

**Intersectoral Initiatives
for Improving the
Health of Local
Communities**

A Literature Review

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MANATŪ HAUORA

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Summary

This report reviews examples of community-based, intersectoral initiatives aimed at improving the health and social circumstances of local populations. Nine different kinds of New Zealand initiatives are covered, plus one recent initiative from the United Kingdom - Health Action Zones.

The report also lists key requirements for effective community-based intersectoral action for health identified in these case studies and in significant overseas reviews.

The New Zealand information comes from published reports and also from unpublished material obtained by contacting researchers, research clients, or service providers directly. It covers initiatives in urban and rural settings, including socio-economically disadvantaged communities and Māori communities.

- The Ministry of Health intends to use this report to inform decisions related to the development of the Intersectoral Community Action for Health (ICAH) programme. The ICAH programme consists of four intersectoral initiatives targeted at areas of high socioeconomic deprivation and significant health inequalities. In addition to the ICAH initiatives being run collaboratively by central and local government agencies with community groups, ICAHs also use principles of community engagement and development i.e. they are “community-based”.

Defining intersectoral action

Intersectoral action for health has been defined as:

A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate 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).

Intersectoral action can include health promotion activities such as: community development; community participation (where programmes draw on communities’ knowledge, expertise and activities); or advocacy. It can also involve service delivery, such as shared management of the health-related problems of a particular person or cross referral.

The main justification for intersectoral action described in the literature is that the determinants of the health of populations and communities are

diverse, complex and multifactorial – and beyond the capacity of the health sector to influence on its own. Intersectoral action involves building constructive relationships with people and agencies from outside the health sector, in an effort to jointly influence these broader determinants.

The 10 intersectoral initiatives described here can be grouped into three categories:

- *over-arching area or settings-based initiatives* (Health Action Zones, Healthy Cities, Health Promoting Schools)
- *issues-based initiatives* (community alcohol action programmes, community injury prevention programmes, community nutrition programmes, Safer Community Councils, health and housing initiatives)
- *case-management services* (Strengthening Families [comprising Social Workers in Schools, Early Start / Family Start, and Collaborative Case Management], Family Service Centres, and Wraparound services).

OVER-ARCHING AREA OR SETTINGS-BASED INITIATIVES

Health Action Zones

In 1997, the UK government invited health authorities, in conjunction with local authorities and other agencies, to submit bids to establish “Health Action Zones” (HAZs). Twenty-six HAZs have now been set up in areas of relative social deprivation and poor health status, mainly in urban, industrialised regions, such as parts of London, the Midlands and the North of England.

HAZ programmes are 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”.

A key strategic objective for HAZs is to “develop partnerships for improving people’s health and relevant services, adding value through creating synergy between the work of different agencies”. This includes building partnerships between different health agencies; local authorities; statutory agencies, the voluntary sector and businesses; the public (to enlist their support and involvement); and other HAZs.

HAZs are among the most complex, largest-scale community-based intersectoral initiatives for health. They work 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 client treatment and care. Usually a large number of partners are involved in these initiatives and

many also interact with other area-based intersectoral initiatives working in their region.

When HAZs were first established, it was planned to allocate them £306 million in government funding in the first three years – the equivalent of one percent of the National Health Service budget. This amount was kept relatively low because it was expected that HAZs would eventually “mainstream” their activities into those of other agencies (with the ultimate aim of making HAZs themselves unnecessary).

A national evaluation of HAZs is underway. Key features identified to date include: the diversity of the activities and programmes provided within HAZs; the complexity of the partnership relationships; impact of budget trimming on the quality of partnerships; and emerging signs of increasing collaborative working.

A change in the health minister’s priorities has meant that HAZs now have to demonstrate they are tackling the national priorities of cardiovascular disease, cancer and mental health problems. These changes have meant that local HAZs have had to move away from a focus on defining local problems and solutions towards a more central agenda - a major change in direction that has caused some problems.

In addition, central government does not appear to be giving HAZs as high a priority as it did at the start. Instead the UK Government now seems to be increasing support for neighbourhood renewal and local strategic partnerships (i.e. more general community development orientated projects).

Healthy Cities

Healthy Cities (including Healthy Communities) is an international movement developed by the WHO as part of its Health For All by the Year 2000 strategy. 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 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). Projects in places such as Manukau, Otago and Nelson have included the employment of co-ordinators to promote the Healthy Cities model in their area and build coalitions between local agencies and citizens to identify and undertake actions to improve health.

A 1994 review found that several of New Zealand’s Healthy Cities projects had established strong community ownership and networks. These had been useful for tackling various public health issues such as child injury prevention and environmental health. However, it was also noted that the health sector had not been sufficiently supportive of the

model to enable a ‘critical mass’ of strong Healthy Cities projects to be established around the country, and that many projects relied for their existence on over-stretched community groups operating with very limited resources.

The Manukau Healthy City project is the longest-running in New Zealand and generally regarded as the most successful. Factors thought to have underpinned this success have included the employment of full-time co-ordinators, the presence of high level political support from the Mayor, functioning committees and funding, and the development of a three year plan to identify specific goals.

Another key element of the Manukau model has been the drawing up of a Manukau The Healthy City Charter. A wide range of local agencies and organisations has signed up to this Charter as a way of publicly declaring their agreement and commitment to action.

A 1995 evaluation of the Manukau project focused on its then recent efforts to influence public policy responses to child hunger. The evaluation concluded that the project had achieved a high level of visibility in the city, strong co-operation between sectoral agencies, and a high level of community involvement. The involvement of Māori community members was particularly evident, with this being attributed at least in part to the formation of Te Ora o Manakau, a Māori wing of the Healthy Cities project in Manukau. This partnership relationship led to the inclusion of Māori-specific objectives within the overall city plan, as well the development of a healthy city plan for local iwi.

An independent evaluation of the Manukau project in 2000 concluded that work was needed to clarify the programme’s roles, responsibilities and governance/accountability structures, as in the last three to four years, these had “lacked focus”. It was also recommended that the programme consider targeting its efforts mainly towards promoting the health of youth and children. Other recommendations were that a Māori Co-ordinator position be established within the project as part of a Treaty-based partnership.

Health Promoting Schools

Health Promoting Schools (also known as “Healthy Schools”) were developed under the principles of the Ottawa Charter for Health Promotion (WHO 1986b). The emphasis is 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 well-being of students, staff, and the wider school community members” (Rissel and Rowling 2000).

In New Zealand, the concept of Health Promoting Schools was first introduced through pilot schemes started in 1997 (Wyllie et al. 2000).

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.

Most schools had successfully established “health teams” and had undertaken a number of health promotion activities.

Some of the barriers found to implementing HPS in schools were: the lack of a supportive principal or school management team; changes in school personnel; a lack of time for school staff to take part in HPS; difficulties for co-ordinators in arranging HPS activities in tightly-scheduled school years; and a lack of understanding of HPS by a few schools.

ISSUES-BASED INITIATIVES

Community Alcohol Action Programmes

Community alcohol action has been defined as a non-linear approach in which activities are devised in response to the diverse needs of different community sectors and where the range of strategies employed can be diverse. The aim is primarily to co-ordinate existing resources within a community, rather than establish costly new organisations. Research and evaluation is seen as an integral part of the process.

Funding for at least one paid position in the community is regarded as a vital ingredient for successful community action. Ideally, the people in these paid positions should be a catalyst for action by building momentum and linkages between other people and agencies in the community.

Building the partnerships required for community action often involves reconciling the competing needs, goals and interests of various groups and organisations. This can be a time-consuming and “resource-hungry” process.

The first New Zealand community alcohol project (CAP) ran from 1982 to 1985 and consisted of large-scale, relatively resource-intensive, quasi-experimental “research-initiated demonstration project” involving six New Zealand cities. The project achieved statistically significant but modest attitude changes in the target cities.

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. Evaluation results suggested the campaign had contributed to a reduction in rates of drink-driving, traffic accidents, as

well as a decrease in the severity of injuries found in road accident victims attending Wanganui Base Hospital's Emergency Department.

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 NZ, ACC, and the Canterbury Area Health Board's Road Safety Unit. A co-ordinator was employed to run the 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, with the group including representatives from national bodies such as ALAC, the Police and the Alcohol and Public Health Research Unit, as well as regional and local level agencies such as Liquor Licensing Inspectors, Health Promotion Advisors and LTSA Regional Staff. While initially the project put a major emphasis on community mobilisation, this element achieved only patchy success and subsequently the project was refocused towards the "preservation and enhancement" of existing efforts to influence drinking environments and police activities.

There have also been two successful Māori focused community alcohol action projects that 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 Māori 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.

The WHANAU and TU BADD (Brothers Against Drink Driving) project was developed by the Te Whanau 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 Māori males and campaign messages centred on Māori notions of manhood. Collaborative action involved a range of groups including community, police, councils, marae, education, justice and sports organisations.

Safer Community Councils

In 1990, four pilot Safer Community Councils (SCCs) 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 the 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. Others involved SCCs funding existing initiatives run by other community groups. Most projects targeted wider social issues by promoting projects which 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 NZ Employment Service. Other SCC members included staff from the Department of Internal Affairs, Te Puni Kokiri, and Housing, as well as representatives from the education and health sectors. The roles of the Police and Department of Justice representatives tended to be clearer than those of other agencies, some of which appeared to have a lack of commitment to the scheme. Restructuring of some agencies also resulted in a lack of continuity in the representatives they sent to meetings.

Community Injury Prevention Programmes

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 programmes towards at-risk groups were the bases for the approach. Worldwide there are now 56 formally designated WHO Safe Communities members. including Waimakariri and Waitakere in New Zealand.

To date, few evaluations of overseas Safe Communities programmes have been published. The small number of studies available from Scandinavia, Britain and Australia have concentrated on measuring outcomes, rather than processes, and have shown mixed results.

In New Zealand, “Safe Communities” projects have been developed in Rangiora (Waimakariri), Kawerau and Waitakere. The Rangiora

(Waimakariri) and Waitakere projects are designated WHO Safe Communities members.

The Rangiora and Kawerau projects were originally funded by the Public Health Commission and managed by the Plunket Society. However, in 1996 responsibility for the management of the Rangiora project was passed to the Waimakariri District Council. That same year responsibility for the Kawerau project passed to the Eastern Bay of Plenty Rural Education Activities Programme (REAP).

- An evaluation of the two projects found that the Safe Communities model had worked well in Rangiora - a Pakeha, stable, growing, relatively advantaged community. However, it did not work well in Kawerau, which had a predominantly Māori population, and where many of the people were disadvantaged and mobile. In addition the local authority did not undertake community development activities. It was concluded that the assumption that communities had the capacity to run such projects was inappropriate for Kawerau.

Evaluations of the Waitakere Safe Communities programme found good evidence that a great deal of intersectoral collaboration had taken place. Local agencies' awareness of the programme and participation in it were high. The location of the project within Waitakere City Council and the integrity and commitment of the co-ordinators were seen to be two key factors contributing to this success.

Over the intervention period, there was a significant increase in the proportion of Waitakere people using appropriate car restraints. In addition, there was a significant increase in the proportion of people reporting that they had installed home safety equipment such as fireguards, pool fences and stair gates. Ownership of protective equipment for sport also increased.

Evaluations have also been undertaken on the Turanganui a Kiwa and Ngati Porou Pilot Community Injury Prevention projects. Both projects were collaborations between Tairāwhiti Healthcare and the two respective Māori organisations. Both projects were assessed as demonstrating that the Safe Communities concept could be successfully implemented in large rural and urban settings with high Māori populations. Community surveys found an increase in awareness and knowledge of injury prevention among the target population.

Community Nutrition Programmes

At different times between 1993 and 1995, four community nutrition programmes for Māori 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 Māori organisations to implement the programmes.

All the programmes were based on strong community development perspectives and achieved a great deal of Māori community involvement, empowerment and sense of local “ownership”.

The original programme - Te Kai o Te Hauora - was initiated by Te Hotu Manawa Māori in conjunction with Tairāwhiti Healthcare. It ran for 14 months during 1993-1994 in five communities on the East Coast of the North Island (Pipi et al. 1994). Five kaiāwhina (nutrition community health workers) were nominated by marae committees and other community organisations to work for eight hours per week in their own communities. The kaiāwhina were trained and supported by the project co-ordinator (a qualified dietician).

Evaluation feedback from community members indicated that the programme had used appropriate methods to deliver information (i.e. face-to-face by a local community member using te reo) and that the local community’s awareness of nutrition issues had been enhanced.

Following the above programme, a joint initiative - Te Taro o Te Ora – was established between Te Runanga o Ngāti Porou, Te Runanga o Turanganui-a-Kiwa and Tairāwhiti Healthcare Ltd. It operated from 1994 onwards on the East Coast of the North Island. A process evaluation concluded that programme had met all its objectives, and was particularly successful because of the way it had met the community’s needs and used existing community networks. There was also feedback suggesting there had been a significant change in food offered at participating marae, with more wholemeal bread, fruit, vegetables, lean meat, cereals and water being available instead of less-healthy options.

Another community nutrition programme for Māori was established in 1994 at Wai Health in West Auckland. It was originally funded by North Health as a collaborative initiative between Te Whānau 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 Whānau o Waipareira Trust, Auckland Healthcare, the National Heart Foundation, and the Department of Community Health (University of Auckland). In 1997, Te Whānau o Waipareira Trust took over as sole provider and the joint management group was established.

An evaluation concluded that the programme had met its goals and had delivered services in the ways it had intended. Key informants believed that a number of changes had occurred in local people’s eating habits and in the kind of food that was provided. An extensive consultation process and needs assessment completed before the programme had helped ensure that it was appropriate for the local community, and had a strong sense of community ownership.

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 (Pakeha) dietician to help with programme development and the training of the community advisors. By 1997, no dieticians were linked to the programme.

Like the previous community nutrition programmes, evaluations of the Northland programme found indications of positive changes in local people’s eating patterns, with less fat, sugar and salt being consumed by families and healthier food being offered at marae.

Otara Health and Housing initiative

This was a joint health and housing initiative between the Manukau City Council, Housing New Zealand and the Department of 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 well-being” (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 socio-economically deprived area of 1960s and 1970s state-housing. Ambassadors talked about health and housing issues with residents, and provided them with information and made referrals to other agencies.

A formal evaluation of the campaign found that 7,191 houses were visited, with members of 4,694 households taking part in “full interviews” with the ambassadors. The ambassadors also made a large number of referrals to other agencies (481 in total) including Housing NZ, the Fire Service (for installation of smoke alarms) and the Department of Work and Income, and provided a large number of rodent traps.

CASE-MANAGEMENT INITIATIVES

Strengthening Families initiatives

Strengthening Families is an intersectoral policy initiative introduced by Government in 1997 to improve the overall well-being of families considered to be “at risk”. In the beginning the initiative involved only the Ministries of Health and Education and the Department of Social Welfare. However, it now includes a large number of other government and non-government agencies.

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’ abilities to resolve difficulties and problems. Central to this is promoting clearer definitions and better collaboration between 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, Social Workers in Schools and Family Start (known as “Early Start” in Christchurch, where it originated).

Collaborative Case Management

This initiative aims to formalise and enhance intersectoral collaboration and co-ordination across a number of governmental and non-governmental services. Joint agency meetings with families, and the funding of a co-ordinator in some places (like Christchurch) are two of the main strategies being used.

- Collaborative Case Management has been the subject of two completed evaluations. Both came to similar conclusions. In general staff were generally very supportive of the Strengthening Families concept and its emphasis on interagency collaboration. While many staff felt they were already collaborating with other agencies before the Collaborative Case Management initiative began, the initiative was thought to enhance the quality (but possibly not the frequency) of collaborative interactions. Outcomes for families were perceived to have improved as a consequence.

Social Workers in Schools

Social Workers in Schools (SWIS) is an initiative led by Child Youth and Family. It provides social workers in 56 schools in Northland, East Coast, Porirua-Upper Hutt and targets Decile 1-5 primary and intermediate schools. As well as contributing to the overall goals of Strengthening Families, such as co-ordinating social services for school students and their families, the initiative also aims to “close the gaps” between Māori and non-Māori.

- One evaluation of SWIS has been completed. It concludes the service is needed and has attracted a high level of use. It also identifies a high degree of satisfaction with the service amongst the students and families who have used it. Families prefer to work with school social workers they know, rather than with social workers from outside agencies they have never met before.

Family Start / Early Start

Family Start is a home-visiting, early intervention programme for children currently operating in around 17 sites. The initiative is currently being evaluated, though to date (May 2001) no evaluation reports have been completed.

In 1995, the forerunner of Family Start - known as Early Start - was introduced as a pilot in Christchurch. It was based on Hawaii's Healthy Start initiative. The programme was run by a consortium including the Family Help Trust, the Christchurch Health and Development Study, the Plunket Society, Pegasus Medical Group, and Māori representatives.

Evaluation of the pilot found a great deal of service co-ordination and rationalisation had occurred. Family Support Workers developed systematic family support plans and helped with many referrals to other

agencies. Some families had as many as 20 agencies dealing with their problems.

The programme was also found to be effective in encouraging preventive child health practices such as breastfeeding, non-prone sleeping, use of car restraints, ensuring hazard-free environments, and obtaining GP visits when required.

Family Service Centres

Government funding to establish six pilot Family Service Centres was announced in the 1993 Budget. The concept involved providing early childhood and parent education, health services and social support services to socio-economically disadvantaged families with young children from a dedicated “one-stop-shop” facility).

The establishment process for the pilot centres was managed by a Government interdepartmental steering committee set up specifically for the purpose. “Critical success factors” identified for the centres included the provision of a range of integrated services including early childhood education, a home-based instruction programme for pre-schoolers, family support and counselling services, and health services. It was also expected the centres would be closely linked to their local primary school.

An evaluation of the pilot initiatives found considerable delays in the implementation of the centres. However, it also found five of the centres had successfully engaged a high proportion of low-education, benefit-dependent families. Four had engaged a high proportion of Māori and Pacific families.

The evaluation also noted that the ongoing work of the centres was impeded by “long communication and decision-making chains”, the “slow development of operational policies” and “lack of integration at the funding and contracting level”. Integration between the different services within each centre was judged to be generally quite low, with each service maintaining its own identity. This was thought to be fundamentally a result of each service having different contracting organisations, funding and accountability arrangements.

The evaluation called for greater flexibility in contracts “... to allow funding from different streams to be used across different core services, where these services are providing integrated functions” (Ministry of Health 1997: 252).

Wraparound services

Wraparound services are 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). 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.

In New Zealand, a Wraparound service was first piloted in 1996 in two children’s health camps in Northland (Maunu Health Camp) and Auckland (Pakuranga Health Camp). Participating children were 5-12 years old, lived in the two health camps’ catchment areas, had multiple emotional and behavioural problems, and often needed long-term and external agency support.

An evaluation found a high degree of satisfaction from participating caregivers about the parenting skills they had learnt and the improvement in their children’s behaviour. Co-ordination between health camps and outside agencies (mainly schools, psychologists, and public health nurses) had also improved, and these agencies were generally “satisfied with the quality of the working relationship established between themselves and the Camps” (McClellan 1997: iii).

In May 1998, a large-scale pilot Wraparound service was established in South Auckland. 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 covered by the group included Youth Affairs, Justice, Education, Social Welfare, Te Puni Kokiri, Police, Health, Courts and Internal Affairs (Warren 2000). The pilot programme was run by Te Whanau 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 young people aged 13-17.

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” (WAG). 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.

A comprehensive programme evaluation found that case managers usually established good relationships with clients, and both clients and their families believed there had been improvements with regard to family issues and in young people’s attitudes and behaviour. For instance, their at-risk behaviour, connection with the education system, health and well-being all improved. There were also fewer problems with family / whanau relationships and violent behaviour. Some clients also achieved educational goals. In general, clients wanted Wraparound to continue and were concerned about the possibility of it stopping.

Key Determinants of Effective Community-based Intersectoral Action for Health

The reviewed literature identifies a range of factors likely to influence the effectiveness or “success” of community-based intersectoral action for health. Based on *Working Together: Intersectoral Action for Health*, a publication of the Australian Commonwealth Department of Human Services and Health, these can be grouped into six main headings:

1. All partners agree on the necessity for intersectoral action

- all partners (government agencies, non-government agencies, community groups, etc.) agree they should work together
- the intersectoral action presents a “win-win” situation where all partners benefit
- all partners have a shared vision of what they want to achieve
- all partners give their full support and mandate to the intersectoral action and accept it as part of their core business

2. Support exists in the wider community

- high-level political support (central or local government)
- appropriate legislative environment (e.g. ability to share budgets)
- a supportive economic environment (there is economic growth and resources are not too scarce)
- the prevailing public policy environment facilitates collective action rather than individualism
- a supportive organisational environment
- the initiative is consistent with the socio-cultural beliefs, current concerns and attitudes of the target community, including their priorities for action
- the timing is right
- the location for the intersectoral action is appropriate (e.g. other sectors have to be available to collaborate with)

3. Capacity exists to carry through the planned action

Partner organisations

- there is widespread support among all levels of staff within partner organisations
- activities associated with the initiative are part of staff’s job descriptions
- staff involved in intersectoral planning and management groups are able to make decisions on behalf of their organisations (and it is clear who is able to do so)

-
- the power to make decisions rests at the local, rather than national level
 -

Community participation

- existing community organisations (like NGOs, voluntary agencies, businesses, Māori organisations) are involved in partnerships rather than *ad hoc* groups of “grassroots” individuals” with no existing networks
- Māori initiatives use existing Māori networks such as marae and kohanga reo and have “buy in” from the local Māori community
- the current literature review did not find any evidence concerning conditions that are favourable to Pacific peoples’ participation in intersectoral initiatives for health.

Resources

- all partners (including community representatives) have enough resources and support to participate in the initiative
- extra staff time for collaboration and extra resources for infrastructure and administration are allocated (although financial savings may also be made in some instances)
- at least one full-time local co-ordinator is employed, as well as regional and / or national co-ordinators for initiatives that are located more widely
- administrative assistance is provided to co-ordinators
- long-term funding is assured so initiatives can be properly developed, infrastructures are built and projects have time to “work” (this usually takes several years because of the time it takes to establish partnerships and work collaboratively)
- long-term funding so that skilled staff are attracted and do not have to spend too much time fund-raising rather than facilitating the initiative’s activities
- long-term funding so that partners do not become disillusioned and mistrustful (e.g. where one partner is the funder)

Personal skills

- staff employed on the initiative (e.g. co-ordinators) have a wide range of skills, knowledge and experience in areas such as community development, health promotion, communication, negotiation, management
- front-line initiative staff are locals
- training is given early on to staff in areas they are less familiar with

4. Relationships enabling action are defined and developed

- the roles of, and relationships between, partners are agreed and clearly defined
- there is trust and respect between partners
- well-resourced systems are in place for collaborative working
- systems are in place to enable relationships to be regularly reviewed and renegotiated if necessary

5. Agreed actions are planned and implemented

- a planning and development phase is undertaken, including an assessment of the local community's needs and existing services and programmes
- strategies and action plans are agreed and, ideally, put in writing (e.g. in a memorandum of understanding)
- a manageable number of activities are undertaken so success is achieved, as well as working on building community and organisational infrastructure
- the responsibilities of each partner are defined with regard to what actions they will undertake
- partners share accountability for programme successes and failures

6. Outcomes are monitored

- progress is monitored so that partners can make decisions about their future support
- initiatives are given time to “succeed”.

