contact period with the programme was at least 10 weeks.

The Tracer Programme's kaupapa was to:

- provide 24-hour care for youth at risk which involves removing them from negative influences that have contributed to their 'at-risk' situation
- provide intensive care and support to rangatahi and their whänau, and thus enhance the unity of the whänau

- provide rangatahi with a sense of whanaungatanga, Māoritanga and tinorangatiratanga
- (ultimately) reduce offending and enhance wellbeing, both among individuals and their whānau and within the community at large (Oliver and Spee 2000, cited by Greenaway et al 2004b).

### References

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Greenaway A, Milne S, Henwood W, et al.  2004b.  *A Meta-analysis of Community Action Projects: Volume II.*  Auckland: Centre for Social and Health Outcomes Research and Evaluation and Te Röpü Whäriki, Massey University.

Oliver P, Spee K.  2000.  Evaluation of Mäori Community Initiatives for Youth at Risk of Offending: Report on the Tracker Programme, Waitomo Papakainga, Kaitaia.  Auckland (for Child, Youth and Family).  (Cited by Greenaway et al 2004b.)

## Rough Cut Youth Development Project

The Rough Cut Youth Development Project was run by the Buller Rural Education Activities Programme from 1999–2002 with the aim of reducing youth suicide in the area.  The Department of Internal Affairs, Youth Development Fund, and Work and Income funded the initiative.

An advisory group drawn from the local community and outside film experts managed the initiative (although this group was disbanded in the final year of the initiative).  The REAP manager played a role in developing and running the project later on, and a co-ordinator and a counsellor were also employed.  The initiative comprised annual, 12-week film-making courses taught by professionals from the film industry.  A local school provided accommodation for the course.

The course was available to a group of young people aged 16–25 years (and five adults over 25).  These young people were referred by other agencies who considered individuals to be at risk through 'social disadvantage, low socioeconomic status, family adversity and dysfunction, mental health issues, drug and alcohol problems, and adverse and stressful life events' (Greenaway et al 2004b: 49).

Young people were taught a range of skills relevant to the film industry and were also able to address issues that were barriers to their 'life progress and achievement of wellbeing' (Greenaway et al 2004b: 49).  At the end of the courses, students screened the films they had produced for the local community.

### References

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Greenaway A, Milne S, Henwood W, et al. 2004b. *A Meta-analysis of Community Action Projects*: *Volume II*. Auckland: Centre for Social and Health Outcomes Research and Evaluation and Te Röpü Whäriki, Massey University.

## Otago GP Link Project

The Otago GP Link Project, which started in 2001 as a pilot, aimed to increase access to primary health services for people with serious mental illness living in Otago. This was done by removing the cost barrier for visits to general practitioners for physical illness by ensuring these people were maximising their disability allowances (Disability Allowance, Child Disability Allowance, Special Disability Allowance). In addition, there was a special funding pool available for people who experienced difficulty managing their finances.

The project was managed and co-ordinated by the Otago District Health Board, Work and Income (Southern), and South Link Health. There was also a memorandum of understanding with Te Oranga Tonu Tanga Hinengaro Hauora Services to provide help with cultural issues.

A project co-ordinator looked after the day-to-day running of the programme, provided support to the Community Mental Health Team, GPs and clients, and liaised with other agencies including Work and Income. Work and Income played an important role by helping clients to choose a suitable GP and to claim the maximum allowance to which they were entitled. There was also a special Work and Income case manager for clients who were accessing the special funding pool.

Since the pilot, the project has been extended to cover all mental health clients in the region. An evaluation of the extended project is currently underway.

### *Reference*

Otago District Health Board. 2003/2004. *Mental Health Research and Development Strategy, Evaluation of Mental Health/Primary Care Shared Services*. Dunedin: Otago District Health Board. pp 74–78 and Appendix.

## Christchurch Youth Drug Court

The Ministerial Taskforce on Youth Offending established a Youth Drug Court (YDC) pilot initiative in Christchurch which started operating in 2002. The initiative aimed to deliver better services to young people, including treatment for alcohol and other drug dependency, in order to reduce criminal offending. The initiative's objectives were to:

- improve the young people's health and social functioning and to decrease their alcohol and/or drug use
- reduce crime associated with alcohol and/or drug use
- reduce criminal activity (Carswell 2004: 13).

To begin, an early screening process identified alcohol and drug dependency among recidivist offenders aged 14–16 years whose offences were not related just to alcohol or drugs. Next, if moderate or severe dependency was identified, treatment for this was delivered as soon as possible. Educational, vocational, accommodation and support needs were also addressed.

Young people were also monitored closely by the YDC (every two weeks to monthly) to facilitate their treatment and ensure they met obligations to their victims and the community. The screening process and participation in the programme were voluntary, and if young people left the programme before they had met the requirement of the YDC they were returned to the usual youth justice system.

Facilitating more effective interagency co-ordination and communication was an integral part of the initiative.  An intersectoral, multi-disciplinary team was set up consisting of:

- YDC judge
- YDC court clerk (Ministry of Justice)
- YDC social worker (CYF) who acted as co-ordinator and monitor of treatment plans
- youth justice co-ordinator (CYF)
- Police prosecutor (New Zealand Police)
- youth advocates (lawyers representing the young people)
- youth specialty co-ordinator of alcohol/drug and mental health services (Ministry of Health)
- Group Special Education team leader (Ministry of Education).

This team referred the young people to whatever other services they required, across many sectors.

### *Reference*

Carswell S.  2004.  *Process Evaluation of the Christchurch Youth Drug Court Pilot.*  Wellington: Ministry of Justice.