Working Together concludes that, when assessing the “success” or “effectiveness” of an intersectoral initiative, a key requirement is that the monitoring and evaluation strategy used, and the quality of evidence it provides, should be *acceptable* to all participating sectors and organisations.

On top of this, the monitoring and evaluation strategy should reflect the size, amount of funding and outcomes expected from the initiative. The evaluation should not overpower the actual initiative and be the dominant driver of the process.

Other literature 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).

Implications for Future Initiatives

Community-based intersectoral health initiatives essentially aim to improve the health of the people in a particular locality or area, and by so doing help to reduce broader health and social inequalities. In our view these objectives are appropriate, given the inequalities that exist between different geographic, ethnic and socio-economic groups within New Zealand.

The fact that these initiatives are using intersectoral approaches also seems appropriate, given that the determinants of health are themselves multi-dimensional and “cross-sectoral”.

Effectiveness of community-based intersectoral health initiatives

In the New Zealand initiatives reviewed here, it was comparatively rare for evaluators to attempt to measure broader health status outcomes (such as morbidity and mortality) produced by the initiative. Reasons for this included the methodological difficulties and costs involved in collecting or accessing suitable data, plus difficulties in interpreting results (such as whether health gains occurred because of the initiative or because of other factors). While these same difficulties arise when attempting to assess the impact of other kinds of health initiatives, the difficulties may be greater for intersectoral programmes, especially because of their structural complexity and often broad ranging objectives.

That said, there are indications that 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 these programme may also be easier to demonstrate).

Evaluations of community-based intersectoral initiatives have also focused on assessing changes in people’s health-related knowledge, attitudes and behaviour. Examples of positive intermediate outcomes attributed to some of the initiatives reviewed here include: improved nutrition-related knowledge and provision of healthier food, improved road safety behaviour, and improved student attitudes to health education.

Community-based intersectoral initiatives have also been found to lead to changes in various aspects of the environment such as the physical environment (provision of shade trees), the economic environment (local employment schemes), the social environment (provision of education

and leisure activities for young people at risk of crime), and the policy / legislative environment (influencing child hunger policies).

Effectiveness for disadvantaged people

Many of the intersectoral initiatives reviewed here appear to have worked well for disadvantaged people, at least when “effectiveness” is judged in terms of the kinds of intermediate outcomes achieved.

Case management programmes for “at risk” individuals and families have generally reached their target clients and clients have been satisfied with the services they received.

Issues-based initiatives like injury prevention and nutrition programmes targeting Māori also seemed to be effective, particularly if they were endorsed by the local Māori community; run and developed by Māori in a way consistent with tikanga Māori; and used existing Māori networks (like iwi organisations, marae, and kohanga reo).

However, it is less clear how much some of the overarching, area or settings-based initiatives have benefited disadvantaged people. Partly this is because evaluations of these initiatives have tended to concentrate on looking at the functioning of the initiative as a whole, rather than at specific projects or programmes within the initiative. As well, there has been focus on assessing organisational processes rather than outcomes for individuals.

It is clear, however, that these types of initiatives have had some problems achieving a good level of participation from the “grassroots” community, including disadvantaged people. The main reasons for this appear to be a lack of available time, resources, and motivation of “ordinary” community members, especially if they are socially disadvantaged in some way. This fits with the experience from other countries.

Prioritising proposals for new initiatives

In selecting proposals for new community-based intersectoral health initiatives, the above criteria suggest that priority could be given to proposals that:

- demonstrate there is clear agreement between the partners on the necessity to work together
- show there is support in the wider community, including central and local government, for the type of initiative envisaged
- demonstrate that the partners each have the capacity to contribute to and carry out the initiative
- recognise that the relationships between the partners need to be clearly defined and nurtured on an ongoing basis
- state the intention to develop a clear, strategic plan of action to meet the assessed needs of the local community
- recognise the value of monitoring and evaluating the progress of the initiative.

Role of the Ministry of Health and District Health Boards

There are potentially several ways that the Ministry of Health and DHBs could support the development of community-based intersectoral initiatives.

As funders of demonstration or pilot initiatives, the Ministry and DHBs could ensure that the funding provided is sufficient to enable initiatives to develop and sustain appropriate infrastructures for intersectoral working (including collaborative relationships, co-ordinator roles and administrative functions).

As well, stable funding should be provided for a sufficient length of time to enable initiatives to effectively implement sustained activities such as community development, health promotion, and case-management services.

There are instances where programme designers have called for five, seven or even ten-year time frames for the development of intersectoral initiatives. There is also some research evidence that intersectoral initiatives should be funded for at least 3-5 years (or even longer) to enable effective partnerships and service structures to be developed. However, it is hard to generalise about appropriate timeframes for intersectoral initiatives, given their diverse goals and activities.

While it is possible intersectoral initiatives may eventually produce long-term savings due to efficiencies associated with reducing duplication between agencies, the current literature review has found no evidence that this is the case.

As well as financial support, the Ministry and DHBs could take leadership roles in supporting community-based intersectoral action for health. This could include emphasising their commitment to new initiatives so that other organisations are encouraged to participate in them. Additionally, it could include securing high level political support for the initiatives. Supporting intersectoral initiatives is consistent with the Ministry's new health and disability strategies and guidance to District Health Boards.

However, while community-based intersectoral health initiatives benefit from political *support* from central government, problems can occur if Ministers or central government start trying to set the priorities and agendas for community-based action. One of the fundamental tenets of community development is that planning should be locally-based and activities tailored to the needs of the local population.

Overall, the evidence suggests that a combination of “top down” support and “bottom up” planning and management is the most appropriate recipe for successful community-based intersectoral action.

Developing guidelines

The Ministry and / or DHBs could also develop and promulgate guidelines to assist organisations thinking of setting up community-based intersectoral initiatives for health. The focus would be on recommending suitable processes and examples of “best practice” rather than requiring certain priority outcomes to be addressed.

Role of other organisations and the community

Local authorities have the potential to play an important role as supportive partners in community-based initiatives, both as funders and providers. However, this support may not be forthcoming if the local authority is not experienced in working collaboratively or does not accept that it has a role in promoting health.

Some locally-based health and social agencies, as well as other organisations that deal with aspects of the human and physical environments, will also be in good positions to become partners in intersectoral initiatives. Especially helpful are existing networks and working relationships with other agencies that can be used and built upon.

In general, initiatives that have aimed to engage existing local organisations as partners (or funders), including the voluntary sector, local businesses, Māori organisations (such as runanga and marae committees), 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 “grassroots” 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 “ordinary” community members, especially if they are socially disadvantaged in some way.

Evaluation

Our review indicates that naturalistic (as opposed to quasi-experimental) research techniques are generally the ones most favoured in New Zealand evaluations of intersectoral action. The advantage of these techniques (which include interviews, focus groups, first-hand observation and the analysis of written records) is that they enable details of the sometimes complex processes involved in implementing an initiative to be thoroughly documented, analysed and, where necessary, critiqued.

Depending on the nature of an initiative, as well as the evaluation resources available, it is also often possible to measure certain intermediate outcomes. These could include levels of public awareness, self-reported behaviour change, or client satisfaction with a particular service or campaign activity.

It is only sometimes possible to assess whether or not the ultimate health goals or objectives of intersectoral initiatives have been reached (such as improvements in health status or health gains). For instance, it may be possible where robust statistical information is available and easily accessible. However, even where changes in indicators are detected, attributing causality to the particular initiative is still likely to be a matter of judgement, since other factors, both known and unknown, may also have had an effect.

There are also several distinctive features of community-based intersectoral health initiatives that evaluators need to note. They include:

- the diversity of the initiatives, which mean that making comparisons between initiatives can be quite difficult
- the complexity of partner relationships
- the extra time, resources, infrastructure, activities and “transparency” agencies need to develop and support collaborative partnerships, meaning that evaluations also may take longer to do
- the large number and scope of different activities often undertaken as part of an intersectoral initiative
- the existing 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.

Chapter One

Introduction

Aims of the report

This report reviews international and New Zealand literature on community-based intersectoral initiatives for health. It examines the extent to which these intersectoral initiatives have been effective and the range of factors thought to be important for determining their success or failure.

- More specifically, the report aims to present information to help answer the following questions:
- are the objectives of community-based intersectoral health initiatives appropriate for the New Zealand situation?
- have these intersectoral initiatives been effective, both overseas and in New Zealand?
- have these initiatives been effective in communities with poorer health outcomes, for example communities with high proportions of Māori and Pacific people or places with high levels of socioeconomic deprivation?
- what are likely to be the most appropriate and effective ways of implementing community-based intersectoral initiatives in New Zealand?
- what are suitable criteria for selecting and prioritising proposals for new initiatives?
- what are possible roles for the Ministry of Health, other government agencies, DHBs, local government, iwi and other community agencies in funding, establishing, developing, giving ongoing support to, and running these types of initiatives?
- what are the most appropriate ways of evaluating these types of initiatives?

New Zealand Intersectoral Community Action for Health Initiatives (ICAHs)

- The Ministry of Health intends to use this report to inform decisions related to the development of the Intersectoral Community Action for Health (ICAH) programme.
- The ICAH programme consists of intersectoral initiatives targeted at areas of high socioeconomic deprivation and significant health inequalities. The sites are South Auckland, Northland, Porirua and Kapiti. The initiatives aim to tackle wider determinants of health (e.g. socio-economic deprivation, housing) as well as barriers limiting access to health and disability services, using principles of community engagement and development and by promoting collaboration between central and local government agencies, tangata whenua, taura here, Pacific and other community groups (Ministry of Health 2001c; Porirua Kapiti Healthlinks Project 2000a, Porirua Kapiti Healthlinks Project 2000b).

The ICAH programme has been modelled on the United Kingdom's Health Action Zones (HAZs), described later in this report.

Defining intersectoral action

Before going on it is important to define "intersectoral action for health".

Working Together: Intersectoral Action for Health, a publication of the Australian Commonwealth Department of Human Services and Health, offers the following definition:

A recognised relationship between part or parts of the health sector and part or parts of another sector, that has been formed to take action on an issue or to achieve health outcomes, (or intermediate 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).

The report notes that intersectoral action can take many forms and use a wide range of strategies:

...from activities that are often identified with health promotion, such as community development or advocacy, through to service delivery activities, such as shared management of the health-related problems of a particular person or cross referral (Harris et al. 1995: 25).

The report goes on to give a list of examples of types of intersectoral action. They include:

- sharing relevant information on a particular issue
- networking to share information and 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.

A briefer definition of intersectoral action is given by Canada's Federal-Provincial-Territorial Advisory Committee on Population Health (FPTAC) in their 1999 report *Intersectoral Action Towards Population Health*. They describe it as "actions by partners from many different sectors to ensure the healthiest population" (FPTAC 1999: 7).

The FPTAC also notes that intersectoral action can take many forms and include many types of groups and organisations from different parts of society. Typically, though, intersectoral action involves processes or relationships *that cut across the main sectors of society*. A sector is defined by the FPTAC as "a broad field of activity" within a society or nation, such as the health sector, social services sector, justice sector and so on.

The FPTAC adds that within each sector there are different agencies or organisations (including community groups). These can be differentiated in terms of their mandate and systems of financing and operation (e.g. government agencies or non-government agencies; for-profit or not-for-profit organisations or groups, and so on).

As well, within each sector, different agencies or organisations operate at different levels – whether different geographic levels (e.g. local/community, regional, provincial, national) or different levels of government (local or central). Each of these agencies, in turn, may also have people that operate at the senior decision level, the service delivery level and so on (FPTAC 1999).

Justifications for intersectoral action

The main justification for intersectoral action described in the literature is that the determinants of the health of populations and communities are

diverse, complex and multifactorial – and beyond the capacity of the health sector to influence on its own. Health in this context is typically defined in the broadest sense to include physical, emotional, social, material and spiritual dimensions, recognising that social, cultural and economic factors influence health outcomes as much as health services.

Intersectoral action for health involves building constructive relationships with people and agencies from outside the health sector, in an effort to jointly influence these broader determinants.

Intersectoral determinants of health

The World Health Organisation identifies a wide range of sectors with the potential to influence the determinants of health. They include agriculture, food and nutrition; education, schools, higher learning institutions, culture, media; environment, water, sanitation, habitat, industry, housing, development, urbanisation, industrialisation (WHO 1986a).

In New Zealand, the National Health Committee identifies social, cultural and economic factors as the most important determinants of good health. In particular the committee identifies income and poverty, employment and occupation, education, housing, and culture and ethnicity as the main socio-economic determinants (National Health Committee 1998). Howden-Chapman and Tobias (2000) present a model illustrating some of the pathways by which social and economic factors may lead to good health for individuals, families and communities (Figure 1).

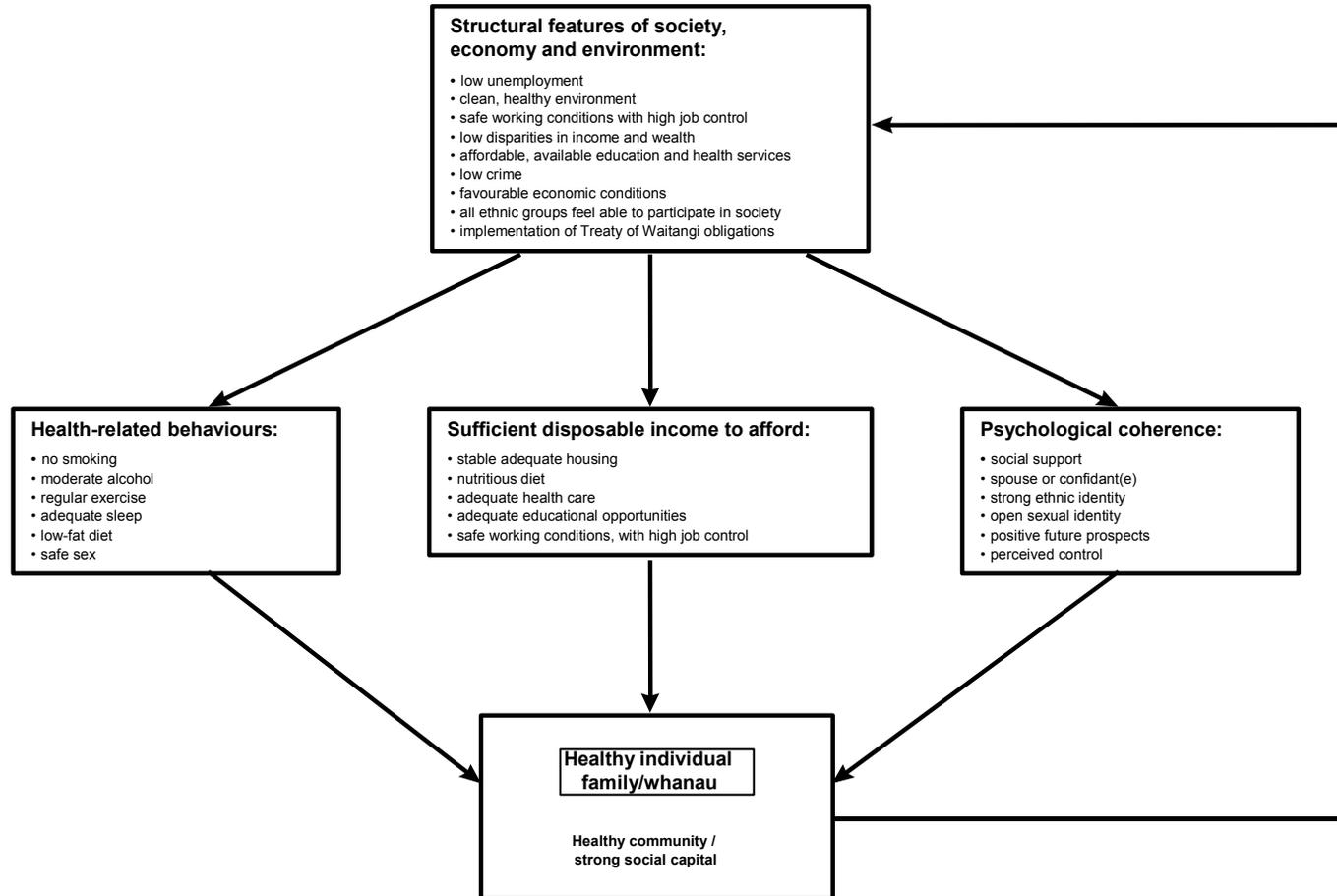
Inequalities in health

Globally, the health status of most populations, as measured by indicators such as mortality rates, has improved gradually over time. However, most developing countries still have significantly poorer health status than developed countries. Also in many countries some sub-groups of the population experience health problems more frequently than other sub-groups. That is, significant inequalities in health status exist both between and within countries (WHO 1986a).

Kawachi and Kennedy (1997: 1037) note that “relative distribution of income in a society matters in its own right for population health”. Increases in the differential between the rich and the poor are thought to reduce the strength of social cohesion (“social capital”)



Figure 1.1: Model of the social and economic determinants of health



Note: Arrows indicate probable causality.

Source: Howden-Chapman and Tobias (2000: 4).

Within New Zealand, inequalities in health status exist between people who are economically “well off” and those who are economically less advantaged. The following socio-economic conditions have been associated with higher mortality rates:

- residence in geographic areas with relatively high social deprivation (as measured by NZDep96)
- occupation (with manual labourers having high mortality rates compared with professionals)
- residence in Health Funding Authority localities with high income inequality (Howden-Chapman and Tobias 2000).

Low income and unemployment are also associated with less-favourable self-ratings of health status, while disadvantaged social position is also related to higher prevalence of asthma, diabetes and disability. People living in more deprived geographic areas (and those in worse social positions) also have higher rates of hospitalisation than others (ibid.).

Additionally, the following health risk factors are more prevalent among the more socially deprived:

- obesity
- high blood pressure
- poor diet (high calorie and saturated fat intake)
- hazardous alcohol drinking patterns
- a high prevalence of smoking (ibid.)

There are also ethnic inequalities in the health status of New Zealanders, with Māori and Pacific people having higher levels of morbidity and mortality for a significant number of health conditions, as well as some higher risk factors. These inequalities appear to be partly, but not entirely, due to differences in socio-economic status (Bathgate et al. 1994; Howden-Chapman and Tobias 2000; Ministry of Health 1999).

Further inequalities in health are experienced by different age groups, men and women, and people living in different regions of New Zealand, as well as between rural and urban areas (Edmondston and Maskill 1989; Howden-Chapman and Tobias 2000).

Intersectoral action for health

In its 1978 Declaration of Alma-Ata, the World Health Organization stated that primary health care:

...involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all these sectors (WHO 1978).

Since then, many other calls have been made to work across sectors in order to address the determinants of health status, and in particular health inequalities (e.g. Howden-Chapman and Tobias 2000; National Health Committee 1998; WHO 1986a; WHO 1997).

Additional potential benefits of working across sectors include resource savings in the form of less duplication of activities and better co-operation between sectors (Harris et al. 1995; Kuhn et al. 1999). Also, intersectoral ways of working may reduce the risk of disadvantaged people “falling through the gaps” of health and welfare systems (McClellan and Warren 1996).

Intersectoral action for health can be targeted at an individual level, for example case-management services that provide enhanced processes of referral of individuals or families to other sectors. However, increasingly, intersectoral action for whole communities (for example using “community development”) is being promoted. One of the main aims of this type of action is to improve the “social capital” of a community, thus leading to improved health of the population (Baum 1989; Kawachi and Kennedy 1997).¹

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

The literature search

The main information source for this review has been New Zealand research reports published in scientific and academic journals, books, and other relevant documents from 1980 onwards. Review articles, plus some reports on specific intersectoral initiatives, have also been included from countries such as Canada, Australia, UK and USA.

Several strategies were used to track down relevant documents. They included searching bibliographic databases (Medline, HealthStar, Index New Zealand and the National Bibliographic Database), New Zealand library databases (including the Ministry of Health intranet database) and Internet web-sites. Material from the Cochrane Library database was also identified from the publication Evidence From Systematic Reviews of Research Relevant to Implementing the “Wider Public Health” Agenda (Contributors to the Cochrane Collaboration and the Campbell

¹ Note there is considerable debate about the definitions of “community development” and “social capital” and their relationship to health (e.g. Lynch et al. 2000).

Collaboration 2000). This publication contains over 1,100 references to public health interventions and their effectiveness.

Searching for relevant material on the web located a considerable amount of literature (particularly on-line reports) not covered by standard bibliographic databases like Medline. Web-sites visited included those of the World Health Organization (WHO), the Departments of Health in USA, Canada, Australia and UK, a large number of New Zealand government departments, research centres like the Kings Fund (London), Centre for Health Economics (York), University of Ottawa, Australian Institute of Health, and HAZnet (a comprehensive website for Health Action Zones in the UK).

We also contacted staff from 25 of the 26 Health Action Zones (HAZs) in the UK by email, as well as several members of the national HAZ evaluation team working on different parts of the national evaluation. This yielded several useful reports.

To obtain as much information as possible on New Zealand initiatives, we contacted a number of New Zealand agencies (mainly by telephone) to ask them to identify any relevant material that they held or were aware of. Agencies contacted included Ministry of Health staff in Auckland and Wellington (including ex-HFA staff), Te Puni Kokiri, Ministry of Social Policy, the Health Promotion Forum, HealthCare Aotearoa, local authorities that we believed were involved in intersectoral initiatives (e.g. Manukau City Council), and health research groups such as the Health Services Research Centre (Wellington), Alcohol and Public Health Research Unit (Auckland), and the Injury Prevention Research Unit (Dunedin).

Our original intention was to also contact District Health Boards to find out if they held relevant information. However, this approach was abandoned after it proved too time-consuming to find suitable people to talk with and seemed to be an unproductive way of finding new material.

The Ministry of Health also provided us with some key articles, a preliminary literature review and a bibliographic database search carried out by the Ministry's information services staff.

Locating the most relevant references to community-based intersectoral health initiatives was not straightforward, particularly when searching library and other bibliographic databases. The most difficult aspect was that references to community-based programmes often did not clearly state whether or not the programmes were intersectoral. This, or similar terms, were seldom used in titles and only sometimes in abstracts. Many evaluations just mentioned the specific name of the initiative.

In addition, as might be expected, a range of other terms were used to describe these kinds of initiatives or programmes. They included "partnership", "coalition", "alliance", "joint initiative", "joint venture", or

“interagency” / “multi-agency” initiative. As well, “intersectoral” approaches were sometimes referred to by names such as “co-ordinated care” and “community development”.

Focusing the review

Initial searches revealed a large body of information describing projects or programmes where health sector agencies worked jointly with non-health sector agencies. Many of these projects or programmes addressed a relatively narrow group of health issues (such as injury prevention). A smaller proportion were more strategically orientated (such as Health Action Zones) and aimed to address conditions affecting a range of health problems.

To keep the review as relevant and focused as possible, it was decided to concentrate mainly on initiatives that met all or most of the following criteria:

- they had some kind of formal arrangement for working across sectors
- their primary aim was improving health status and reducing health inequalities
- they were targeted to people living in sub-national geographic areas (e.g. local region, city, small town or rural area)
- they were primarily targeted to people who were disadvantaged from a health status or socio-economic perspective (e.g. certain ethnic groups, age groups, people with certain health conditions, people with disabilities)
- they had been systematically evaluated, with a publicly-available record of the evaluation results

Initiatives of this kind were most similar to the ICAH model.

Throughout the search, particular effort was put into collecting as much relevant information as possible on New Zealand initiatives. This was because of the Ministry’s wish to assess the best ways to implement ICAHs and their effectiveness in New Zealand communities. Many New Zealand communities exhibit particular issues of health disadvantage among specific population groups such as Māori and Pacific peoples.

The special emphasis on New Zealand material means that some evaluations of New Zealand initiatives are included in the review, even though they do not meet all the criteria outlined above. For example, we have included evaluations of Healthy Cities initiatives, even though they sometimes covered locations and populations that in general were not particularly disadvantaged socio-economically. Safer Community initiatives have been included because, although they do not primarily aim to achieve health gains (their main focus is crime prevention), they have a strong health component and have been systematically evaluated.

Points to note

A key gap in the review is information on intersectoral initiatives *primarily* involving Pacific people. We were unable to find any reports on this topic (though several of the initiatives reviewed below have included a Pacific component).

While there is good up-to-date information available for several of the initiatives described below, for others there is no recent information. It is yet to be verified which initiatives are still running, and, if so, in what form.

There may be a bias in the literature (particularly in peer-reviewed journals) towards reporting “successful” initiatives, or glossing over difficulties. Information about initiatives where there were major problems, or which did not get off the ground, may be harder to find.

A final point to note is that none of the material reviewed here includes studies that have attempted to compare the effectiveness (or costs) of community-based *intersectoral* programmes with those of community-based programmes that are *not intersectoral*. Such studies appear to be exceedingly rare, doubtless because of the methodological challenges they present.

That said, we are confident that the literature we have reviewed here covers the main issues pertinent to the effectiveness of community-based intersectoral initiatives for health. In particular the evidence relating to the determinants of successful intersectoral action for health is notable for its consistency, both across the groups of case studies we examined and in the overseas review articles.

What the rest of the report covers

Chapter Two of this report presents a number of case studies of community-based intersectoral initiatives for health, drawn primarily from New Zealand.

Chapter Three then uses these case studies, along with relevant review articles, to develop a list of some of the more important factors thought to be crucial for determining the effectiveness of these kinds of initiatives.

The report ends by discussing the implications of these findings for future community-based intersectoral health initiatives in New Zealand.

Chapter Two

Examples of Community-based Intersectoral Action for Health

Introduction

This chapter describes ten types of community-based intersectoral initiatives for health. The purpose of these descriptions is to provide case study material for Chapter Three.² The information on nine of the initiatives is drawn principally from New Zealand, while the material on one (Health Action Zones) comes exclusively from the United Kingdom.

For each initiative, information is provided on history, aims, main activities and processes, and evaluation strategies. Results and impact of the initiatives are also considered, including the effectiveness of intersectoral relationships and factors shaping the character of these relationships.

Each of the initiatives can be grouped into one of three broad categories (see Table 2.1 overleaf):

- over-arching area or settings-based initiatives – Health Action Zones, Healthy Cities, Health Promoting Schools (ICAHs also belong to this group)
- issues-based initiatives - community injury prevention programmes, community nutrition programmes, Safer Community Councils, health and housing initiatives
- case-management services - Strengthening Families (SWIS, Early Start / Family Start, Collaborative Case Management), Wraparound services, Family Service Centres.

However, all ten initiatives have three things in common. They are community-based, they are attempting (at least in part) to influence the underlying determinants of health, and they involve working across sectors (either directly or by using a strong system of referrals to other sectors).

² Readers may wish to read Chapters Three and Four before looking in detail at these case studies.

Table 2.1: Types of intersectoral initiatives reviewed

	Name of initiative	Target population	Target issues	Approaches usually used
1. OVER-ARCHING AREA OR SETTINGS-BASED INITIATIVES	<ul style="list-style-type: none"> • HAZs • Healthy Cities • Health Promoting Schools (ICAHs) 	Whole population of the area or setting and / or smaller demographic subgroups (for instance based on age, sex, ethnicity, neighbourhood)	A wide range of population issues e.g.: <ul style="list-style-type: none"> • health • welfare • physical environment • employment • education 	<ul style="list-style-type: none"> • Population-based health promotion / public health / prevention programmes • Personal health and welfare services (sometimes)
2. ISSUES-BASED INITIATIVES	<ul style="list-style-type: none"> • Community injury prevention programmes • Community nutrition programmes • Health and housing initiative • Safer Community Councils 	Whole population of the area or setting and / or smaller demographic subgroups (for instance based on age, sex, ethnicity, neighbourhood)	One health (or other sector) issue e.g.: <ul style="list-style-type: none"> • injury • nutrition • housing • crime 	Population-based health promotion / public health / prevention programmes
3. CASE-MANAGEMENT SERVICES	<ul style="list-style-type: none"> • Strengthening Families (SWIS, Early Start / Family Start, Collaborative Case Management) • Wraparound • Family Service Centres 	At-risk, disadvantaged individuals and their families	A wide range of personal issues e.g.: <ul style="list-style-type: none"> • health • income • family relationships • education • behaviour 	Personal health and welfare services

Health Action Zones (United Kingdom)

As part of its policy of establishing new Area-Based Initiatives (ABIs) in 1997, the UK government invited health authorities, in conjunction with local authorities and other agencies, to submit bids to establish “Health Action Zones” (HAZs). 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) (Judge et al. 1999).

The 26 HAZs have been 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 front-line staff
- taking an evidence-based approach
- developing a person-centred approach to service delivery
- taking a whole systems approach (Judge et al. 1999)

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” (HAZnet nd).

HAZ programmes are 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”(ibid.) i.e. they are using an explicitly intersectoral approach.

The other main strategic objective of HAZs is to “develop partnerships for improving people’s health and relevant services, adding value through creating synergy between the work of different agencies”. Inter-agency relationships involved in the establishment and ongoing management of HAZs include those: between different health agencies; with local authorities; between statutory agencies, the voluntary sector and businesses; with the public (to enlist their support and involvement); and between different HAZs (Department of Health 1997).

It could be said that HAZs are among the most complex, largest-scale community-based intersectoral initiatives for health. They work with large populations (from 181,400 in Luton HAZ to 1.4 million in

Merseyside HAZ), 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 is a large number of partners involved in these initiatives and many also interact with other area-based intersectoral initiatives that are working in their region.

When HAZs were first established, it was planned to allocate them £306 million in government funding in the first three years – the equivalent of one percent of the National Health Service budget. This amount was kept relatively low because it was expected that HAZs would eventually “mainstream” their activities into those of other agencies (with the ultimate aim of making HAZs themselves unnecessary).

Evaluation methods

As part of HAZs' “evidence-based approach”, a *national* evaluation is being conducted, consisting of several stages, as well as ongoing *local* evaluations in each of the 26 HAZs. In addition, some HAZs are being evaluated as part of more general research on area-based initiatives.

National evaluation

The national evaluation is being conducted by research staff from a number of universities. Progress reports available to date include a description of the characteristics of the 26 HAZs, a discussion of appropriate evaluation methods (Judge et al. 1999), and a review of quarterly progress reports accompanied by information from interviews with the HAZ project managers (Bauld et al. 2001). Final reports for all the various strands of the national evaluation are due to be completed at the end of 2002 (National Evaluation Team 2001).

The national evaluation team are using two main evaluation models to assess the progress of HAZs – the “theories of change” model and the “realistic evaluation” model. These models acknowledge the difficulty of attributing causality to any changes in health outcomes that may occur as a result of complex community initiatives. That is, *processes* (and the theories and assumptions behind them) and *contexts* are being studied in depth using naturalistic methods, rather than focusing on local changes in health status indicators (Barnes et al. 2000; Bauld and Judge 1999; Judge 2000; Judge et al. 1999).³

Within the national evaluation, there are also sub-projects that apply to themes running across all 26 HAZs, such as an evaluation of smoking cessation programmes (Adams et al. 2000) and another on collaborative

³ A further recently-published paper discussing the national HAZ evaluation methodology is not yet available in New Zealand libraries (Judge and Bauld 2001).

partnerships (Barnes et al. 2000; Barnes et al. c. 2001; Sullivan et al. c. 2001).

Local evaluations

All 26 HAZs also have their own ongoing local evaluations. These are looking in more detail at the effectiveness of HAZ programmes in their own communities (Bauld and Findlater 2000). Many of these evaluations are also using “theories of change” and “realistic evaluation” techniques. While some of the “first wave” HAZs have completed some stages of their evaluations, most of the “second wave” HAZs have yet to do so (personal communications with HAZ staff April-May 2001).

Evaluations of Area-Based Initiatives

Evaluations of HAZs are also being conducted as part of research assessing area based regeneration initiatives in East London, Newcastle, Plymouth, South Yorkshire, Sandwell and West Cumbria (DETR 2000a; Office for Public Management 2001).

National Evaluation Results

Results from the national evaluation (Bauld et al. 2001; Bauld and Judge 1999; Judge et al. 1999) and a workshop attended by evaluators and providers from 17 HAZs (Barnes et al. 2000) have identified some very useful information on developments within the HAZ initiatives to date.

Diversity

HAZs are very diverse in their size and complexity, serving populations as small as 181,400 and as large as 1,400,000. Some HAZs comprise just parts of health authorities or local authorities, while others include several of these authorities (Judge et al. 1999).

HAZs provide a very wide range of activities and programmes. This includes those focusing on: the broader determinants of health (unemployment, housing, education); specific health problems (e.g. heart conditions, mental health); the health of particular “at risk groups” (young people, older people, ethnic groups, parents); lifestyle factors (smoking); community development/empowerment, health and social services; and establishing partnerships and evaluation (Bauld and Judge 1999; Judge et al. 1999).

In 2000, between them, the 26 HAZs had 582 key purposes or workstreams – population-based, health-problem-based, process-based, goal-based, behaviour-focused, setting-focused, and structural-focused (Bauld et al. 2001).

Resources

The national evaluation notes that limited resources have been provided for HAZs. Partner agencies' staff have taken on responsibilities on top of what they were already doing (Bauld and Judge 1999). HAZs were also given considerably less funding than some of the other Area-Based Initiatives (ABIs) and "in spite of a recognised need for long term planning, funding was only committed for three years" (Barnes et al. 2000: 3).

Because of the time required to put partnerships into place, and difficulties in attracting suitable staff, there was underspending in the first funding year and as a result budgets were trimmed for the next financial year. The budget cuts caused HAZs to take a major change in direction (e.g. putting increased efforts into identifying supplementary or alternative funding, reducing programmes, and seeking cross-funding). The cuts also resulted in damage to partnership and community perceptions.

In terms of "freedoms and flexibilities" the new Health Act 1999 allows health and local authorities to share budgets where they have joined-up services. But some HAZs report they have applied for freedoms that were not granted and no reasons were given for this decision (Bauld et al. 2001).

Mainstreaming

Latest reports suggest HAZs are now moving towards sustainability by mainstreaming their activities into those of other agencies (Barnes et al. 2000; Bauld et al. 2001). Barnes et al. (2000: 6) suggest:

at this point in time HAZ appears to be understood more as a 'process' for achieving change and less as a "sector" within which change can take place. Again this may benefit localities as ways of working and initiatives begin to influence and become embedded in the mainstream. However this assumes that these methods and practices are sufficiently robust to survive and thrive in this changing environment. Without the protection of HAZ, it is possible that some of the creative ideas and practices will be diluted or marginalised.

Establishing and maintaining inter-agency partnerships

Partnerships under the HAZ model have been found to be typically very complex because of the number of agencies and individuals involved. The diversity of agencies and groups involved means it has been a difficult and time-consuming process in some cases to reach consensus, because of political, cultural and organisational differences (Bauld and Judge 1999). Consequently it took some HAZs a long time (a year or

more) to put partnerships into place (Bauld and Judge 1999; Bauld et al. 2001).

However, despite these difficulties a number of successful partnerships have been developed, especially in areas where there was already a history of positive inter-organisational working (Bauld et al. 2001).

Generally positive features have been partners' shared visions and values, ownership and trust. The level of collaboration was felt to have increased since HAZs have been operating (Bauld et al. 2001).

However, ongoing problems include:

- issues of control
- time constraints
- historical rivalries
- organisation cultural issues (ibid: 25)

Sullivan et al. (c. 2001: 7) have suggested that the success of relationships between stakeholders in HAZs will depend on whether partnerships are:

- plausible - how far is the logic of [the] partnership accepted by stakeholders?
- doable - are partnership resources sufficient to achieve the specified goals?
- testable - can evidence of partnership achievement be specified?
- meaningful - are outcomes sufficiently important to warrant the effort expended on investment in the partnership activity?

Balancing “early wins” and long-term change

It is apparent that HAZs feel under pressure to show success early to maintain enthusiasm and fulfil accountability to their funding agencies. Thus they have implemented a large number of projects and other activities, some of them short-term. However, there is recognised to be a tension between this and achieving long-term health goals and reducing inequalities (Bauld and Judge 1999).

Linking partnerships to wider reform agenda and other initiatives

Other community regeneration / development initiatives in the United Kingdom include Employment Zones, Education Action Zones, and Single Regeneration Budgets. Other health initiatives include Health Improvement Programmes (HImPs) and Primary Care Groups. The evaluation and workshop found that the links between HAZs and HImPs were unclear and frontline HAZ staff had insufficient knowledge of the linkages (Barnes et al. 2000; Bauld and Judge 1999). Also there was a feeling that too many special initiatives were being introduced at the same time (Barnes et al. 2000).

Performance management framework

While it was seen to be important to centrally monitor the performance of HAZs, national requirements for performance management reporting did not take into account local conditions. This meant there was limited scope for individual HAZs to demonstrate their own activities. For instance, many local HAZs felt the questions they were required to answer were not appropriate for the types of activities they were carrying out, and the information they were being asked to collect was not useful for their own purposes (Bauld et al. 2001). Also, a “culture of performance management was [felt to be] somewhat at odds with the wish to create a learning culture” (Barnes et al. c. 2001: 4).

Central government policy

A change in the health minister’s priorities has meant that HAZs now have to demonstrate they are tackling the national priorities of cardiovascular disease, cancer and mental health problems. This represents a shift towards a “top down” strategic approach away from the original “bottom up’ philosophy. Other government expectations now include making progress on waiting lists - a health-service rather than health-determinants issue (Bauld et al. 2001). These changes have meant that local HAZs have had to move away from local problems and solutions towards a central agenda - a major change in direction that has caused some problems (Bauld et al. 2001).

Additionally, central government does not appear to be giving HAZs as high a priority as it did at the beginning. Instead the Government now seems to be increasing support for neighbourhood renewal and local strategic partnerships (i.e. more general community development orientated projects) (Bauld et al. 2001).

Community participation

Five different types of community involvement and participation were identified in the “first wave” HAZ implementation plans. These were:

1. Community participation in the HAZ development and implementation process (partnerships, governance and accountability arrangements)
2. Community development processes (especially objectives relating to health improvement and reducing health inequalities)
3. User involvement in decision making about services, practice and policy development and personal service provision
4. Public communication and information strategies
5. Involvement in generating evidence and knowledge (Barnes et al. c. 2001; Sullivan et al. c. 2001).

Barnes et al. (c. 2000: 1) also note that “an objective of community empowerment was implicit or explicit in other core programmes, most notably those which were described as aiming to increase social capital and reduce social exclusion”. Community capacity building and organisational building were also in many of the HAZs’ original programme plans.

Since they were established, HAZs have been “engaging the community” in a variety of different ways at different operational levels (Barnes et al. c. 2001). HAZs report they have made mixed progress towards engaging communities in their planning and activities. While 23 of the 26 HAZs said they currently provide resources to support community involvement, 14 report a great deal of community input at a strategic planning level and 17 at an operational level. While not every HAZ has achieved community involvement at all levels, HAZs are generally optimistic about future community involvement (Bauld et al. 2001).

Relationship with central HAZ team

The national evaluation identifies some tensions in the relationships between local HAZs and the central HAZ team, although this was partly attributed to changes in central government directives (ibid).

Smoking cessation services evaluation

A national evaluation consisting of an overview of the smoking cessation services of all 26 HAZs, along with case studies and interviews in seven, has been completed. It found that, despite some expected teething problems, all of the studied HAZs had established a wide range of smoking cessation services by the first part of 2000. These services were being set up in ways that “reflect local needs and circumstances”. There were some problems with communication between central and local administrators, attracting suitably skilled staff, collecting data for monitoring, and the provision of nicotine replacement therapy. However, there was also evidence that the services were reaching disadvantaged people, and were achieving some positive results in terms of clients setting quit dates and quitting smoking by the end of four weeks (Adams et al. 2000).

Local evaluations

Descriptions of the activities of most of the 26 HAZs are available from the HAZ website (<http://www.haznet.org.nz>), which also has links to each HAZ’s individual website. As already mentioned, only some of the local HAZs have completed evaluations to date. Four local evaluations of first-wave HAZs are described below. This is followed by a summary of

an evaluation of Plymouth HAZ, reviewed as part of an evaluation of local Area-based Initiatives.

Northumberland HAZ

The Northumberland HAZ is a single-health-authority / multiple-local-authority programme that serves a population of 310,000 in the North of England (Judge et al. 1999). It was one of the “first wave” HAZs and was evaluated by researchers from the University of Birmingham after its first year of operation (Sullivan et al. 1999).

The HAZ ran eight main programme streams, each governed by a programme board. The eight streams were: person-centred care; equitable resourcing; healthier living; information for health; partnerships in education and employment; private sector and regeneration; public involvement; and communication. Examples of projects underneath these streams are smoking, exercise and employment programmes.

The research for the evaluation included analysis of HAZ documents, semi-structured interviews with 30 stakeholders (focusing on partnerships), a written questionnaire distributed to a range of participants, one focus group, plus “Wheel of Involvement” exercises with community and voluntary sector representatives (Sullivan et al. 1999).

Results from this work suggested that perceptions of partnership practice were generally favourable. A large majority of stakeholders agreed with statements like “partnership working in Northumberland has proved that more can be achieved by working together than separately as individual organisations” and “Northumberland HAZ initiative offers a genuine opportunity for innovation and creativity in the way local health objectives and priorities are pursued”.

However, there was somewhat less enthusiasm from community representatives who “remain circumspect about [the HAZ’s] role and capacity” (ibid. 10).

Most stakeholders understood the key goals of the HAZ and believed these goals were shared by various sectors. However, community representatives were again more ambivalent in their responses. Many respondents thought that the development of the HAZ alongside other initiatives such as Primary Care Groups and the Health Improvement Programme (HImP) encouraged creativity across and within sectors. However, others were concerned about the impact of these programmes on one another and how they could be better integrated.

Most survey participants agreed that there did not appear to be effective communication between the local HAZ Development group and relevant stakeholders. There were also different perceptions from different stakeholders about whether informal and formal linkages between relevant agencies had improved (with overall about three-quarters believing there had been an improvement).

Most stakeholders believed that the HAZ was “doing the right thing” and that the HAZ provided people with the means to get things done. The HAZ Development group believed that “value had been added” and that the HAZ initiative had allowed broader definitions of health and health outcomes to become its “core business”. A variety of positive changes in processes and outcomes were identified by other stakeholders e.g. removing organisational boundaries, involving local people in decisions, and an improved quality of life for service users. Innovations such as Healthy Living Centres, integrated information technology and a person-centred approach to care were seen as positive developments.

However, several people commented that it was difficult or impossible to attribute some of these changes to the HAZ (especially with the HAZ becoming such an integral part of what local organisations were doing).

The image of the HAZ was generally thought to be favourable, although most stakeholders did not have concrete evidence about how community agencies and local people viewed the HAZ. The HAZ’s level of communications with professionals, frontline staff and local people was usually perceived to be low or uncertain.

The main strengths of the initiative were perceived to be its: partnership working; co-ordination of activity; holistic focus; commitment of key players in the process; appropriate use of resources, and innovation.

Perceived weaknesses included:

- organisational cultures – including perceptions of both too much and too little involvement by clinical and other health organisations. As well, competition between local authorities was regarded as destabilising.
- the difficulty of incorporating HAZ responsibilities into existing jobs considering other pressures such as Primary Care Groups activities
- bureaucracy issues such as the operation of the programme boards and the lack of performance management measures
- a lack of resources, over-reliance on resource “freedoms” that may not materialise. and existence of multiple resource streams
- the use of the notion of partnership as just a “veneer”, especially with regard to private and voluntary sectors and community participation.

Priorities for the future operation of the HAZ most commonly identified by stakeholders were: better access and management of resources; development of a capacity to make, identify and measure real health gains; and further development of partnerships.

Detailed analyses of various dimensions of partnership relationships were also carried out. These found there were generally very positive comments about the commitment of the HAZ Development Board and Programme Boards to developing partnerships, although it was noted there may not yet be appropriate structures in place to allow partners to “share”.

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- Everyone saw the local health authority as having the balance of power in the HAZ, although some felt that local authorities and other agencies should have more power in the future.
 - It was also observed that there had been a degree of “culture clash” in the partnership relationships, particularly between health and local authorities. This may also have occurred in terms of how public sector organisations viewed private and voluntary agencies.
 - The evaluation noted that most agencies involved in HAZ partnerships, such as the Health Authority, local authorities, primary care groups, private organisations and the police, were generally “well rounded”, with well-established activities in dimensions such as community orientation, leadership and direction, monitoring and evaluation, partnerships, etc.
 - Stakeholders perceived “community involvement” to be essential, though they had differing views of what this actually should involve in practice. The majority favoured a “bottom up” approach where the HAZ was there to facilitate community-led initiatives. Others favoured a “top down” approach whereby improved access to information and services would lead to citizens taking responsibility for their own health.

Despite these aspirations, the evaluation found that the actual level of community involvement had not been high. This was attributed at least in part to the short timeframe the HAZ had been operating and the perception that community involvement was “difficult and not something that health organisations were good at”(ibid. 36).