## Heartland Services

Heartland Service Centres were one-stop shops in rural and provincial areas of New Zealand enabling people to access a number of government departments and other agencies in one place. Funded through and led by the Ministry of Social Development, the initiative included a large number of partners from a wide range of sectors.  Health-related partners on the initiative's national reference group include ACC, Occupational Safety and Health and the Ministry of Health.  There were 16 other partners on the reference group including CYF, Work and Income, Te Puni Kōkiri, New Zealand Post/Kiwibank, Courts, Immigration Service and the LTSA.

The initiative included two main components – service centres and outreach services.  Service centres were located in relatively large service towns such as Kaitaia, Pukekohe, Wairoa, Takaka and Queenstown.  By 2004 there were 28 service centres with two further centres planned. Outreach services consisted of a number of agencies synchronising their visits to smaller places and operating from existing facilities such as community centres, district council service centres, medical centres or iwi/Māori service centres.  Locations of outreach services included Opononi, Whitianga, Te Puke, Featherston, Cromwell and Wanaka.

The aims of Heartland were to:

- improve access to government services for people in rural areas
- improve interagency collaboration

- support community/voluntary agencies in rural areas (Family, Child, Youth and Community Research and Evaluation Unit 2004: 1).

Heartland Services employed co-ordinators who established and maintained rapport with community members and helped people to access the services they needed. These services included health services such as outpatients clinics.

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Family, Child, Youth and Community Research and Evaluation Unit. 2004. *Evaluation of the Heartland Services Initiative*. Wellington?: The Family, Child, Youth and Community Research and Evaluation Unit. (For Centre for Social Research and Evaluation, Te Pokapu Rangahau Arotaki Hapori).

Heartlands website. http://www.heartlands.govt.nz.

Larner W, Butler M. 2003. *'Headline' Local Partnerships in Aotearoa/New Zealand*. Auckland: Local Partnerships and Governance Research Group, University of Auckland.

## Family Service Centres

Government funding to establish six pilot Family Service Centres was announced in the 1993 Budget. The six centres were modelled on an initiative already underway in a Papakura primary school, developed by the Pacific Foundation for Health, Education and Parent Support. The concept involved providing early childhood and parent education, health services and social support services to socioeconomically disadvantaged families with young children, using a dedicated one-stop-shop facility.

The initiative formed part of a government strategy to 'break cycles of intergenerational disadvantage and improve the ability of families to be self-reliant' (Kennedy 1994: 74). The expectation was that the centres would help reduce the need for more expensive social welfare, health and educational interventions with participating families later. The total budget for the initial three-year pilot was over $7 million.

Selected on the basis of a weighted deprivation index, the six pilot sites were Otara, Mangere East, Opotiki, Huntly, Porirua (Cannons Creek) and Motueka. Specified objectives for the centres included:
- increasing the participation of Mäori and Pacific children in early childhood education
- improving the educational achievement of special needs children
- improving relationships between families and schools
- increasing childhood vaccination rates and take-up of well child checks
- reducing the incidence of child abuse and family breakdown
- increasing families' access to existing services.

'Critical success factors' identified for the centres included the provision of a range of integrated services such as early childhood education, a home-based instruction programme for preschoolers, family support and counselling services, and health services. It was also expected the centres would be closely linked to their local primary school.

Each pilot centre was run by local community groups under contract to the then Department of Social Welfare (now the Ministry of Social Development). Staff at each centre included a part-time or full-time manager. Access to the centre services was free or involved only a minimal charge. Emphasis was put on providing culturally-appropriate services and consulting local people about how the centres should be developed and run.

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Ministry of Health. 1997. *Final Report: Family Service Centres Evaluation*. Wellington: Ministry of Health.

# Appendix 2: Intersectoral Initiatives Included in 'Headline' Partnerships by Local Partnerships and Governance Research Group

Larner W, Butler M. 2003. *'Headline' Local Partnerships in Aotearoa/New Zealand*. Auckland: Local Partnerships and Governance Research Group, University of Auckland.

- Adult Literacy Strategy
- Auckland Regional Migrant Services Trust
- Capacity Building Programmes of Action (MINPAC)
- Community Renewal (Housing NEW ZEALAND pilot projects)
- Community Road Safety Programme
- Community Youth Project Partnerships
- Computers-in-homes
- Connecting Communities
- Crime Prevention and Community Safety Partnerships
- Family Start
- Healthy Cities
- Healthy Housing
- Heartland Services
- Intersectoral Community Action for Health
- Mayors Taskforce for Jobs
- Regional Partnerships Programme
- Rural Housing Programme
- Schooling Improvement Initiatives
- Social Work Services Partnership
- Social Workers in Schools
- Special Housing Action Zones Programme
- Strengthening Families
- Stronger Communities Action Fund
- Te Rarawa (Whole of Government memorandum of understanding)
- Youth Suicide Prevention Strategy

# Appendix 3: Intersectoral Initiatives Included in SHORE/Whāriki's Meta-analysis

Greenaway A, Milne S, Henwood W, et al. 2004. *A Meta-analysis of Community Action Projects: Volumes I and II.* Auckland: Centre for Social and Health Outcomes Research and Evaluation and Te Röpü Whäriki, Massey University.

- Waitomo Papakainga Tracker Programme
- Moerewa Community Project
- Peaceful Waves/Matangi Malie
- Pasifika Healthcare Gardening Project
- Whaingaroa Catchment Management Project
- He Rangihou New Day Project (of Opotiki Safer Communities Council)
- Rough Cut Youth Development Project
- Christchurch Youth Project
- TAIERI (Taieri Alliance for Information Exchange and River Improvement)
- Pacifica Governance and Management Project

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