Feedback from community representatives also confirmed that, so far, there had been a lack of community involvement. This was evidenced by their lack of awareness of the details of the development and operation of the HAZ, lack of involvement in consultation processes, and not having received copies of key documents like the HAZ Implementation Plan.

Community representatives felt they had little influence, limited involvement and were not treated well in the partnership. They criticised the HAZs for involving them only at a late stage of the development of the HAZ, so they had to “fit in” with what was already happening. They also criticised the HAZs for not appreciating their depth and range of experience and capacity to think laterally and cross-sectorally, and their reluctance to give up power and control, and to be “transparent” in their dealings with other sectors (e.g. how the HAZ decided who would be on boards).

Nevertheless, community representatives still supported the initiative and wanted to play a part in the future, albeit on their own terms.

The evaluation suggested various strategies could be useful for achieving more successful community involvement in the programme. They included: building on existing mechanisms; maximising the use of

local authority and voluntary sector resources; identifying “champions” within communities and related organisations; and establishing new mechanisms to engender public-orientated perspectives.

Overall, the evaluation recommended that the HAZ take action in eight areas: community involvement; communication; accountability; reviewing “inner” and “outer” networks; improving the effectiveness of HAZ organisation; managing strategic relationships to sustain mutual benefits; building HAZ as “core business”; and learning to learn from the organisation’s experience.

Tyne and Wear HAZ

Tyne and Wear HAZ covers a much larger, complex multiple-health-authority / multiple-local-authority area situated adjacent to the Northumberland HAZ. It serves a population of 1,100,000 (Clarke et al. 2001; Judge et al. 1999).

The evaluation of the overall operation of the HAZ is underway, but is not yet finished. However, a large number of evaluations and other research projects concerning individual HAZ activities are either planned, still being conducted or are completed. Projects with completed and ongoing research activities are listed below to give readers an idea of the diversity of HAZ programmes.

- smoking cessation programme for young people
- research on young people and binge drinking
- mental health stigma and discrimination
- playground injuries research project
- promotion of healthy schools
- review of accident and emergency services
- social interaction and parenting programme
- workplace health award
- preschool outdoor developmental health project
- Saturday contraception clinic
- integration of health and social work team in mental health
- community mental health support worker pilot
- Community Help and Neighbourly Care for Everyone (CHANCE) - including an exercise component
- live at home scheme for elderly people
- “Caring for Carers” programme for older people, children and young people
- older persons support team
- alcohol initiative for young people
- WHOOPS! Child safety project
- “Whole Health” training for community volunteers
- patient-held record for ischaemic heart disease care
- “Safety Crackers” - a home-environment safety project for children.

These projects are being run in different parts of the Tyne and Wear HAZ. In general, completed research and evaluation projects had positive results in terms of process measures, although outcomes are not being assessed by most evaluations (Clarke et al. 2001).

Bradford HAZ

The Bradford Health Action Zone serves a population of 486,000 in West Yorkshire. The population is covered by one health authority and one local authority which have one common geographic boundary (Judge et al. 1999).

Activities include projects on:

- diabetes
- screening for treatable eye disease
- community-based initiatives focusing on accident prevention, and on exercise, diet, smoking and alcohol
- new multi-agency partnerships on domestic violence, sexual health and breaking cycles of sex offending
- fourteen Healthy Living Centres
- assistance to Asian Disability Network with communication about services to the public
- collaboration between nurses, therapists and social services staff on new approaches to joint working in “Rehabilitation and Recuperation”
- planning of more seamless services in Mental Health by improving the interface between primary and specialist care (HAZnet nd).

A 2001 report to the HAZ steering group summarised information from around 100 individual HAZ projects within the region. The report identified a number of emerging themes relating to the context of projects, their activities, “change mechanisms”, outcomes and dissemination (Henderson 2001).

Overall, preliminary evidence pointed towards HAZ projects contributing to a trend towards population health gains (particularly improvements in health behaviour and services delivery i.e. intermediate outcomes).

Projects were most likely to succeed if they had:

- a strategic alignment with national and local strategies
- top level commitment and leadership
- ownership by all stakeholders
- planning and development time built in
- a proper budget assessment of resources needed
- effective and realistic performance management systems
- clear vertical and horizontal lines of communication
- training mechanisms
- an appropriate environment
- a strategic and operational understanding of community infrastructures
- “added value”

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- a realisation of opportunity costs (ibid).

Lambeth, Southwark and Lewisham HAZ

Lambeth, Southwark and Lewisham (LSL) HAZ was also among the first HAZs to be established. It covers part of the Greater London area and consists of a single health authority region (comprising several local authorities) where 730,000 people live (Judge et al. 1999).

Since it began, the Lambeth, Southwark and Lewisham HAZ has focused on services and projects for young people and children, with the aim of extending these to older people later on. It has nine main programmes. They are:

- building healthier environments and communities
- improving parenting support and skills
- improving opportunities for disabled children and young people with special needs
- working with excluded children and young people to bring them back into the mainstream
- reducing unwanted teenage pregnancies and improving sexual health
- reducing youth crime
- reducing substance misuse
- increasing employment opportunities and health through work
- smoking cessation (HAZnet nd).

Initial impressions on a range of themes have arisen from the first phases of the evaluation of the LSL HAZ (Centre for Urban and Community Research 2001).

Central government policies

- Increasingly more complex local service-delivery structures are being developed in response to national HAZ policy changes (and the HAZ structure itself is becoming more complex). This has created a potential for other agencies to feel “left behind” by changes in the HAZ’s focus (i.e. away from child and youth issues towards national priorities). It was also felt that other major changes in the country’s health system may be obscuring the HAZ’s activities, and the HAZ may need to be relaunched in some way.

Changes in contracting arrangements

- The fact that the HAZ was moving away from open tendering could exclude some small community organisations (including those representing minority ethnic groups) from future HAZ activities. Also the HAZ’s move away from funding projects towards a “Whole Systems of Change” approach may be marginalising agencies other than the health and local authorities. The evaluators believed that ways of “empowering the community” in this context needed to be thought through.

Relationships with other agencies

- The evaluation concluded that the HAZ could be an effective model of new ways of working if it made relevant, practical information available to other agencies. Also its ability to be seen as a “catalyst of change” depended on other agencies’ perceptions of it. Other agencies noted that being involved with the HAZ required them to do extra work. They thought this could be minimised by using or simplifying existing structures and activities, rather than by creating new ones.

Community involvement and participation

- It was found that the “capacity, ability, and willingness” of different voluntary and community sectors to participate in strategic planning for the LSL HAZ varied significantly. Community and voluntary groups were also sometimes put off by the HAZ’s language (which tends to be abstract and jargon-filled).

Analysis, monitoring and evaluation

- The evaluation suggested that learning from previous HAZ projects should be enhanced. It also suggested that the HAZ should have more capacity to analyse the processes associated with “service modernisation” and “systems change”. There also needed to be a more explicit plan for assessing how the HAZ was meeting the needs of black and minority ethnic communities.

Other issues

- It appeared from the evaluation that the HAZ’s decisions were not always followed-up with action. Another suggestion was that the HAZ should investigate the best ways to prioritise projects for mainstreaming.

Plymouth Area-Based Initiative

A fifth HAZ, located in Plymouth, has been reviewed as part of evaluations of various aspects of Area-Based Initiatives in the region (DETR 2000a; Office for Public Management 2001). Other Area-Based Initiatives in the area include a Single Regeneration Budget initiative, an Employment Zone, an Education Action Zone and a Crime Reduction Programme. The intersectoral co-ordination of these various Area-Based Initiatives (many of which are run intersectorally themselves) was the focus of one evaluation (Office for Public Management 2001).

Plymouth HAZ covers a relatively small geographic area in the south-west of England. It comprises one local authority and just part of a health authority. The HAZ population is around 260,000 (Judge et al. 1999).

Having been established earlier than many of the other local Area-Based Initiatives, the HAZ has taken a lead role in fostering intersectoral strategic planning and co-ordination in Plymouth through a civic “Pathfinder” partnership. The HAZ has also been particularly active in “mainstreaming” its activities within other organisations.

The evaluation identified the following themes and issues relating to intersectoral partnerships between the Area-Based Initiatives.

In terms of fostering local strategic partnerships, the evaluation found that the initiatives had established themselves well and had a clear role. However, it cautioned that the initiatives were perhaps setting themselves too broad an agenda. Civic partner membership issues had arisen that may be difficult to resolve and there was a need to try to balance representativeness with practicality (there had been too many members in the past).

- The evaluation also concluded that the initiatives needed a more stable infrastructure, should aim to engage “the community” more effectively, and needed to consider whether and how they should address “small area” (neighbourhood) issues. In addition, the initiatives needed to institute effective systems for analysing their performance.
- It was also noted that the initiatives no longer had local political commitment (since the council had changed from Labour to Conservative).

In terms of co-ordination and collaboration, the evaluation found evidence of three main types of interaction between Area-Based Initiatives: strategic co-ordination; networking; and joint service delivery

The work of the Plymouth HAZ had been closely integrated into the work of the civic partnership, though that of other Area-Based Initiatives had not.

Networking had provided the Area-Based Initiatives with opportunities for sharing information and identifying opportunities for joint work. However, only the HAZ and the “Single Regeneration Budget” initiatives had established jointly-funded projects.

Factors that the evaluation found had facilitated closer linkages between the ABIs and joint working included: the identification and acceptance of broad agendas that required linkages with other organisations to be effective; long timeframes that gave time for relationships to develop; a history of pre-existing partnership working; availability of adequate resources to enable participants to attend meetings and communicate in other ways; and the presence of a sense of ownership of the civic partnership.

Factors that were found to be barriers or disincentives to the formation of closer linkages included; out-of phase and / or tight timeframes; different initiatives having different geographic coverage; the extra difficulty and time often involved in working collaboratively; and the fact that each Area-Based Initiative was already a partnership itself.

The evaluation also commented on the Area-Based Initiatives’ success with mainstreaming. Mainstreaming was defined as securing funding to continue activities, ensuring that mainstream agencies identify good practice and incorporate lessons from experience with earlier activities into policy. Mainstreaming should ensure that activities continue when Area-Based Initiatives come to an end.

- The evaluation found that only the HAZ had progressed significantly in mainstreaming its practices. Barriers identified to mainstreaming included: weak links between the Area-Based initiatives and mainstream agencies; so-called “projectitis” (where an emphasis on quick action in the form of projects diverts resources away from establishing a sustainable infrastructure); a lack of willingness by some Area-Based Initiatives to adopt a partnership approach due to a sense of loss of control; and an absence of adequate evaluation processes to show that initiatives were being effective.
- The evaluation also commented on evaluation requirements, noting that promising initial progress towards “joined up” evaluations of the Area-Based Initiatives in Plymouth had now been abandoned. The evaluation also noted that while the HAZ has the most wide-ranging approach of the Area-Based Initiatives to evaluation, “there is no confidence that the methodologies available will enable observed changes attributable to the ABI to be disentangled from changes due to other factors” (Office for Public Management 2001: 9). However, it was further noted that the civic partnership has made a good start

towards developing a set of indicators against which progress could be measured.

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 (Health Promotion Forum 1994; Hutt and Bowers 1997; WHO 1986b).

Starting with pilot sites in eleven European cities, the movement has grown to now include well over 1,000 cities or communities world-wide (Grey 1996; Hutt 1998). 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 (Randle and Hutt 1997).

New Zealand initiatives

Enthusiasm for the Healthy Cities model developed in New Zealand not long after the European pilot sites were established and 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 (1991), Southland (1992), North Shore (1992), Masterton (1993), Wanganui (1993), Porirua (1993), Gisborne (1996) and Merivale (a suburb of Tauranga) (1997) (Health Promotion Forum 1994; Hutt and Bowers 1997).

By 1997, the Southland, Christchurch, Wellington and North Shore projects were classified as “inactive” (Hutt and Bowers 1997). Currently in 2000, apparently only Manukau, Masterton and Nelson/Tasman have significant ongoing activities (pers. comm. Health Promotion Forum April 2001). Porirua City has established a Healthy Safer City Trust.

Projects in places such as Manukau, Otago and Nelson typically involved the appointment of a full or part-time Healthy City or Healthy Community co-ordinator, employed either by the local health authority (Hospital Board, Health Development Units, Area Health Boards or Crown Health Enterprises) 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.

Generally speaking, New Zealand Healthy Cities projects aimed to involve both the key leaders and agencies in a city, as well as the general public or lay people. The latter would be encouraged to articulate and lobby for their needs using community participation strategies (Grey 1996).

In 1990 the Health Promotion Forum was contracted by the Department of Health for a three year period to co-ordinate the activities of existing Healthy Cities projects and promote the concept in other areas (Health Promotion Forum 1994). Subsequently the Health Promotion Forum was funded largely to act as a national clearing house for Healthy Cities information (Randle and Hutt 1997). More recently this has included facilitating an annual meeting of people running Healthy City and Healthy Community projects. Service development guidelines for Healthy Cities and Healthy Communities were issued by the Ministry of Health in 1996 (ibid).

Some Healthy City projects, such as Manukau and Nelson, have been systematically evaluated. In addition, some valuable reviews of Healthy Cities activities have been written by local project co-ordinators, staff from the Health Promotion Forum, and others, including university-based commentators. Together these provide an indication of some of the successes, as well as problems, experienced by the different New Zealand projects.

Reviews of New Zealand's Healthy Cities projects

The 1994 review by the Health Promotion Forum included a SWOT analysis (strengths, weaknesses, opportunities, threats). Identified strengths of the projects included the establishment of strong community ownership and networks, especially in places such as Manukau where the model had been in place for several years. These networks had been useful for tackling various public health issues such as child injury prevention and environmental health (Health Promotion Forum 1994).

Other identified strengths included the relative autonomy of the Healthy Cities co-ordinators and workers. This enabled them to be effective independent advocates for public health issues at the local level.

Weaknesses noted were that the Healthy Cities model had a tendency to be perceived by some as vague and unfocused, since it employed community development principles that were not well defined. As well, its focus on intersectoral working posed the risk that no single agency would be prepared to take responsibility for sponsoring or hosting the programme.

Other identified weaknesses were that the health sector had not been sufficiently supportive of the model to enable a 'critical mass' of strong projects to be established around the country, and that many projects relied for their existence on over-stretched community groups operating with very limited resources. It was also noted that projects were dependent for their operation and survival on a myriad of planning cycles and bureaucratic processes.

A further perceived weakness was that outcomes from the projects were difficult to measure (Health Promotion Forum 1994).

Another noteworthy observation by the review was that Health Cities Co-ordinators were "often employed in low status positions within their organisational hierarchy and feel they are expected to 'change the world' from their positions of relative powerlessness" (Health Promotion Forum 1994: 22).

The review added that internationally some of the most successful community and city-based public health initiatives have occurred when commitment and resources have been provided by local government and health authorities in partnership, and where other sectors have also been involved through co-operative ventures.

The review concluded:

"... unless central government signals that [Healthy Cities] is being taken seriously, it is unlikely to develop much more of the potential it has already realised. While there have been real advantages in the fact that [Healthy Cities] activities have largely occurred at a grassroots level, and it has therefore established a certain 'bottom-up' credibility, central government cannot leave responsibility for the success or failure of the programme to community workers and voluntary support networks indefinitely and expect much more than what is on the ground now" (Health Promotion Forum 1994: 25).

A second analysis of the 'state of the play' of New Zealand's Healthy Cities projects was completed three years later in 1997 by Randle and Hutt. They found nine Healthy Cities (or Healthy Communities) projects operating, receiving varying levels of support from government agencies, local government and the private sector (Randle and Hutt 1997).

The report places the New Zealand experience in an international context. While information on the longer-term impact of New Zealand projects is limited, Healthy Cities projects in places like Canada and Australia have been found to help raise awareness of health issues amongst decision-makers and citizens. There is also evidence that projects have facilitated negotiation between diverse parties over specific health issues (such as clean water), whereas previously these parties were in conflict (Randle and Hutt 1997).

However, overseas evaluations note that the effectiveness of local action is often constrained by its ability to affect conditions created provincially, nationally (or even globally).

Randle and Hutt (1997) also highlight “the inherent tensions between components of the [Healthy Cities] concept, notably between the community ‘bottom-up’ approach, and the bureaucratic ‘top-down’ approach” (ibid: 15). They add that in Australia a primarily ‘top-down’ approach has been used for developing Healthy Cities projects and consequently many participants perceive that the projects have been dominated and controlled by ‘professionals’.

In saying this, Randle and Hutt emphasise that:

... it is difficult to generalise from evidence from international evaluations to New Zealand [Healthy Cities projects]. [Healthy Cities projects] are very context-driven and international adaptations are very different given differences in culture, governmental structures and political support (ibid: 22).

Their report goes on to note that, compared to other countries, New Zealand’s Healthy Cities initiatives have tended to be more “bottom-up” than “top-down”. For some workers this is recognised as a strength, “ensuring projects are designed and implemented by the community in an acceptable manner and with consideration for equity issues”. However, say Randle and Hutt,

... the well documented and inherent difficulties with community involvement, from which the [Healthy Cities] concept is not exempt, may limit the effectiveness of [Healthy Cities] programmes. This may be the result of, for example, the ‘hijacking’ of processes by vocal groups or professional groups, or insufficient funds of groups ... (ibid 1997).

They conclude that there is a need in New Zealand for greater national co-ordination and support (resourcing) of Healthy Cities projects.

Manukau the Healthy City – Te Ora o Manukau

First steps towards the establishment of the Manukau Healthy City project came in late 1987, when South Auckland’s Deputy Medical Officer of Health approached the Mayor of Manukau City, Barry Curtis, to discuss the concept (Jaffe 1991). Further meetings involving senior staff within the Council led to the establishment of a Council working party.

In July 1988 the Council’s Community Development Committee adopted the concept in principle and resolved to form a Manukau Healthy City Committee. Four months later, the heads of various government

agencies located in Manukau City met and agreed on the contributions each could make to the project. For some of the agencies this included financial contributions as well as offers of staff time and access to resources. The South Auckland Health Development Unit provided the services of a current employee for four days a week to co-ordinate the project.

In May 1989 workshops were held to develop a vision of Manukau as a Healthy City, identify priorities, establish working relationships and develop organisational processes. Marketing and public relations specialists were involved in the design of a marketing strategy, slogans and artwork and a “community involvement” task group was established. By 1991, the formal structure of the Manukau Healthy City project included the previously mentioned Healthy City Committee responsible for the overall policy direction (comprising heads of local government departments and local authorities), plus a Healthy Cities Representatives Working Party responsible for the management of the project and implementation of policies (comprising staff members from a number of the local agencies). There were also Task Groups (or subgroups) set up beneath the Working Party to work on specific projects. In addition there was a paid Project Co-ordinator funded by a number of agencies, with guaranteed funding for a year (Jaffe 1991).

Identified Success Factors

The Manukau Healthy City project is the longest-running in New Zealand and generally regarded as the most successful. Factors identified as important to this success have included the employment of (subsequently) four full-time co-ordinators, the presence of high level political support for the project from the Mayor, functioning committees and funding, and the development of a three year plan to identify specific goals (Grey 1996).

It has also been noted that, compared to other parts of New Zealand, Manukau also has had “more visible problems that motivated its citizenry to act”, which may be another reason for its comparative success (ibid: 85).

The three-year plan is formulated over several months by an intersectoral team in consultation with community groups and agencies. This process is thought to help develop widespread community “ownership” of the resulting goals.

Another key element of the Manukau model has been the drawing up of a “Manukau The Healthy City” Charter. A wide range of local agencies and organisations has signed up to this Charter as a way of publicly declaring their agreement and commitment to action (Jaffe 1991; Grey 1996).

Other Evaluations

A 1995 evaluation of the Manukau project focused on its then recent efforts to influence public policy responses to child hunger. The evaluation concluded that the project had achieved a high level of visibility in the city, strong co-operation between sectoral agencies, and a high level of community involvement. The involvement of Māori community members was particularly evident, with this being attributed at least in part to the formation of Te Ora o Manakau, a Māori wing of the Healthy Cities project in Manukau (Randle and Hutt 1997). This partnership relationship led to the inclusion of Māori-specific objectives within the overall city plan, as well the development of a healthy city plan for local iwi (ibid).

A subsequent 1997 evaluation recommended that the Manukau project be made even more culturally appropriate and further improve its relationship with, and involvement of, Māori and Pacific communities. It also recommended that systems be refined to ensure the project had adequate input into the Manukau City Council's strategic planning processes (ibid).

Latest Evaluation

An independent evaluation of the Manukau project was completed in 2000 by staff from the Health Services Research Centre, Victoria University of Wellington (Hutt and Scott 2000). The evaluation used semi-structured interviews and focus groups to gather comments and opinions about the project from various people, including stakeholders and signatories to the Charter. As well, policy documents and other written material were scrutinised. The goal of the evaluation was to document and analyse processes associated with the running of the project, as well as gather information about its overall impact.

A number of interesting findings and recommendations emerged from the evaluation. One was that urgent work was needed to clarify the programme's roles, responsibilities and governance / accountability structures, as in the last three to four years, these had "lacked focus" (Hutt and Scott 2000). It was also recommended that the programme consider targeting its efforts mainly towards promoting the health of youth and children.

Other recommendations were that a Māori Co-ordinator position be established within the project as part of a Treaty-based partnership, that programme plans and objectives be delivered in a manner appropriate for Māori, that the programme be aligned more closely with the strategic policy and socio-economic research arms of the Council, and that the programme develop a media strategy.

Nelson Healthy City Project (Nelson / Tasman Healthy Communities)

A distinctive feature of the Nelson Healthy City project has been its so-called “talking heads” group of mayors and managers from local agencies. Reports indicate that these leaders gather regularly to discuss how their sector or agency’s policies and plans are likely to impact on the health of the residents of the Nelson region (Hutt 1998). This and other work related to the project (such as networking, producing newsletters and leading community seminars) have been facilitated by a half-time co-ordinator funded by (what was then) Nelson Marlborough Health Services.

A 1995 evaluation of the project concluded that there was a lack of understanding in the wider Nelson community of the Healthy City concept and health promotion principles (ibid). It also concluded that action was limited by the perception that the Healthy City structure was primarily designed to foster debate and dialogue between groups.

A later evaluation found the “talking heads” group has been a useful forum for training and discussing issues but not particularly effective in generating new strategies. The evaluator concluded that there was a need to move beyond talk to action (ibid).

Christchurch Healthy City Project

Grey’s (1996) detailed analysis of factors contributing to the demise of the Christchurch Healthy Cities project is instructive for identifying several potential obstacles to the development of effective intersectoral action for health at the local level. She attributes the non-establishment of the project to several factors including:

(1) *poor timing*: attempts to set-up the project were made at the very time the Canterbury Hospital Board, the Health Department and local government agencies were being restructured, resulting in several key people being lost from these organisations and ongoing turnover in committees.

(2) *a lack of high level political commitment*: Grey notes the project had no “buy in” or co-ordination from central government and even at the local level there was no public political endorsement of the project. Instead, responsibility for the success of the project was left largely to local community workers and volunteer networks.

(3) *no clear mandate*: Core agencies, such as health agencies and city councils, demonstrated little or no official commitment to the project and so the project was largely “based in people, not in job descriptions or structures at core agencies”. Although there was a planning group for the project, its membership consisted largely of middle level public

servants talking with other middle level public servants with little real decision-making powers of their own.

(4) *a lack of community involvement*: The project “never developed to the point where participation from the public was solicited or could be integrated into activities” (Grey 1996: 79).

(5) *inadequate resourcing and an ineffective project management structure*: People working on the project received no institutional rewards, funding, support, office space, administrative assistance, or access to those in power.

(5) *a lack of Healthy City project skills*: Grey observes that many of the people working on the project were “amateurs and naïve”. What was needed, she says, was experienced professionals who “knew about marketing and how to talk to politicians” and project leaders who were social entrepreneurs, skilled in the techniques of effective group working. It was considered problematic to assign “public servants the brief of implementing a challenge to society’s institutions and values” (Grey 1996: 84).

In addition, Grey notes the impact of new public sector management systems emphasising measurable outputs, performance targets, inflexible deadlines, budgetary constraints and workforce cutbacks - values and systems that were not easily compatible with the Healthy Cities philosophy of “expansiveness, sharing information, and unmeasurable ideas and visions” (Grey 1996: 80). Grey also observes that in this context local agencies tended to be preoccupied with their own budgets, politics, problems and pressures. This was not a supportive environment for building new forms of intersectoral working.

Based on this analysis, Grey proposed six preconditions or requirements for establishing effective Healthy Cities projects in the New Zealand context:

(1) the social climate and political setting needs to be at least receptive.

(2) corporate cultures need to be receptive to the philosophy of the programme. Value congruency is needed.

(3) sufficient time must be given for the development of support for the project. Rushing ahead to fulfil agreed performance targets and other inflexible deadlines is counter-productive.

(4) adequate and ongoing resourcing is required

(5) project co-ordinators and committee members require certain essential skills including effective leadership skills and skills in small group facilitation, negotiation, inter-personal communication, advocacy,

political awareness and the ability to sell ideas (persuasion, public speaking, personal mana and a sense of humour).

(6) political commitment at a high level is essential, including from central government agencies. Co-ordination from the centre is important, as is collaborative input across agencies, and both processes need to be properly funded and supported.

Health Promoting Schools

Another over-arching type of intersectoral health initiative, this time in a school setting, is Health Promoting Schools.

Health Promoting Schools (also known as “Healthy Schools”) were developed under the principles of the Ottawa Charter for Health Promotion (WHO 1986b). The concept involves joint working between the health and education sectors and aims to develop in schools:

... an organized set of policies, procedures, activities and structures, designed to protect and promote the health and well-being of students, staff, and the wider school community members (Rissel and Rowling 2000).

Health Promoting Schools (HPS) are expected to promote health: within their general operations; health curricula; teaching processes; social, policy and physical environments; and as part of their links with students’ families, the local community and other agencies (ibid.). That is, they use a “community development” model (Dowden and Kalafatelis 1999).

Healthy Schools / Health Promoting Schools have been established in many countries, including Canada, the USA, Australia and the UK (Randle et al. 1997; Jones 2000). A review of overseas schemes, concludes:

Healthy Schools potentially offer the most systematic and efficient means available to promote the health of youth and enable young people to avoid health risks. The school, as a social structure, provides an educational setting in which the total health of the child during the impressionable years is a priority concern (Randle et al. 1997: 14).

In the UK, a review of eight pilot Healthy Schools found the following to be key factors in making partnerships in these settings work (Jones 2000):

- developing clear and common vision among partners
- shared goals and benefits
- supportive management
- open channels of communication
- equity between partners
- ample time for partnerships to develop and be nurtured.

In New Zealand, the concept of HPS was first introduced through pilot schemes started in 1997 (Wyllie et al. 2000). Evaluations have assessed how successful these pilot schemes were in the Northern

Health Funding Authority region (Jenkins 1999; Casey et al. 1998; Postlethwaite et al. 2000; Wyllie et al. 2000), and in the Midland, Central and Southern Health Funding Authority regions (Dowden and Kalafatelis 1999).⁴

These evaluations used the Public Health Commission's definition of Healthy Schools / Health Promoting Schools / Kura Waiora. This involves work in five main areas (Dowden and Kalafatelis 1999: B-1):

- Building on policies to promote the health and well being of students and staff.
- Creating school environments which promote the health and well being of students and staff.
- Strengthening local community involvement.
- Developing personal skills to promote health and well-being of students and staff.
- Co-ordinating school health activities aimed at promoting the health and well being of students and staff.

Health Promoting Schools in the Northern Region

The Northern Region of the Health Funding Authority contracted four Crown Health Enterprises, one city council and one school to establish HPS initiatives in Northland and Auckland. One regional co-ordinator was employed in both Northland and Auckland and ten local co-ordinators / facilitators were employed to support primary, intermediate and secondary schools either in an "intensive", "cluster" or "sub-regional" manner (Wyllie et al. 2000).

Co-ordinators working under the "intensive" model were responsible for health promotion in just one school. "Clusters" of schools that were either geographically close, or had particular Māori health needs, were serviced by another group of co-ordinators.

The third model involved co-ordinators working with public health nurses in a larger group of schools that were geographically close to one another (Wyllie et al. 2000).

The evaluation took place over 18 months (from mid-1998 to early 2000) and was divided into two stages. The methodology involved interviews with local and regional co-ordinators and some managers, collecting data from schools, focus groups with public health nurses and health promoting schools managers, and observation by evaluators working with co-ordinators.

Of the 59 schools that officially became Health Promoting Schools in the region, over 40 took part in the two stages of the evaluation.

⁴ Bennett and Coggan's 1999 evaluation of the "Mentally Healthy Schools Initiative", which was later combined with "Health Promoting Schools", has not been reviewed in this document.

The Health Funding Authority (HFA) wanted schools to have the flexibility to develop initiatives that were most suitable for their own situations.

Although the initiatives aimed to improve *long-term* health outcomes, it was agreed that attempting to measure changes in health status among staff and students would be inappropriate. Instead it was decided that the evaluation should focus on examining the extent to which suitable policies and actions had been implemented that *reasonably could be expected to contribute* to achieving the desired long-term health outcomes (Wyllie et al. 2000). Therefore the evaluation concentrated on scrutinising processes and assessing shorter-term impacts such as:

- the capacity for students and staff to act on their own concerns
- strategies and plans for delivering policies and actions
- liaison with other schools, agencies and communities
- co-ordination of health services.

Establishment Process

The evaluation identified a number of issues and problems relating to the establishment of Healthy Schools, leading the evaluators to conclude that this was a crucial “make or break” stage in their development.

One issue concerned the need for guidelines. While the funders aimed to grant providers a lot of freedom in implementing the initiative, the evaluation concluded that providers could have benefited from receiving specific guidelines on the anticipated role of regional co-ordinators, the training of local co-ordinators, and how the needs of Māori and other ethnic groups’ should be addressed.

Another issue was the complexity of the regional co-ordinator role. Particularly in Auckland, the work of the regional co-ordinator was made more complicated by the wide range of providers employing local co-ordinators. This situation eventually led to the co-ordinator concentrating on national level initiatives, such as conference organisation.

A third issue was training. While the co-ordinators who were employed were usually very skilled in one area (typically either health, education or social work) they needed training in other areas *before* they started working with schools.

Selection policies and consultation was another issue. In Northland, schools had only ten days to decide whether or not to apply for selection, meaning that many of these schools had a poor understanding of what being a “Health Promoting School” involved. They also did not have enough time to consult with the rest of the school community. In other regions there were also some schools that did not fully understand the concept of the initiative and did not consult very thoroughly with other

staff, Boards of Trustees (BOTs), students or parents before committing to joining the initiative.

Factors that Helped Sustain Health Promoting Schools

The most successful Health Promoting Schools had principals who were “at least supportive and usually enthusiastic” about the concept (Wyllie et al. 2000: 44). The HPS co-ordinators also had key roles in supporting and driving the initiative, as did school “health teams” established as part of the scheme.

Many schools already had an existing ethos that was consistent with the HPS approach so that it was relatively easy for them to introduce it. However, others found it more difficult, and a few actually left the scheme during the course of the evaluation. Co-ordinators encouraged schools to take up “ownership” of their own HPS scheme by gradually withdrawing from very active roles once schools were capable of taking on more responsibilities.

The evaluation noted that having a semi-formal contract or “Memorandum of Understanding” between co-ordinators and schools helped to clarify the roles and responsibilities of both partners.

As mentioned above, schools established health teams, usually with between five and 25 members consisting of (in order of frequency) principals, public health nurses, HPS co-ordinators, health co-ordinators, students, parents, other school staff and BOTs. “Other staff” and BOT membership declined over the evaluation period. While team members were very enthusiastic about HPS, they also found it hard to find enough time to be involved.

Having a supportive school Board of Trustees was acknowledged as being an important factor for success, as were: increasing the status of school health co-ordinators; giving teachers release time to attend HPS meetings; and having a public health nurse who was knowledgeable about HPS and willing to expand their role beyond personal health issues.

The main barriers to implementing HPS in schools were: the lack of a supportive principal or school management team; changes in school personnel; a lack of time for school staff to take part in HPS; difficulties for co-ordinators in arranging HPS activities in tightly-scheduled school years; and a lack of understanding of HPS by a few schools.

Activities

Many schools undertook some kind of needs analysis to identify the health issues of most concern in their school. As a result, most schools formed an action plan and were involved in a number of activities and

projects related to HPS. Having a strategic approach enabled some schools to be realistic about the number of new projects they took on.

Some of the most common topics in which schools developed activities were those addressing (with examples of activities) :

- 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 well-being - reducing stress; improving communication; Smokefree policy.

Impacts of Health Promoting Schools

In the second phase of the evaluation, over 150 personnel in 41 schools completed questionnaires asking them how much they felt HPS had contributed to a number of changes in their schools. More than 50 percent of respondents felt HPS had contributed either “a lot” or “some” to the following issues (presented in order of frequency):

- increased emphasis on student health and well-being, within the school (85%)
- greater student awareness of and involvement in health issues (79%)
- improved school physical environment (that contributes to student health and well-being) (74%)
- students better able to make healthy decisions (73%)
- development of more or better policies / guidelines on health issues (72%)
- greater staff awareness of and involvement in health issues (72%)
- improved co-ordination of health services within the school (65%)
- increased student pride in their school (63%)
- improvements to way health taught in school (61%)
- increased emphasis on staff health and well-being (61%)
- improved student access to health services (both at school and in community) (54%).

Areas that were perceived not to have changed significantly because of HPS were school attendance, ability of students to learn, and the focus on meeting the needs of Māori, Pacific and other “minority” ethnic groups.

Community Participation

Increasing the involvement and awareness of students was felt to be one of the most successful features of HPS. Students were represented on two-thirds of health teams, took part in planning HPS activities, ran some of these activities and represented their schools at HPS events.

There was limited awareness of the initiative among Boards of Trustees and other staff, and this was reflected in a decrease in their involvement in school health teams over the evaluation period.

With some exceptions, parents' awareness of HPS and their level of involvement appeared to be less encouraging. This was thought to be due to a number of factors including their lack of time; their beliefs that schools are responsible for and hold the expertise in such matters; the mobility of some families; socioeconomic factors; a lack of resources (such as transport and childcare); and feelings of intimidation.

Likewise HPS were not generally felt to foster Māori participation or cater specifically for Māori health needs. However, most school health teams had at least one Māori member and some schools did make a special effort to cater for Māori health concerns through activities such as hui, workshops, identifying resources, and making links with Māori community agencies. The West Auckland cluster of schools also made Māori health their priority.

Similarly, the HPS initiative was also not found to particularly focus on the needs of Pacific people (or other ethnic "minorities") in schools. However, there was considerable progress in some schools related to addressing Pacific peoples' health concerns with activities such as Pacific Heartbeat, cultural performances, and making links with local Pacific health providers.

Some schools networked with other schools and felt that this was a very worthwhile thing to do. As well, some schools with established HPS initiatives helped new schools to establish their own schemes. Schools generally found it easier to network with similar types of schools (i.e. primary, intermediate or secondary) in their own geographic area.

Overall Success of HPS in the Northern region

The evaluators concluded that the level of achievement experienced by schools involved in the HPS initiative varied widely in the first three and a half years. They stated:

Almost all schools have some achievements they attribute to HPS, most have several and a few have a very impressive list. It does seem that in most schools, HPS is still something that is happening on the fringes, rather than being embraced by the whole school

and being integral to the operations of the school. ... Like most change processes, things take time to change. The slowness of change and tangible outcomes has been frustrating for some who have been involved (Wyllie et al. 2000: 79).

Health Promoting Schools in the Midland, Central and Southern Regions

A slightly earlier evaluation identified very similar issues for the Health Promoting Schools located in other parts of New Zealand (Dowden and Kalafatelis 1999). These researchers also used a variety of methods in their evaluation including: consulting with key stakeholders and health providers; a “stock-take of health providers’ activities; a questionnaire survey of 36 HPS schools and 50 control schools; and case studies of seven HPS schools and three control schools.

Again, it was found that schools were implementing HPS in very different ways. HPS seemed to be “adding value” to the health environment of some school communities through the following changes:

- encouraging a wider view of what “health” means (including emotional as well as physical aspects)
- building on health promotion activities that were already in place (e.g. by making projects ongoing rather than “one-off” and by planning strategically)
- involving a much wider variety of people in decision making (e.g. other teachers, non-teaching staff, BOT, students, parents, families / whanau, local businesses, other schools)
- improving schools’ awareness of their communities’ needs
- encouraging a more positive school atmosphere and improving attitudes (e.g. improved co-operation in health-related classes, staff seeing themselves as “role models)
- improving schools’ understanding and use of health (and other) services and resources available to them.

On the other hand, it was felt that a few schools were not covering the main themes of HPS - community development and health promotion. For instance some schools were working in isolation rather than collaborating with “the community” or other schools and agencies.

The following factors were identified as being good guidelines for whether schools should be selected for the HPS initiative (i.e. these conditions tend to contribute to the “success” of the scheme):

- the school must want to participate
- the principal and Board of Trustees should support, be actively involved in and promote the initiative
- the school community should understand what is involved in participating in HPS
- the school must be happy to involve all members of the school community in HPS activities

-
- the school should already have, or be willing to develop, links with other local schools.

A lack of leadership from the Ministry of Education was identified as a major barrier in determining the success of HPS (this was noted as a problem in the Northern Region too). It was suggested that the Ministry could help schools to adopt the initiative by presenting the benefits to the *core role* of schools and helping schools to understand the value of HPS in a wider sense (e.g. making better links with the wider school community).

The evaluators believed that links with the Health and Physical Education curriculum could also be made more explicit than was already the case. The role of the Ministry of Health in communicating and collaborating with the Ministry of Education was also seen as very important in this context.

Other barriers included the lack of time available for extra school activities, apparent parental “apathy”, and lack of financial resources available to schools.

The relationships between the Purchaser (HFA) and health providers (employers of HPS co-ordinators / facilitators) as well as between health providers and school communities were examined in some depth in this evaluation. The importance of everyone understanding the concept and philosophy of HPS was emphasised. It was suggested that written agreements be developed between provider and schools (similar to the suggestions made in the case of Northern HPS initiative).

Adequate training of front-line staff was viewed as essential, particularly in the areas of understanding the concepts of HPS (community development and health promotion); understanding school environments (structures, policies, time-frames); marketing and explaining HPS; facilitating activities; negotiating skills; encouraging the scheme’s sustainability; engaging the whole school community; and evaluating results.

Again, the fact that HPS is designed to be a long-term initiative was emphasised, so further reviews and evaluations should not “focus only on tangible outcomes”, or there is a risk of understating the progress made” (Dowden and Kalafatelis 1999: 13).

Most schools took one to three years to get HPS schemes going (i.e. that is when they started to implement health promotion activities). Stakeholders believed that there would be a major credibility problem if funding was withdrawn from the initiative after the pilot period, and that schools would not rejoin if resources were unavailable for a while.

Community Alcohol Action

The description of case studies now moves on to the group of issues-based intersectoral initiatives for health, starting with community alcohol action.

Community action has been defined as:

... initiatives, activities, programs, and efforts that are developed and managed by local citizens. ... Such projects typically attempt to involve representatives from a large variety of local institutions, organisations, and citizens in order to increase local identity with the project, thus creating a sense of ownership (Allamani et al. 2000: 3).

Community action has similarities with many aspects of community development. However, in many cases there is a substantial research and evaluation component to community action that is not always evident in other community development initiatives. This includes researchers providing “research-based knowledge to facilitate the development of effective community strategies to reduce alcohol-use-related harm” (Casswell 2000: 55).

Main principles

In New Zealand, community alcohol action projects have mainly focused on problems such as public intoxication and drink-driving. This partly reflects the presence of key individuals in the alcohol research and public policy sectors committed to this kind of work. These individuals generally conceptualise community action (or community action research) as a non-linear approach in which activities are devised in response to the diverse needs of different community sectors and where the range of strategies employed can be diverse. The aim is primarily to co-ordinate existing resources within a community, rather than establishing costly new organisations. Research and evaluation is seen as an integral part of the process (Casswell 2000).

Work in other countries

Apart from New Zealand, community alcohol action projects have also been popular in North America, Australia and Scandinavia (ibid). In some projects the ideas and enthusiasm of researchers have been the key resource, while others have included funding to hire full or part-time co-ordinators, community facilitators or activists. Some larger-scale research-based initiatives have been funded as pilots or trials by national or local health services and/or governments, especially in the United States.

One comparatively recent overseas community prevention trial aimed to reduce alcohol-involved accidental injury and death by altering policies related to server intervention / host responsibility type programmes and enforcement of laws on underage drinking. The trial found that single night vehicle crashes (an indicator of alcohol-related injuries) dropped significantly in the intervention communities compared to controls (Kuhn et al. 1999; Holder et al. 1997a; Holder et al. 1997b).

Relationships with community sector

Practitioners of alcohol action research tend to distinguish between community action that focuses on promoting good use of professional resources and joint working amongst existing community organisations (the prevailing New Zealand approach) and community action which emphasises building the grassroots involvement of ordinary community members (a common feature of United States approaches) (Casswell 2000).

Extensive, direct and voluntary participation by ordinary citizens is usually not the goal of New Zealand community alcohol action projects. Few ordinary members of the community, especially those from lower socioeconomic groups, are thought to have the time (or interest) to devote to alcohol issues. In fact, putting too much emphasis on involving grassroots people in the development of community action is regarded by some practitioners as potentially self-defeating.

Paid positions

In New Zealand, having sufficient funds for at least one paid position in the community is regarded as a vital ingredient for successful community action (Casswell 2000). Ideally, the people in these paid positions should be catalysts for action by building momentum and linkages between other people and agencies in the community. Attempting to achieve the same on a voluntary basis (by using unpaid community members or citizens) is considered unwise, as it is much harder to sustain continuity and a strategic focus under these conditions.

Resources

Community alcohol action is not without its challenges. For one thing, building the partnerships required for community action often involves reconciling the competing needs, goals and interests of various groups and organisations. This can be a time-consuming and “resource-hungry” process. As well, the goals of community action sometimes conflict with corporate interests, which, in some cases, make it hard to secure political support at higher levels of government (Casswell 2000).

Early New Zealand initiatives

The first New Zealand community alcohol project (CAP) ran from 1982 to 1985 and consisted of large-scale, relatively resource-intensive, quasi-experimental “research-initiated demonstration project” involving six New Zealand cities (Duignan and Casswell 1992). 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 “references” 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.

A comprehensive evaluation strategy was used that included formative, process as well as outcome evaluation techniques (Duignan and Casswell 1992). The outcome evaluation component included general population surveys before and after the interventions. The project achieved statistically significant but modest attitude changes in the target cities. Some unplanned awareness of the mass media campaign were found to have crept into the reference cities, as a result of national controversy about aspects of the advertisements used (Casswell et al. 1990).

Subsequent initiatives

Building on the lessons learned, community alcohol action projects were subsequently initiated in a variety 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” 1987/89), 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” 1995/6), Otago, and rural Waikato (“Waikato Rural Drink Drive Project” 1996-98).

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 were 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

This project originated out of concerns expressed by the then Under-Secretary to the Minister of Transport about the role of alcohol in traffic accidents. The Ministry of Transport subsequently agreed to design a pilot programme for a single New Zealand city that involved education, enforcement, community intervention and publicity. This was the first time in New Zealand actions related to enforcement were combined with community-action type efforts (education and publicity) in a single programme (Ministry of Transport 1988).

Following discussions with relevant government departments and the Wanganui City Council, it was decided that Wanganui should be the site for the pilot programme. While initially it was generally agreed that the programme should run for 12 months, resource constraints led to it being scaled back to a three month pilot.

From the beginning the aim was to mobilise local resources and organisations in Wanganui to join forces to promote responsible attitudes to alcohol consumption and driving after drinking. To assist this, the programme started by drawing up some clearly stated goals and objectives. In addition three major committees were established: a Steering Committee chaired by the Under-Secretary for Transport; a Working Party made up of representatives from a wide range of Government and community groups; and an Interdepartmental Committee of Head Office officials. (It was subsequently noted that there could be a case for this committee structure to be “streamlined” in any future programme.)

Activities conducted during the pilot included: designing and delivering an alcohol awareness course to a total of 470 students (including sessions at three marae), implementing a special squad of traffic officers to focus solely on drink-driving enforcement including random-stopping; delivering server intervention programmes to bar staff; implementing an “I’m Safe Mate” designated driver scheme; media publicity; and poster competitions. Organisations and people who participated included Wanganui based Ministry of Transport staff, Police, hotel managers, the Hotel Workers Union, ACC, the Wanganui Area Health Board, school staff and students, and community volunteers.

Efforts to monitor the success of the programme included using a “before and after” research design to assess changes in rates of traffic accidents, breath alcohol levels in the driving population, general alcohol-related crime and overall levels of alcohol consumption. As well, where possible, comparisons were made with national data. The results suggested the campaign had contributed to a reduction in rates of drink-driving, traffic accidents, as well as a decrease in the severity of injuries found in road accident victims attending Wanganui Base Hospital’s Emergency Department. There was also evidence of a drop in alcohol consumption overall (Ministry of Transport 1988).

An analysis of the Wanganui initiative by Alcohol and Public Health Research Unit staff concluded that reliably measuring programme outcomes was difficult and questioned whether community interventions of this type merited full-scale process or outcome evaluations (Duignan and Casswell 1989).

Christchurch “Lifesaver” Project

This project aimed to integrate resources and expertise from various organisations, institutions and communities “...by moving from a narrower road safety perspective to the broader public health perspective” (Norton and Kirk 1993: 6). 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 NZ, ACC, and the Canterbury Area Health Board’s Road Safety Unit. A co-ordinator was employed to run the project and the first year of the campaign was independently evaluated based on interviews with key stakeholders, a community awareness survey and analysis of Land Transport and Emergency Department data.

The evaluation report notes intersectoral working to be one of the challenges of the project. As well, some tensions and a clash of values were identified over definitions of community development. One group argued that the process fundamentally relied on low-key, almost intangible groundwork with ordinary citizens in local neighbourhoods, not the imposition of an agenda from the outside. The high-profile “Lifesaver” campaign was criticised for putting too much emphasis on working with professionals in local agencies (Norton and Kirk 1993: 37).

The evaluation also noted that the Christchurch CAAP had only one year’s funding initially, which meant it was difficult to give specific direction to the campaign.

Waikato Rural Drink Drive Project

This project was stimulated by concerns amongst staff in the Alcohol Advisory Council (ALAC), Police and other national agencies about the high proportion of alcohol-related fatal road crashes occurring in rural areas of New Zealand (Stewart and Conway 2000). Following a qualitative study of key rural informants in the Waikato area, ALAC decided to fund a pilot community action project in the Te Awamutu Police District.

It was originally envisaged that the project would identify and implement community-based strategies to reduce crashes. Following meetings in the community to discuss the project, it was decided that an overall

project co-ordinating group would take responsibility for running the project. The group included representatives from national bodies such as ALAC, Police and the Alcohol and Public Health Research Unit, as well as regional and local level agencies such as Liquor Licensing Inspectors, Health Promotion Advisors and LTSA Regional Staff. It was also agreed that the co-ordinating group would aim to establish and mobilise seven community groups within each of the seven local government regions in the police district. These community groups would develop activities in their communities to raise awareness about the risks of drink driving and challenge attitudes supportive of drink-driving. Five thousand dollars was made available to each community group to support this work, provided the work met certain agreed criteria (e.g. proposal originated from the local community; local community consultation has occurred; basic planning and evaluation requirements were met). A project-planning guide was also developed by ALAC staff and distributed to project participants.

Soon after the project got underway, local police were successful in securing funding from national headquarters for a major pilot initiative aimed at improving compulsory breath testing (CBT) in the area. This involved a booze bus and funding and equipment for mobile police patrols to travel around the district testing suspected drink drivers.

Several months into the project it was evident that the community groups were not operating as well as initially hoped. Only one of the groups had initiated any meaningful activities (a school-based anti-drink drive poster and video competition) and within the project co-ordinating group there was growing concern about the viability of relying on grassroots community action.

Eventually it was decided to shift the focus of the project away from community mobilisation and towards the “preservation and enhancement” of existing efforts to influence drinking environments and police activities. In particular this involved putting the remaining resources for the project into improving data collection and dissemination procedures for a last drink survey, which identifies the last place where drink drive offenders consumed alcohol prior to being apprehended by police. Data from the survey helps police to deploy mobile police patrols for CBT more effectively. Key stakeholders, including ALAC, supported this reorientation of the project and funding for ongoing work on the last drink survey was secured from various sources.

The project evaluators, who were closely involved with the project from the start, identified several reasons for the problems associated with developing the community groups. These included the intensive work and organisational resources required to maintain an effective community group, especially if the people charged with setting up and running the groups already had many other professional duties and commitments. Members of the project co-ordinating group usually did

not have a mandate in their job descriptions to do this work, and, in some respects, they were resentful of having to try to meet the agenda of an external agency (in this case ALAC).

As well there was concern over the degree of paperwork, administration and other related tasks required to obtain approval to spend what was generally accepted to be only modest funding for local community initiatives. More broadly, it was observed that ordinary citizens “are often too busy in their own lives earning a living and caring for family to become actively involved” (Stewart and Conway 2000: 151). Communities, especially disadvantaged communities, were noted to be suffering from stress and “community battle-fatigue”, at least in part as a result of market-driven economic policies and major retrenchments and re-organisations in the business and state services sectors. As the evaluators conclude:

The broader economic, work, and organisational environments facing communities must be taken into account by funding agencies and researchers when tackling alcohol-related issues (Stewart and Conway 2000: 152).

Māori-focused Community Alcohol Action projects

In the mid 1990s, the Alcohol and Public Health Research Unit developed two alcohol action projects in partnership with disadvantaged Māori communities. Both projects were funded jointly by the Health Research Council, ACC, ALAC and Ministry of Transport and aimed to develop and implement a broad range of strategies, including marae-based programmes, to reduce alcohol-related traffic crashes among Māori (Moewaka Barnes et al. 1996a; Moewaka Barnes et al. 1996b; Moewaka Barnes 2000).

The Health Research Council funding once again reflected the substantial evaluation research focus of the projects. Funding for the delivery of the programme’s health promotion activities was devolved through subcontracts to two Māori trust boards. Details of the programmes to be provided were not specified in contracts. Agreement was simply reached on four general objectives.

Each trust board developed their own project, based on their own consultations with community members and representatives. A kaimahi (or worker) was selected by the respective Trust Boards. These workers became responsible for developing and defining the kaupapa of their specific projects, with the evaluation workers taking a backseat.

Whiriwhiri te Ora

The Whiriwhiri te Ora or Choose Life programme was a marae based programme developed by the Huakina Development Trust Board, based

in Pukekohe, which represents marae covering the area from Mercer to Muriwai. Marae were recognised to be a focal point for the lives of many rural Māori. A hui-a-mahi was used early on as part of strategic planning, and continued to be used to refine the process.

The project campaign was launched at the Whatapaka marae with the Māori Queen in attendance. Kaumatua were closely involved in the campaign, as were Māori wardens, who, along with kaimahi, gave addresses to many groups and organisations. Manakitia (or host responsibility) policies and competitions were designed and implemented in various settings. A Lost Generations display was created, showing photographs of various Tainui people who had died as a result of drinking and driving crashes, juxtaposed with pictures of their surviving whanau members. This emphasised the reality of the personal and community loss associated with drink driving. Special waiata were also composed. Posters, radio, television and billboards were also used to deliver Whiriwhiri te Ora campaign messages. 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.

A detailed evaluation of the project was conducted using interviews, discussion groups, observations and media analysis. No attempts were made to measure changes in traffic crashes, as longer-term impacts were assumed (Moewaka Barnes 2000).

The evaluation report concluded that the Whiriwhiri te Ora campaign had experienced “a considerable level of success” and was achieving “sufficient impetus to begin to make a difference”. This success was attributed to the project being adequately resourced (both financially and through people giving time for free), its emphasis on community ownership and on-going consultation with relevant sections of the community, which, though very time consuming, was found to be essential (Moewaka Barnes et al. 1996a).

WHANAU and TU BADD

The WHANAU and TU BADD (Brothers Against Drink Driving) projects were developed by the Te Whanau O Waipareira Trust Board, a confederation of 50 Māori organisations covering a predominantly urban area from Waterview in West Auckland through to Helensville (Moewaka Barnes et al. 1996b). The campaign included the development of haka, waiata and posters featuring messages about Māori and alcohol.

The Brothers Against Drink Driving project was targeted to 20-30 year old Māori males and was officially launched at Hoani Waititi marae in West Auckland. The campaign messages centred on Māori notions of

manhood and aimed to encourage young men to take responsibility for issues surrounding drinking and driving.

The evaluation of the project, which used a similar methodology to Whiriwhiri te Ora, concluded that it had achieved “a considerable level of success” in meeting the agreed objectives, given the resources put into the initiative. The TU BADD campaign was found to have a high visibility and reached an ‘at risk’ group “often put in the too hard basket” (Moewaka Barnes 2000: 23). This was made possible by fostering a good level of community ownership and facilitating collaborations with a range of groups including community, police, councils, marae, education, justice and sports organisations.

The evaluators identified several keys to success for future Māori community action projects. They included linking with an existing organisation with high standing in the Māori community; adequate resourcing, realistic timeframes, and community control over the development and implementation of strategies to meet agreed objectives (Moewaka Barnes et al. 1996b).

Youth-focused Community Alcohol Action projects

More recent New Zealand community alcohol action projects have focused on young people.

One initiative, the Youth and Alcohol Project, relied on health promotion advisers from various cities and towns working with schools, tertiary education institutions, clubs and sports teams to address issues relating to drink driving, alcohol-related violence and safer drinking environments (Hill and Casswell 1999).

Another project, Community Action on Youth and Drugs (CAYAD), ran in six city and rural areas with relatively large Māori youth populations and/or high youth unemployment (Hokianga, Whangaruru, Kaitaia, West Auckland, Opotiki and Nelson). The project, which was funded jointly by the Ministry of Education, the Alcohol Advisory Council and the Health Funding Authority, combined school-based alcohol and drug education with community action. A community action worker employed in each location was responsible for developing local resources and alliances between organisations and agencies, as well as encouraging young people to develop their own alcohol harm reduction strategies (ibid). For example, the He Rangihou New Day Project, developed in Opotiki, 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 (Te Pou et al 1999).

Safer Community Councils

In 1990, Safer Community Councils (SCCs) 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 (Gray 1993).

The main focus of the local SCCs was local crime prevention and promoting “safer” communities. Key objectives were to:

Foster recognition that crime, and crime prevention are issues that concern the whole community and that control or prevention cannot be the responsibility of the various traditional agencies of social control and law enforcement alone.

Provide a forum at the local community level to identify crime problems affecting that community and co-ordinate the resources and expertise of local government, government departments, iwi authorities, private organisations, educational institutions, relevant cultural authorities and other organisations to address the problems involved.

Facilitate and promote local initiatives focusing on crime, its prevention, and the context within which crime occurs.

Promote the development of effective crime prevention initiatives which are suited to New Zealand, in particular taking account of the status of Māori people.

Promote and support worthwhile crime prevention projects (ibid).

All four pilot projects were evaluated. The evaluation was based on interviews and a review of documents, along with short telephone surveys of local residents towards the end of the pilot period.

Resources

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.

Most of the SCCs found it difficult and time-consuming obtaining funds from elsewhere. They were also ineligible for some types of funding (e.g. from the Department of Social Welfare). Being a short-term scheme also made it difficult applying for funding from certain organisations.

The possibility of some kind of population-based funding was raised, as both Manukau and Christchurch SCCs covered a much larger population than the other two SCCs.

Planning

It was seen as advantageous to set clear goals very early on and have a strategic plan with measurable goals and regular reviews. However, not all the SCCs fulfilled these ideals. There also appeared to be degree of mismatch between the Prime Ministerial Council's aims (crime reduction) and those of the local SCCs (a wider concept of crime prevention).

All of the SCCs formed sub-committees to deal with various components of their work. This was seen as a positive move that increased SCC members' involvement with the scheme and networking with other agencies.

Those interviewed for the evaluation believed it was important that SCCs maintained their own identity (e.g. by being located on their own and having their own accounts). They noted some people were confused about the SCCs' relationships with local authorities and other schemes (e.g. the Healthy Cities project in Manukau).

Co-ordinators

Co-ordinators were felt to need considerable amounts of expertise, skills, and drive and be well-known by the community - qualities which all co-ordinators appeared to have. However, the evaluation found that co-ordinators might have benefited from more support from other agencies (central and local), from one another, and from some administrative assistance. They did not always have very clear lines of accountability either.

Projects

Once launched, the SCCs operated in different ways and ran a wide range of different (mainly short-term) projects. These primarily focused on youth (preventing young people committing crimes) and elderly residents and women (preventing them from becoming victims). However, publicity to the wider population also occurred, mainly through local newspapers.

Some of the projects were initiated by SCCs themselves. Others involved SCCs funding existing initiatives run by other community groups. Some projects were directly linked to crime prevention, with examples including Māori wardens and other neighbourhood patrols; Safer Community pamphlets; education kits for schools; art competitions; and crime prevention seminars. However, most projects targeted wider social issues by promoting projects such as parenting skills, after school activities, reading support, budget advice, involvement in sports teams and smoke detectors (Gray 1993).

The evaluation concluded that SCCs may need to employ project managers in situations where they initiate projects themselves, as SCC co-ordinators did not have time to manage these special projects as well as do everything else.

Projects generally were not being evaluated in a systematic or comprehensive way.

Relationships with other agencies

Each SCC included representation from the local authority, Police, the Departments of Justice and Social Welfare, and the NZ Employment Service. Other SCC members included staff from the Department of Internal Affairs, Te Puni Kokiri, and Housing, as well as representatives from the education and health sectors.

The roles of the Police and Department of Justice representatives tended to be clearer than those of other agencies, some of which appeared to have a lack of commitment to the scheme. Restructuring of some agencies also resulted in a lack of continuity in the representatives they sent to meetings. Having senior level staff on the SCC was positive because they could make decisions and commitments, but the downside was these senior people had little time to contribute to “hands on” management and organisation.

Overall, there appeared to be a lack of commitment and support from central government (e.g. the Crime Prevention Unit was often slow to respond to the SCCs because of a lack of resources).

Community participation

The evaluation concluded all SCCs had generated significant community involvement, mainly by including local businesses, representatives from different ethnic organisations and support agencies. In addition, the Christchurch SCC made extra efforts to include members from target populations (e.g. youth).

Nevertheless, the number of community-initiated projects was judged to be generally low. The relevance of some of these was also questioned. Public participation in some of the SCC-initiated projects was also low. All SCCs intended to encourage greater community participation in the future.

In Wairoa, it was felt that the SCC there did not have a particularly Māori focus, despite the high proportion of Māori in the population.

Public awareness of SCCs

Telephone surveys were conducted with 397 people living in the four SCC areas. Table 2.1 summarises the results of these surveys. Overall, there was better public awareness and understanding of the scheme in the smaller centres (particularly Ashburton), compared with the two city locations.

Grey (1996) notes that the Safer Community Councils initiative differed significantly from the Healthy Cities initiatives in that it was centrally initiated and had high level political commitment. It also had a high profile in the community (there was ongoing media interest), had a structural relationship with a core agency, had a functioning committee structure, and was adequately funded.

Table 2.2: Summary of public awareness of Safer Community Councils, by four pilot locations

	Ashburton (n=97)	Christchurch (Sydenham) (n=200)	Manukau (n=200)	Wairoa (n=100)
Percentage of people who had heard of a local safer community programme	76%	25%	16%	36%
Agencies / people who were believed to run the programme (in order of frequency - for those who had heard of the programme)	Named co-ordinator Police Neighbourhood support SCC	SCC Neighbourhood support City Council	SCC Named co-ordinator	Named co-ordinator SCC Police Community support constable
Percentage of people who had specifically heard of the “Safer Community Council”	80%	25%	13%	49%
Where people had heard of the SCC (in order of frequency - for those who had heard of it)	Newspaper Radio Through a project Seen the office	Fun Day Newspaper Radio Through a project	Newspaper Radio Through a project	Newspaper
Percentage of people who thought the SCC was “doing a good job” (of those who had heard of it)	64%	34%	35%	47%
Percentage of people who thought the SCC should continue (of those who had heard of it)	77%	63%	54%	73%

Community Injury Prevention Programmes - “Safe Communities”

The WHO’s “Safe Communities” concept was developed from Swedish injury prevention programmes that ran in the 1980s. Intersectoral collaboration, community involvement / development, and targeting programmes towards at-risk groups were the bases for the approach (Simpson 1999). Worldwide there are now 56 formally designated WHO Safe Communities members, including Waimakariri and Waitakere in New Zealand. They are required to follow twelve programme criteria (WHO Collaborating Centre on Community Safety Promotion 1997):

Formation of a cross sectoral group that is responsible for injury prevention.

Involvement of the local community network.

Address all ages, surroundings and situations.

Address the concerns of high-risk groups (such as children and the elderly), high-risk environments and aim to ensure equity for vulnerable groups.

Have a mechanism to document the frequency and causes of injuries.

Take a long-term approach.

Undertake evaluations that include indicators showing effects and provide information on the process as it advances.

Identify relevant organisations in the community and assess their potential for participation in the programme.

Ensure the participation of the health care community in both the registration of injuries and the injury prevention programme.

Aim to involve all levels of the community in solving the injury problem.

Disseminate information on the experience both nationally and internationally.

Be willing to contribute to the overall network of “Safe Communities”.

To date, few evaluations of Safe Communities programmes have been published. The small number of studies available from Scandinavia, Britain and Australia have concentrated on measuring outcomes, rather than processes, and have shown mixed results. Scandinavian studies have

generally shown reductions in injury, whereas Australian studies have been more ambivalent (Simpson 1999). Nevertheless seven international “coalition” injury prevention programmes reviewed by Kuhn et al. (1999) showed some positive results, with policy changes occurring in one injury prevention programme, statistically-significant changes in injury outcomes in three studies, and statistically-significant knowledge changes in another.

Rangiora and Kawerau projects

An evaluation of “Safe Rangiora” and the “Safe Kawerau Kids Injury Prevention Project” (SKIP) by the Injury Prevention Research Unit reviewed the progress of these two projects from 1993, at the beginning of the establishment process, until April 1998 (Simpson and Morrison 1998; Simpson 1999).

Both community injury prevention projects were established along “Safe Communities” lines, primarily addressing injury prevention among children aged less than 15 years. The projects were both originally funded by the Public Health Commission (PHC) and managed by the Plunket Society. In 1996 this management role was taken over by the Waimakiriri District Council and the Eastern Bay of Plenty Rural Education Activities Programme (REAP). During this period the Public Health Commission’s funding role was also taken over by the four Regional Health Authorities.

Both Safe Rangiora and SKIP ran a number of individual projects, including “Keep Kids Safe Near Water”, “Fun in the Sun”, Poisons Awareness, playground safety and use of car restraints. Many of these were local promotions of national campaigns, rather than locally-developed (“bottom up”) approaches. The evaluation methods consisted of (Simpson and Morrison 1998; Simpson 1999):

- key informant interviews with project management members, those implementing parts of the projects (e.g. collaborating organisations) and community representatives
- focus group discussions with pre-school parents
- reviewing written documentation and archival records
- regular communication with co-ordinators
- observation through site visits
- two community surveys in each town (relating to 300 children in each location)

The results of the evaluation from 1996-1998 are summarised in the table overleaf.

	SKIP (Kawerau)	“Safe Rangiora”
Community context	A very small district (population 7,830) with a high Māori population (58%). High unemployment, low education, downturn in local economy, high population turnover, a relatively high hospitalisation rate for injury among children, although not seen as a priority because of other social problems.	Population 9,864, a satellite district of Christchurch with a growing population. Generally middle-income, 7% Māori, low unemployment, high level of community consultation and participation, relatively low rates of childhood hospitalisations for injury. However, a community feeling that they did not need such a programme, even though evidence suggested they did.
Participation/ownership	Community participation and feeling of ownership not achieved because of lack of knowledge of the issue, lack of awareness of the programme and lack of time for co-ordinator to network face-to-face. However, there was an increase in the participation of other agencies. The management committee did not take much responsibility for the programme. Links with Māori community were not extensively established.	Community ownership increased with the move to local council management. Strong links with community representatives and other agencies were maintained, although representation by Māori was sought but not obtained due to other pressures on local Māori organisations. Government agencies (ACC, Crown Public Health) were on the programme committee and they had valuable skills, knowledge and time. Other government and NGOs were also involved. The local council were very supportive and saw injury prevention as being compatible with “Agenda 21” (sustainable development). A sense of community ownership increased with time, although those most at risk may not have had a voice. There was an increase in seeking feedback on projects.
Leadership	Co-ordinator was the driving force throughout the programme. However, the co-ordinator was relatively inexperienced in the area of injury prevention. Local council did not see health or social issues as its business, although there was support from the Mayor.	The co-ordinator took a very important role, and was experienced, but the perception was that dependency of the programme on this person decreased over time.
Management	REAP’s role caused some problems, especially as this organisation was based in Whakatane, not Kawerau and to some extent was seen to be in	The change of management to the Waimakariri District Council was achieved smoothly and successfully. The steering committee was

	<p>competition with SKIP. The co-ordinator took on the bulk of management activities which limited her ability to develop new initiatives and work in the community. The management committee lacked personnel and did not have representation from some key government agencies that deal with injury. Committee's structure and function were never clearly defined.</p>	<p>renamed the "Advisory Committee" and responsibilities were shared among members. There was support from the council with regards to accommodation and administrative staff.</p>
Focus and Planning	<p>Priority issues were identified from the community survey and from data from doctors: cycle helmet wearing, broken glass, playground safety. Also added burns and scalds, poisons, Kidsafe weeks. Some of these were implemented, although others weren't due to a lack of ability to develop a community-owned programme, and lack of support for the co-ordinator.</p>	<p>The focus of the programme did not change substantially throughout the project: home safety, Kidsafe weeks and road safety. They were well-organised with realistic expectations, and collaboration with other projects was successful and perceived to be very advantageous.</p>
Data collection	<p>GPs originally collected data based on ACC forms, but the ACC changed the forms to less-detailed versions and the data collection was abandoned.</p>	<p>The programme aimed to start developing a local data collection source, although there were no expectations to achieve this. Access to emergency department records became problematic once the system was computerised. Ongoing data collection by GPs was being explored, as were alternatives.</p>
Sustainability	<p>While there was support for the continuation of SKIP, how this would be achieved was unclear.</p>	<p>Safe Rangiora was making plans to apply for WHO Safe Community status (which it now has), and council was pursuing funding options.</p>
External relations	<p>The co-ordinator was in contact with other community injury prevention programmes throughout New Zealand, and other agencies like Safekids and injury prevention research centres. However SKIP was not on e-mail or the world wide web.</p>	<p>The co-ordinator was actively involved in injury prevention networks (increasingly so were the committee). Contact with Safekids, and hosting of international visitors, attendance at conferences.</p>
Major achievements	<p>Influencing the council to maintain safer public playgrounds; increased contact with the council and other community organisations; a decrease in</p>	<p>Local council's agreement to manage the programme, development of working groups to deal with specific injury issues, raising the profile of</p>

the amount of broken glass in public places; the programme and injury prevention issues.
surviving for several years and establishing a base
on which further work could be built.

Overall, the study concluded that the CIPP in Rangiora had worked well whereas there were “quite a few problems” in Kawerau. The differences in development of the two programmes were largely explained by:

- a difference in other community priorities in the two locations
- the capacity of each community to participate in and support CIPPs (but in both cases there was a lack of Māori participation)
- different patterns of participation and organisation
- the style of leadership and type of management
- the level of intersectoral collaboration (the local councils had quite different views of their roles).

Some of the assumptions of the WHO Safe Communities model did not apply to the NZ situation, particularly Kawerau. In New Zealand city councils do not routinely have responsibilities for health issues or health data collection, unlike Scandinavian countries. In Kawerau there were not many other sectors to collaborate with because it was such a small town. Because of the relative disadvantage of the population in Kawerau, energy was needed to build up community capacity and a smaller scale, grass roots programme, such as a marae based initiative, may have been more successful.

Lessons learnt

- The evaluation considered the Safe Communities model had worked well in Rangiora - a Pakeha, stable, growing, relatively advantaged community.
- However, it did not work well in Kawerau, which had a predominantly Māori population, and where many of the people were disadvantaged and mobile. In addition the local authority did not usually undertake community development activities. It was concluded that the assumption that communities had the capacity to run such projects was inappropriate for Kawerau.
- Another finding was that the assessment of the community context is essential before a programme begins.
- The evaluation concluded that the effectiveness of the programme had been enhanced by employing a dedicated, paid co-ordinator with knowledge and experience of injury prevention and community development principles. It added that the assumption that voluntary labour could be used in these types of programmes was probably outdated.
- Peoples’ different interpretations of what “community development” and “community participation” means were also highlighted by the

evaluation. Some people argued the local council was a “community representative”, while others argued it was not.

- The evaluators also observed that external direction of the programme had the potential to negate a sense of local self-determination. They questioned, too, whether local authorities should be the hosts for CIPPs in all New Zealand communities. Finally, they cautioned that intersectoral collaboration may not be possible in rural or minor urban communities where often there are no other agencies to collaborate with.

Waitakere Community Injury Prevention Project⁵

Another injury prevention programme was set up in the Waitakere City Council (WCC) region of Auckland in 1994. This project was initiated when the WCC responded to a call from the Public Health Commission for organisations to establish pilot injury prevention programmes (funded for a period of three years). The WCC 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 (Coggan et al. 1998c).

The aims of the Waitakere programme 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.

Early on in the project three key sub-projects were formed - a Māori project (Puriri), a Pacific project and a general population project - with a co-ordinator being appointed for each of these (ibid.).

An evaluation comprising formative, process and outcome elements was conducted from 1994-1997 and results from these are available in a series of reports by the Injury Prevention Research Centre (Coggan et al. 1997; Coggan et al. 1998a; Coggan et al. 1998b; Coggan et al. 1998c).

Formative and process evaluations

The formative and process evaluations consisted of a review of programme documents, participant observation at meetings and hui, key informant interviews (with programme implementers and community

⁵ Now known as “Safe Waitakere” - a WHO designated “Safe Community”.

representatives), the setting up of an injury prevention monitoring system, telephone and organisational surveys and case studies.

The formative evaluation suggested that the PHC's framework was somewhat ambitious and that it was unrealistic to expect measurable reductions in injury rates within three years.

The programme proposal was developed through intersectoral collaboration, and appointing co-ordinators for each of the three main components of the programme appeared to work well. Seven priority injury areas were identified (Māori, Pacific, children, young people and older people, alcohol and road-related injuries).

The disestablishment of the PHC meant that new funders took over the programme (the four regional health authorities and ACC). These funders had different requirements for the programme, so that the road safety priority was removed. While the management group was without a chairperson at the beginning of the programme - causing some delays - WCC staff and an elected Council member had a great deal of involvement with it. This was seen as positive, as well as the presence of the researchers who helped with development of the programme.

The broad strategies used by the programme included (Coggan et al. 1998c: 9):

- promotion
- education and training
- advocacy and action for hazard reduction and environmental change
- advocacy within Council to emphasise adoption of safety policies and practices
- advocacy with Hoana Waititi Marae to emphasise adoption of safety policies and practices.

Most of these strategies focused on injury prevention among children and older people, as there were not enough resources to cover all age groups.

Having three components of the programme (Māori, Pacific, general) with their own co-ordinators worked well. However, it was found to be very complex to try to work with at least seven different Pacific communities. The management group also worked well in the roles of support and monitoring, although there was no representation from clinical staff or some of the priority areas. Continuity of funding was perceived to be the key to sustaining the programme.

There was good evidence that a great deal of intersectoral collaboration had taken place and local agencies' awareness of the programme and participation in it were high.

The location of the project within WCC and the integrity and commitment of the co-ordinators were seen to be some of the main factors contributing to this success.

However, five barriers were identified as hindering it: namely changing health funding criteria and the “new right” philosophy of government agencies; the high proportion of young and low-income people in the area; lack of availability of injury prevention professionals; and lack of resources available to fund inter-agency support (Coggan et al. 1998c).

A case study of the Council examined its role in the programme in depth and found a large number of achievements and advantages of having strong Council support. For instance, safety issues were being mainstreamed into Council activities, plans and staff development; and partnerships with “the community” were being built.

The marae project was also very successful, with strong support and a feeling of ownership for the project being evident. Injury prevention was obviously being approached from a Māori perspective and there was increased community awareness about the issues through activities such as hui, a mural, a child restraint campaign, initiatives for kaumatua, a tamariki safety day, and the development of a marae safety checklist (Coggan et al. 1998c, Coggan et al. 1998a).

The Pacific component of the programme focused on falls, burns / scalds, and sports and intentional injuries among young people. It undertook a large number of activities including: education kits on burns and scalds; displays at Pasifika Healthcare and Lynmall during Kidsafe Week; education sessions; development of injury prevention brochures; rap song and art competitions; and a community survey of falls among local preschool children (Coggan et al. 1998a).

Outcome evaluations

Injury statistics for Waitakere and Hamilton (a comparative, “control” location of similar population size) were analysed under an injury monitoring system. While originally it had been intended to use data from a variety of sources, in the end only New Zealand Health Information Service morbidity and mortality data and hospitalisation data were used to measure health outcomes. This was because of the inconsistency of other data sources.

However, the lack of timely ACC and NZHIS data made it difficult to make an accurate assessment of the effectiveness of the programme on health outcomes. Hospitalisation rates for injuries *increased* slightly in both Waitakere and Hamilton from 1995-1996, and this increase was predominantly among non-Māori in Waitakere.

Additionally, outcomes were measured by pre- and post-intervention surveys with the public and organisations in Waitakere and Hamilton, (Coggan et al. 1998c). While there was no reduction of self-reported injury in either community over the previous year, adults' requirements for medical treatment decreased in Waitakere (Coggan et al. 1998a).

Over the intervention period, there was a significant increase in the proportion of Waitakere people using appropriate car restraints. In addition, there was a significant increase in the proportion of people reporting that they had installed home safety equipment such as fireguards, pool fences and stair gates. Ownership of protective equipment for sport also increased.

In addition, several Waitakere-based organisations had become more aware of injury prevention issues and the programme, and many had contacted programme staff (Coggan et al. 1998c).

Turanganui a Kiwa and Ngati Porou community injury prevention projects

Evaluation results for the Turanganui a Kiwa and Ngati Porou Pilot Community Injury Prevention Projects (Brewin et al. 1997) have been summarised by Coggan and Simpson (1999). Both projects were collaborations between Tairawhiti Healthcare and the two respective Māori organisations, although originally they were envisaged to be just one project. Both projects ran for three years between 1995 and 1998, and had a shared management team. Like the other community injury prevention projects described above, the Tairawhiti projects were initially funded by the Public Health Commission (PHC), but were later funded by the Regional Health Authority after the PHC was abolished.

Both projects were assessed to have shown that the Safe Communities concept could be successfully implemented in large rural and urban settings with high Māori populations.

Turanganui a Kiwa project

This pilot community injury prevention project operated in the Tairawhiti region, on the East Coast of the North Island. It served the Turanganui a Kiwa Māori population in the city of Gisborne and was based at the Tairawhiti runanga. The project evaluation methods included key informant interviews, document analysis, a review of the resources produced, participant observation, communication with co-ordinators, and pre- and post-intervention surveys.

A needs assessment had been carried out at the start of the project, and this identified the following injury issues as priorities:

- road traffic child (tamariki) safety
- family violence
- alcohol-related harm
- environmental hazards (with respect to tamariki road safety and smoke alarms for elders (kaumatua)).

The co-ordinator successfully integrated new injury prevention activities into existing programmes and initiatives through a number of organisations (including sports groups). Promotional activities included using various media and holding hui at schools, marae and sports clubs.

Targeting critical issues and learning from past activities contributed to the positive impacts of the initiative. These included:

- an increased public awareness and knowledge of injury prevention
- an improved use of seatbelts
- improved feelings of personal safety
- a decrease in drink driving (and travelling in cars with drivers who had been drinking)
- an increased use of safety equipment by sports participants
- improved road safety behaviour among children
- the installation of 120 smoke alarms in kaumatua's homes.

The strengths of the project were considered to include: the consultation about priority areas; a Māori co-ordinator who had strong links to the local community and who was skilled in the areas of community development and health promotion; the manageable number of projects that were implemented; resources that were culturally appropriate for Māori (e.g. using the Māori language - te reo); the integration of activities into other community development and health promotion programmes; a focus on safe drinking in sports clubs; the level of publicity achieved; additional resources obtained; "training and empowerment" of Māori; and the close collaboration with the evaluation team (Coggan and Simpson 1999).

Less successful features of the project included having a joint management group with the other local Māori community injury prevention project (see below), and the expectation that the co-ordinator would perform all the administrative tasks as well as organise activities. Also there were difficulties associated with satisfactorily addressing family violence issues, as well as developing an effective injury monitoring system (due to the lack of timely data).

Ngati Porou community injury prevention project

A parallel scheme was established for Māori from Ngati Porou in the large rural area north of Gisborne and was operated from the Ngati Porou runanga based in Ruatoria. This initiative was evaluated using similar research methods as those used for the Turanganui a Kiwa project (Coggan and Simpson 1999).

Instead of having a single co-ordinator, the Ngati Porou project had a team of three. Membership of this team changed at the start of the project, but became more stable later on with the recruitment of two team leaders. A needs assessment at the start of the project identified the following injury prevention issues that needed addressing:

- road traffic safety
- family violence
- alcohol and drug related harm
- environmental hazards (playground safety, forestry road safety).

Project-related activities were focused on marae and improving the knowledge and skills of iwi members. These were successful strategies, as community surveys showed that there had been an increase in the awareness and knowledge of injury prevention among the target population. Participants in a marae-based drivers licence initiative also had improved feelings of well-being, and there were increases in the proportions of people who said: they always or mostly made sure their vehicles were safe; always used child restraints; and never exceeded the speed limit.

The commitment and leadership of the project team were seen to be two of the main strengths of the project, along with the support of the management group. Consulting with the community about injury prevention needs, and the holistic, marae-based approach were also positive features. Again, the initiative appeared to be sensitive to local Māori needs, providing them with suitable resources, activities and training and “empowering” them in the area of injury prevention.

Collaboration and support from the Land Transport Safety Authority and the Police also contributed to the success of the project, along with a high level of media publicity and “close co-operation between the evaluators and the Ngati Porou CIPP” (Coggan and Simpson 1999: c. 37).

Perceived weaknesses were similar to those experienced by the Turanganui a Kiwa project, comprising:

- having a joint management group
- a lack of continuity of team members at the start of the project
- the expectation that administrative as well as organisational tasks would be undertaken by the team

- the difficulties in trying to address family violence issues
- the unrealistic expectation that forestry road safety issues could be addressed in the time available
- the difficulties in establishing an effective injury monitoring system.

Community Nutrition Programmes for Māori

At different times between 1993 and 1995, four community nutrition programmes for Māori 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 Māori organisations to implement the programmes, which were all evaluated by the Alcohol and Public Health Research Unit (Moewaka Barnes et al. 1998a; Moewaka Barnes et al. 1998b; Pipi et al. 1994; Tunks et al. 1998). Te Hotu Manawa Māori (the Māori equivalent of the National Heart Foundation) was also involved in the programmes.

All the programmes were based on strong community development perspectives and achieved a great deal of Māori community involvement, empowerment and sense of local “ownership”. Existing networks, such as marae and kohanga reo, were invaluable in helping course graduates to spread nutrition messages to their local Māori communities.

Presented below are short descriptions of the different programmes, including evaluation findings on “what worked” and “what did not”.

Te Kai o Te Hauora

The original programme - Te Kai o Te Hauora - was initiated by Te Hotu Manawa Māori in conjunction with Tairāwhiti Healthcare. It ran for 14 months during 1993-1994 in five communities on the East Coast of the North Island (Pipi et al. 1994).

Five kaiawhina (nutrition community health workers) were nominated by marae committees and other community organisations 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).

The project co-ordinator had extensive local knowledge and had already run “mana kai hui”⁶ in several of the participating communities. From this experience, she identified two major nutrition areas that Te Kai o Te Hauora should address, namely:

- physiological conditions e.g. coronary heart disease, diabetes
- lifestyle factors e.g. smoking and alcohol.

⁶ Hui to encourage “healthy food choices while acknowledging the special role of traditional kai [food]” (Pipi et al. 1994: 6).

The kaiawhina were first required to collect data about their area's population, existing levels of nutrition awareness and the community's perceived needs for further information. Because of the long distance between the five communities, and the resulting isolation, the kaiawhina met one another once a month and the co-ordinator made site visits.

The activities of kaiawhina varied, depending on their community's needs, but included networking with community members, and running hui that involved korero (discussion), cooking demonstrations, preparing special meals and visual displays.

The hui covered topics such as exercise, fats, cancer, child nutrition, obesity, vitamins, healthy drinks, snacks and lunches, the food pyramid, healthy marae catering, food safety and hygiene, and low-cost meals.

Data collection for the evaluation of the programme consisted of the analysis of documents (including feedback sheets from hui participants), key informant interviews with stakeholders, and group discussions.

The evaluation found that the programme's plan and its progress were well-documented and generally its aims had been met in the ways that had been intended.

Feedback from community members suggested that their awareness of nutrition issues had been enhanced and appropriate methods had been used to deliver the information (i.e. face-to-face by a local community member using te reo). The possibility of establishing a community garden was seriously discussed during the course of the programme, a suggestion that met with considerable support, but also some concern that it may not be appropriate.

Stakeholders believed there had been a need for the programme because of the previous lack of nutrition awareness and poor dietary habits of community members. These factors were thought to be due to difficulties accessing healthy foods, a lack of appropriate cooking equipment, and lifestyle issues. Stakeholders believed there had been improvements in nutritional awareness and behaviour, particularly in homes and marae. They also stated that the kaiawhinas had been well-accepted by their communities.

Evaluation participants also suggested that the main way of improving the programme was to expand current activities e.g. to further reach men and children, explore alternatives to dessert and consider some cultural issues (like manaaki – i.e. being a good host).

Te Taro o Te Ora

Following the above programme, a joint initiative - Te Taro o Te Ora – was established between Te Runanga o Ngati Porou, Te Runanga o Turanganui-a-Kiwa and Tairāwhiti Healthcare Ltd. It operated from 1994 onwards on the East Coast of the North Island (i.e. the same region as Te Kai o Te Hauora) (Tunks et al. 1998).

This programme involved training one full-time and three part-time kaiāwhina who were nominated by their local communities. In turn, these kaiāwhina trained marae workers from 11 marae in the topics such as healthy food menus, food preparation, and food safety. Because of the turnover of marae workers, it was estimated that, by the time of the outcome evaluation, over 50 people had been trained during this nutrition programme.

An earlier process evaluation concluded that Te Taro o Te Ora had met all its programme objectives, and was particularly successful because of the way it had met the community's needs and used existing community networks (Tunks et al. 1997). Other strengths had been the expertise of the (unpaid) programme management group members; the skills and expertise of the co-ordinator; and the effective way in which nutrition messages were being communicated by the kaiāwhina and marae workers.

The outcome evaluation of Te Taro o Te Ora consisted of key informant interviews and practitioners' hui (Tunks et al. 1998).⁷ This stage of the evaluation concluded that an appropriate programme delivery framework had been achieved. Having a joint venture meant that a range of skills, resources and networks could be easily accessed. However, the programme management group felt that there needed to be some financial recognition for their time and travel costs (neither of which were reimbursed).

The role of kaiāwhina was absolutely essential to the success of the programme. However, three kaiāwhina left the programme (e.g. due to illness) which caused difficulties, and it was also problematic finding kaiāwhina who were able to deliver nutrition messages fluently in te reo. There was also a high turnover of marae workers for a number of reasons (including some gaining the confidence to take up further higher education opportunities or full-time employment).

The information resources that had been developed were well received, though it was suggested more could be produced in te reo, and a wider range of posters, recipes and pamphlets could be available.

⁷ The evaluation research co-ordinators had trained local people to be "community researchers" in order to conduct some of the interviews.

There was also feedback that there had been a significant change in food offered at participating marae, with more wholemeal bread, fruit, vegetables, lean meat, cereals and water being available instead of less-healthy options. Providing healthier food also led to expectations that this practice would be continued, with complaints being made if it was not. Marae visitors too, appreciated the healthy food that they were served. The majority of participating marae also went “smokefree” because of the programme.

Schools where kaiawhina had spoken also reported that their students were bringing healthier snacks and lunches to school, and were more often having breakfast. Two schools even made soup from their own vegetable gardens that they served in “soup kitchens”. Targeting children was felt to be a good investment because they were more flexible in their eating habits and had a strong influence on other family members.

Food hygiene and safety messages (especially those related to storage) were also felt to have been effective in marae, homes and schools.

However, lack of access to fresh fruit and vegetables in some of the more isolated communities, and a lack of kitchen equipment such as chillers and stoves were believed to be barriers to eating healthy food for some East Coast Māori. Some of the marae workers could also have benefited from more support from their marae.

Overall, Te Taro o Te Ora was judged to be a success, particularly with respect to the level of community involvement and ownership for the programme that was achieved.

Kai Oranga Tinana Mo Waipareira

Another community nutrition programme for Māori was established in 1994 at Wai Health in West Auckland. 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 disestablished (Moewaka Barnes et al. 1998b).

Like Te Pataka o Te Tai Tokerau in Northland (see below), Kai Oranga Tinana Mo Waipareira was developed as a certificated training

programme in kai and nutrition for community workers.⁸ A total of 67 people graduated from the 1996 and 1997 courses. However, after 1997, there was a greater focus 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.

The programme evaluation consisted of: participant observation; analysis of practitioners' hui; analysis of documents and resources from the training programme; and interviews with key informants and training graduates, mainly conducted by a community researcher nominated by Te Whanau o Waipareira Trust.

The programme's goals were:

To empower and increase community workers' (paid or voluntary) nutrition knowledge and skills so they will have the confidence to disseminate nutrition information to those in the community whom they work with and for (Moewaka Barnes et al. 1998b: 16).

The evaluation concluded that the programme had met these goals, and had delivered services in the ways it had intended. An extensive consultation process and needs assessment completed before the programme began ensured that it was appropriate for the local community, and had a strong sense of community ownership.

The training programme was well run, provided a high standard of information, was delivered using a Māori framework and produced graduates who were enthusiastic to use their new knowledge to improve their own health and the health of their whanau and marae members. In addition, many of the graduates who were already working in other settings applied the skills they had learnt to their workplaces, including community services and Te Whanau o Waipareira Trust itself. For other graduates, the qualification also opened up employment opportunities (for instance one graduate was eventually appointed as one of the co-ordinators).

A range of other community activities took place including resource and newsletter production, media advocacy, community food skills sessions, competitions, visual displays, policy development and networking with community groups.

Key informants believed that a number of changes had occurred in local people's eating habits and in the kind of food that was provided. For instance, in kohanga reo, children were perceived to be eating more fruit instead of biscuits and chips, and were drinking more water instead of

⁸ The courses were certificated by AIT (the Auckland Institute of Technology - now Auckland University of Technology).

soft drinks. Local families were more aware about what kind of food was healthy and economical, and they tended to be eating less fat, sugar and salt than before. Te Whanau o Waipareira Trust's café was also offering much healthier food, although, because it was open to the public, it continued to sell less healthy options as well.

It was felt that it was entirely appropriate that Te Whanau o Waipareira Trust had taken over the sole administrative role in 1997 as it reinforced the sense of Māori ownership of the programme. However, there was some concern that the disestablishment of the management committee may cause problems later on.

Plans for the future included extension of activities to sports clubs, exercise programmes and people who did not belong to the networks in which the programme was already active.

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 initiative had been named "Te Pataka" after consultation with local Māori (Moewaka Barnes et al. 1998a).

The programme aimed to provide a training programme in basic nutrition in order to produce Māori "community nutrition advisors". Each iwi area was to have a co-ordinator, appropriate teaching resources were to be developed, dental health issues were to be addressed, and marae-based sessions on topics such as budgeting, cooking, diet, and meal planning were to be run.

A programme co-ordinator, belonging to Ringa Atawhai and from Tai Tokerau, was appointed from the beginning of 1995, along with a (Pakeha) dietician to help with programme development and the training of the community advisors. By 1997, no dieticians were linked to the programme.

The programme evaluation was carried out in the same way as that of Kai Oranga Tinana Mo Waipareira; that is using participant observation, a practitioners' hui, analysis of documents and other resources and key informant interviews (see above).

As planned, AIT-certificated training programmes took place, with 63 advisors graduating over two years. The course was judged by graduates to have been very informative, useful and delivered in an appropriate way and at accessible venues (e.g. marae). However, some

of the younger 1997 graduates would have preferred the input of a dietician to provide more in-depth technical expertise for their course. Graduates had used their knowledge, particularly with their whanau and marae, and to a lesser extent in other situations, such as kohanga reo, schools and churches.

Isolation of some community advisors led to support groups being set up in some places after courses had finished. While many of the graduates would have liked to continue their education in nutrition, a lack of appropriate training institutes in Northland was perceived as a barrier.

Several of the women on the courses said they now had more confidence in participating in decisions regarding kitchen facilities at marae - previously mainly the responsibility of men.

Other programme activities in Northland included: developing resources; visual displays; community nutrition sessions; media advocacy; creating healthy environments; and linking with school gardening projects, diabetes initiatives, and alcohol and smokefree policies.

Like the other three community nutrition programmes, key informants in Northland believed there had been positive changes in local people's eating patterns, with less fat, sugar and salt being consumed by families and healthier food being offered at marae. Dietary changes also included eating smaller meals, cutting the fat off meat and an increased consumption of water and salads. In addition, some interviewees mentioned that they had been trying to persuade local shops to stock healthier alternatives, such as canola oil.

Key informants said they looked forward to a time when Te Pataka was unnecessary, when healthier eating habits became part of everyday life.

Otara Health and Housing Initiative

This was a joint health and housing initiative between the Manukau City Council, Housing New Zealand and the Department of Work and Income. It was co-ordinated and supported by Otara Health Inc. in 2000. The scheme aimed to carry out a six-month campaign in order to “provide Otara residents with clear information about housing matters which affect their health and well-being” (Haigh 2000: 1).

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 socio-economically deprived area of 1960s and 1970s state-housing. Ambassadors talked about health and housing issues with residents, and provided them with information and made referrals to other agencies.

A formal evaluation was conducted as part of the programme (Haigh 2000). It recorded the ambassadors’ activities over 25 weeks during March to August 2000. During that time, the teams visited 7,191 houses. Of these, a quarter were not able to be accessed because they were not occupied, no-one was at home, or gates were locked or guarded by dogs. A further nine percent of households were not interested in receiving advice. However, nearly a half of the remaining 4,694 households took part in “full interviews” with the ambassadors, and just over half were given information following a discussion.

The ambassadors also made a large number of referrals to other agencies (481 in total). These were mainly to Housing NZ (346), especially in relation to housing maintenance. Another 58 were referred to the Fire Service for installation of smoke alarms in private houses. Other referrals were made to the Department of Work and Income (31), Crockers Property (30), Manukau City Council (11) and the Housing Tribunal (5).

The ambassadors also supplied rat and mice baits to 229 households that required them (demonstrating a significant rat and mouse problem in the area). Another issue was that many residents did not know about the weekly paper (recycling) collection in the area - the ambassadors gave them information about this.

Householder survey

To obtain consumer feedback, 87 householders, already visited by ambassadors, were randomly selected and interviewed about their views of the scheme. All 87 interviewees remembered the ambassador's visit. The issues that they most commonly remembered discussing with the ambassadors were rat and mouse infestations (97%), fire prevention (88%), rubbish disposal (including car bodies) (88%), house maintenance (78%), heating and dampness (71%) and (welfare) benefits (71%).

The vast majority (95%) said they had found useful the information they had received. Half of those interviewed were able to identify housing and health problems, the main ones cited being: house maintenance, rats and mice, fire alarms and welfare benefits.

The 87 interviewed householders were also asked about how they would prefer to learn about housing and health issues. Their preferences are listed below:

- health and housing visitor (62%)
- TV (61%)
- newspapers (40%)
- pamphlets (34%)
- radio (33%)
- health professional (32%)
- friend or family (20%).

Overall, over three-quarters of householders indicated they had a positive attitude towards the scheme.

Feedback from agencies

Staff of the three key participating agencies (Department of Work and Income, Housing NZ and Manukau City Council) were also interviewed. These agencies had provided resources, ambassador training and had accepted and dealt with referrals.

They felt that Otara Health's co-ordinating role and community-development approach had been very successful. It was felt that "local solutions to local problems" were being used, locals were being trained and employed, and information was being given to local residents. Co-operation between agencies had been good, and the campaign fitted in well with the government's "Closing the Gaps" policy.

They suggested that a folder be available to hold the various pamphlets and information sheets that were given out, and that Otara Health Inc. should be acknowledged on this material.

In addition, Otara CAB and Otara Budgeting both gave their endorsements to the scheme, saying they had an increase in the number of clients as a direct result of ambassadors' visits.

Strengthening Families

The first of the case-management-type of intersectoral initiatives for health discussed in this report is Strengthening Families.

Strengthening Families is an intersectoral policy initiative introduced by Government in 1997 to improve the overall well-being of families considered to be “at risk”. In the beginning the initiative involved only the Ministries of Health and Education and the Department of Social Welfare. However, it now includes a large number of other government and non-government agencies (Richardson 1999; Strengthening Families nd.).

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’ abilities to resolve difficulties and problems. Central to this is promoting clearer definitions and better collaboration between the health, education and welfare sectors, both locally and nationally, and better use of existing resources (Strengthening Families nd).

Over 50 local management and co-ordinating groups for Strengthening Families have been set up in different centres throughout New Zealand.

In addition, Northland, Porirua/Hutt Valley and East Cape have been identified as priority geographic areas for generating initiatives aimed at increasing participation in early childhood education services, primary and secondary schooling, use of primary health and dental services, and immunisation.

A variety of intersectoral projects and programmes have been developed and implemented under the Strengthening Families banner. They include Collaborative Case Management, Social Workers in Schools and Family Start (known as “Early Start” in Christchurch, where it originated), all of which use case-management as their main strategy.

Collaborative case management

This initiative aims to formalise and enhance intersectoral collaboration and co-ordination across a number of governmental and non-governmental services. Joint agency meetings with families, and the funding of a co-ordinator in some places (like Christchurch) are two of the main strategies being used (Strengthening Families nd).

Collaborative Case Management has been the subject of two completed evaluations:

A Christchurch evaluation surveyed (using written questionnaires) 81 workers from a variety of agencies who had been involved in Strengthening Families cases. Three focus groups of 24 people from 16 agencies; and 14 interviews with members of the local management group and national co-ordination team were also conducted (Richardson 1999).

Comments on Collaborative Case Management were also obtained in a subsequent national postal survey of 643 health, education and welfare workers who had previously undertaken Strengthening Families training (Visser 2000).

- Similar themes emerged from both the national (Visser 2000) and Christchurch (Richardson 1999) evaluations. In general staff were very supportive of the Strengthening Families concept and its emphasis on interagency collaboration. While many staff felt they were already collaborating with other agencies before the Collaborative Case Management initiative began, the initiative was thought to enhance the quality (but possibly not the frequency) of collaborative interactions and outcomes for families were perceived to have improved as a consequence.
-
- Factors contributing to the effectiveness of Collaborative Case Management that staff identified included the commitment of participating agencies to the Strengthening Families concept and the opportunity it gave them to meet, network and communicate openly with people from other agencies. Other factors were the way the initiative enhanced their ability to clarify issues, develop a shared vision and plan for families, and share work and resources with other agencies. Having a local co-ordinator was also seen to be very effective and essential for the success of the initiative, as was using neutral facilitators for meetings. In addition, staff noted that the initiative had dovetailed well with existing infrastructure and systems and had encouraged greater accountability.

Some problems and obstacles were also identified. These included: finding time to meet and work with other agencies; heavier workloads (Collaborative Case Management increased workloads, although most believed it was worth the extra effort); and insufficient resources to support the initiative.

The attitudes and lack of commitment of individuals from other agencies were also problematic on occasions, evidenced by not attending scheduled meetings and failure to undertake promised action. Staff also noted other obstacles, such as poor communication, the Privacy Act

preventing the sharing of information with other agencies, and differences in the philosophies and cultures of other agencies. In addition, staff observed that some families could feel overwhelmed and disempowered by the Collaborative Case Management process.

Other issues identified by the evaluations included a lack of responsiveness to Māori and other cultural groups, difficulties in implementing the process in rural areas, and the suggestion that the initiative could be diverting resources away from other families considered to be less “at risk”. It was also found that Child Youth and Family’s lack of resources meant they sometimes “passed the buck” to other agencies, did not attend meetings and had inexperienced staff participating.

Further findings from the evaluations were that national initiatives were being developed without local consultation about priorities and that some local management groups were becoming too large and unresponsive. It was also noted that the initiative lacked a process to evaluate outcomes

Social Workers in Schools

Social Workers in Schools (SWIS) is an initiative led by Child Youth and Family. It provides social workers in 56 schools in Northland, East Coast, Porirua-Upper Hutt and targets Decile 1-5 primary and intermediate schools. As well as contributing to the overall goals of Strengthening Families, such as co-ordinating social services for school students and their families, the initiative also aims to “close the gaps” between Māori and non-Māori (Belgrave et al. 2000; Strengthening Families nd).

There is one completed evaluation of Social Workers in Schools (Belgrave et al. 2000). It was conducted by three regional research teams and involved three distinct research phases:

Phase One consisted of semi-structured interviews with providers, social workers, principals, teachers and agency representatives before, or just as, SWIS was being introduced. At the same time; paper-based records were reviewed to collect evidence on school suspension levels, expulsions, academic achievement, rates of referral to Child, Youth and Family, staff and student turnover, school health profiles, and levels of “inappropriate” behaviour.

Phase Two consisted of telephone follow-up interviews four to five months later with staff and a further review of paper-based records (although this record-keeping system was abandoned during the evaluation); interviews with students and their caregivers

Phase Three consisted of interviews with staff on site; interviews with clients; and the collection and analysis of quantitative data on outcomes.

- The evaluation concluded the service was needed and had attracted a high level of use. It also identified a high degree of satisfaction with the service amongst the students and families who had used it. Families preferred to work with school social workers they knew, rather than with social workers from outside agencies they had never met before.
- Referrals to the service came from both schools and families themselves. Social workers were regarded as playing an especially valuable role when referrals were made on to CYFs.
- The evaluation found that the initiative worked best in schools that were enthusiastic about the service, where social workers were frequent visitors (or based in the school) and were well-known to children, and where good relationships had been established between principals and social workers.

The initiative also worked best in schools where the social worker was seen to be responding to the needs of the community, was child-focused and family-centred, acted independently when there was a conflict between students and schools, and addressed the needs of both high risk and lower risk families.

The provision of Māori and Pacific social workers was identified as have a major benefit to mainstream schools, where the principals are often Pakeha. The Māori and Pacific social workers had strong links to the local community and an ability to access resources and appropriate processes. They also had important roles within the school relating to supervision, training and staff development.

The evaluation noted that the Social Workers in School model contained sufficient scope for both “bottom-up preferences” as well as “top-down requirements” to be addressed.

- Generally, social workers worked effectively with public health nurses. In addition, social workers with local knowledge, but without formal qualifications were able to work well.
- The evaluation found the initiative did not work as well in schools where there was a lack of enthusiasm for the programme or a lack of clarity about the role of the social worker, where the social worker was unable to spend much time at the school (e.g. because of the large geographic spread of schools) or was hard to contact. In addition, in some cases personality differences between a social worker and

school staff prevented the development of good working relationships. As well, in some schools the continuity of the service was disrupted by changes in personnel.

- Another issue highlighted by the evaluation was that some school-based social workers tended to feel isolated and lacked supervision if they weren't working in teams. There was also a risk their safety might be compromised when working in isolated areas.
- The evaluation also found inconsistency among schools about what types and severity of situations were appropriate for social workers to deal with. Some referred basic school administrative issues to the service (e.g. non-payment of school fees), while others referred students only for very serious matters.
- There was low participation in the initiative by kura kaupapa Māori because of perceptions that SWIS was an outside, mainstream service, and an expectation that social workers in kura kaupapa Māori should be competent in te reo.
- The evaluation also found early warning referrals were not always possible because of the partial involvement by some schools and the problems of covering rural schools. In addition, partnering workshops required principals to be away from their schools for two days, and did not always result in partnership agreements between schools and social workers (often because staff from government agencies lacked the authority to commit their organisations to certain activities).
- According to the evaluation, there was little evidence that relationships with other agencies was enhanced by SWIS (i.e. no new relationships were established). The exception was public health nurses and when social workers had contracts with other agencies they could bring in, or when schools already had other services provided from them.
- The evaluation found that only a few social workers participated in Collaborative Case Management meetings under the Strengthening Families model.
- It was also noted that referrals to CYF increased in some areas because of the presence of SWIS, increasing its workload. In addition, there were concerns about the boundaries between SWIS and CYF's work and responsibilities. There were concerns, too, that written records were not always as comprehensive as they should have been. Workers tended to regard them as repetitive and cumbersome.

- The evaluation made several recommendations. One was that social workers should provide regular, written reports to principals about the work they have done in their own schools and across all schools. Another was that partnership agreements should be regularly reviewed. It was also recommended that protocols and record keeping systems should be more responsive to children's needs, and that children, caregivers and community agencies should be regularly informed about what SWIS services are available and how to access them. Other conclusions were that, while principals were keen to employ their own social workers, this could reduce the latter's independence in matters involving the school and confidential records.

Family Start / Early Start

Family Start is a home-visiting, early intervention programme for children currently operating in around 17 sites. The initiative is currently being evaluated, though to date (May 2001) no evaluation reports have been completed.

Early Start

In 1995, the forerunner of Family Start - known as Early Start - was introduced in Christchurch. It was based on Hawaii's Healthy Start initiative (Duggan et al. 2000; Fergusson et al. 1997; Fergusson et al. nd). Since then, Early Start has become part of the Strengthening Families initiative and has been extended to other New Zealand locations under the name of Family Start (Strengthening Families nd).

The programme is a home-based family support system aiming to meet the needs of high-risk families and their children. The Christchurch pilot programme was run by a consortium including the Family Help Trust, the Christchurch Health and Development Study, the Plunket Society, Pegasus Medical Group, and Māori representatives.

Families were recruited to the programme by way of a three-step process: (1) identification of at-risk families by Plunket nurses (2) a one-month probationary period (3) an in-depth needs assessment and informed consent procedure.

- Participating families were assigned a Family Support Worker who contacted them through home visits and telephone calls in a mentor/advocate role. The Family Support Worker assisted families with:
 - preventive child health activities (like immunisation, breastfeeding)
 - improving maternal well-being
 - parenting skills
 - family economic functioning
 - crisis management.

In a pilot for the programme, 51 families were followed for an 18-month period. Data were collected, case histories reviewed and 39 families completed written questionnaires after 12-15 months of the programme (out of 46 who were enrolled at the time).

During the pilot a great deal of service co-ordination and rationalisation occurred. Family Support Workers developed systematic family support plans and helped with many referrals to other agencies. Some families had as many as 20 agencies dealing with their problems.

The programme was also found to be effective in encouraging preventive child health practices such as breastfeeding, non-prone sleeping, use of car restraints, ensuring hazard-free environments, and obtaining GP visits when required.

- As well, the pilot successfully addressed maternal depression by encouraging mothers to seek appropriate medical treatment.

Other benefits included improved child-rearing skills and reductions in the risk of child abuse (there were no hospitalisations for this during the pilot). Physical violence between partners also declined. However, it was unclear in the pilot whether these three particular outcomes were due to the Early Start programme or other factors.

- There was a high degree of client satisfaction with the programme, with most families believing the programme had helped them significantly and that it was culturally-appropriate.
- Three factors were found to have inhibited the effectiveness of the pilot to some degree. The first was that support services were regionally-based, meaning they were unable to help families who moved. The second was that a few families did not get on with their Family Support Worker. The third was the difficulty of influencing long-standing problems of parents such as smoking, drug and alcohol abuse, relationship problems and economic circumstances (income, employment, budget skills).

Family Service Centres

Government funding to establish six pilot Family Service Centres was announced in the 1993 Budget. The six centres were to be 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 socio-economically disadvantaged families with young children from a dedicated “one-stop-shop” facility (Kennedy 1994; Ministry of Health 1997).

Aims of the initiative

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 down the track. 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 Māori 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, and increasing families’ access to existing services (Kennedy 1994).

“Critical success factors” identified for the centres included the provision of a range of integrated services including early childhood education, a home-based instruction programme for pre-schoolers, 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. Staff at each centre included a part-time or full-time manager. Access to the centre services was free or involved only a very minimal charge. Emphasis was put on providing culturally appropriate services and consulting local people about how the centres should be developed and run.

The establishment process for the pilot centres was managed by a Government interdepartmental steering committee set up specifically for the purpose. A competitive tendering process was used to select provider groups at each location.

An overview paper published at the time noted “some resistance from provider groups to the imposition by Government of a service model they had no part in developing” (Kennedy 1994: 79). As well, some organisations who were unsuccessful during the tendering process became critical of the initiatives, increasing factionalism between provider organisations in the local communities. The high level of funding provided to the centres (both for capital expenditure and ongoing running costs) was another controversial topic.

Evaluation findings

Four years later, in 1997, a comprehensive evaluation report on the initiative was completed. The report emphasised that its findings on the effectiveness of the Family Service Centre model were tentative rather than conclusive. This was because the evaluation was finished before the full implementation of all six pilot centres. As well, there had been difficulties obtaining robust quantitative evaluation data on many aspects of the centres’ activities and their outcomes. Cautioned the evaluation report: “Findings are open to a number of interpretations, and in most cases there is insufficient evidence to conclusively point to one interpretation” (Ministry of Health 1997: 222).

While the Family Service Centre model “had a brief with broad specifications” (Ministry of Health 1997: 220), fundamental to it was engaging families from the target groups and facilitating positive changes in the lives of these families using multifaceted services.

The evaluation found there had been considerable delays in the implementation of the pilot centres. By the end of 1996, only two of the six new centres were operating the four core services. As well, considerable variation in service and programme development was apparent across the pilot sites. Implementation was either delayed or complicated by several factors including the slow development of operational policies, the complexity of the negotiation processes involved, the multiplicity of accountability and reporting relationships that needed to be worked through, tensions surrounding the implementation of a centrally-determined and highly prescribed model to be delivered by community-based providers, and problems communicating information between central government joint agencies and family service centre personnel. The evaluation concluded that the proposed six-month timeframe for the establishment of centres had been unrealistic.

Assessing the ongoing, day to day work of centres, the evaluation found that five of the seven centres had successfully engaged a high proportion of low-education, benefit-dependent families. Four of the seven had engaged a high proportion of Māori and Pacific families. Centres located in the heart of their target communities and populations had better success at engaging these people than other centres located on the periphery. Participants at centres were found to be primarily female caregivers and their children. Generally there was a low level of participation by men in Family Service Centre programmes and services.

The evaluation also noted that the ongoing work of the centres was impeded by “long communication and decision-making chains”, the “slow development of operational policies” and “lack of integration at the funding and contracting level”. Integration between the different services within each centre was judged to be generally quite low, with each service maintaining its own identity. This was thought to be fundamentally a result of each service having different contracting organisations, funding and accountability arrangements. Because accountability was not to the centre as a whole but to specific services within it, this impeded aspirations by Family Service Centre personnel to work more closely with each other and share tasks and responsibilities in ways that would have added value to the overall centre operation.

A key conclusion of the evaluation was that, in future, prior to deciding on the location for a “one-stop-shop-type” Family Service Centre facility, it would be important to undertake a thorough needs analysis. In addition, flexibility should be allowed in the Family Service Centre model so that alterations could be made to suit local circumstances and community requirements.

Another key conclusion was that separate funding streams also did not provide incentives to work in an integrated manner. The evaluation called for greater flexibility in contracts “... to allow funding from different streams to be used across different core services, where these services are providing integrated functions” (Ministry of Health 1997: 252).

Wraparound Services

Wraparound services are 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 are based on the Vermont model of individualised care which provides 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 that is 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.

Health Camps pilot Wraparound programme

In New Zealand, a 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 have since changed the name.⁹ They also 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) (McClellan 1997).

The Health Camps Pilot Wraparound Programme selected clients using a number of criteria. Children were 5-12 years old, lived in the two health camps’ catchment areas, had multiple emotional and behavioural problems, and often needed 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.

⁹ The Health Camps Wraparound Service was renamed “The Co-ordinated Family Care and Support Programme / Tui Tui Nga Teaki Whanau, Me Te Awhina” (McClellan 1997).

An evaluation reviewed records and case files, interviewed programme staff and parents, and sent questionnaires to outside agencies that had been involved with the Wraparound clients and their families (McClellan 1997).

A smaller number of families than expected (14 instead of 20) had made use of the health camps Wraparound service by the time of the evaluation (the end of June 1997). Nevertheless, there was a high degree of satisfaction from caregivers about the parenting skills they had learnt and the improvement in their children's behaviour.

Co-ordination between health camps and outside agencies (mainly schools, psychologists, and public health nurses) had also improved, and these agencies were generally "satisfied with the quality of the working relationship established between themselves and the Camps" (McClellan 1997: iii). Other positive features of the programme included its comprehensive range of services, its flexible, individualised approach, the involvement of families, and the availability of ongoing support. The only perceived weaknesses were the lack of a 24-hour crisis service and the lack of Māori / Pacific advisory input at Pakuranga Health Camp.

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 covered by the group included Youth Affairs, Justice, Education, Social Welfare, Te Puni Kokiri, Police, Health, Courts and Internal Affairs (Warren 2000).

The pilot programme was run by Te Whanau 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 local¹⁰ young people aged 13-17 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 / whanau
- physical or mental health problems (including unplanned pregnancies, drug and alcohol problems, suicide attempts)
- risk behaviours such as dangerous driving
- conduct disorders.

¹⁰ Enrolled, or eligible to be enrolled, at six local secondary schools in Otara and Mangere.

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” (WAG). 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.

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” (Warren 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
- drivers’ licence training
- anger management
- exercise programmes
- outdoor pursuits courses
- health services
- legal advice
- motivation and self-esteem courses.

A comprehensive programme evaluation consisted of: document and case file reviews; interviews with key stakeholders; interviews and focus groups with service providers and clients; and interviews with caregivers (Warren 2000).

The evaluation found that Wraparound succeeded in providing services to around 200 of its target client group. Referrals to the programme were made by a variety of agencies, and its services were very acceptable to clients, who were generally highly satisfied with their experiences of Wraparound. The fact that it was a voluntary programme, which encouraged clients to set their own goals, contributed to this satisfaction.

Case managers usually established good relationships with clients, and both clients and their families believed there had been improvements with regard to family issues and in young people’s attitudes and behaviour. For instance, their at-risk behaviour, connection with the education system, health and well-being all improved. There were also fewer problems with family / whanau relationships and violent behaviour. Some clients also achieved educational goals. In general, clients wanted Wraparound to continue and were concerned about the possibility of it stopping.

Case managers believed the approach of drawing on the strengths of clients and their families was critical to the programme's success. High contact hours and caseloads of 12 or less were also seen to be important (although some case workers had caseloads of up to 14 during some stages of the programme). Working with families at an early stage was also cited as being essential.

However, initially there was a great deal of criticism of the programme from other agencies (mainly unsuccessful bidders) when the contract was awarded to Te Whanau o Waipareira Trust. The fact that the provider came from West Auckland (rather than South Auckland) and was Māori (rather than Pacific) were factors that some agencies took issue with.

While Wraparound staff saw developing ways of working collaboratively with other agencies as essential, the programme met with hostility from some quarters. Criticisms included: a perceived failure of the service to communicate, share information and collaborate with others (this appeared to be a two-way problem); the turnover of case managers; and aspects of the client-selection process. Interestingly, Wraparound staff were at first keen to collaborate with Strengthening Families schemes, but eventually felt that Strengthening Families was not culturally-appropriate, did not have a family focus, used unskilled staff and relied too heavily on government agencies.

Another explanation offered for the poor working relationships between the services in the area, including Wraparound, was the competitive environment in which they all worked. This competitive environment made it more difficult for the various support agencies to trust one another (Warren 2000: 90).

Other problems with Wraparound included: contractual issues; the difficulty in attracting skilled staff (especially Māori and Pacific); a gap in drug and alcohol services to which young people could be referred; non-attendance at WAG client-referral and selection meetings (which led to WAG operating only intermittently); and Wraparound's relatively short time frame (2¼ years for the programme, one year for clients).

Chapter Three

Key Determinants of Effective Community-based Intersectoral Action for Health

This section summarises and illustrates factors identified in the literature as important for determining the effectiveness or “success” of community-based intersectoral action for health.

The factors have been identified using the mainly New Zealand community-based initiatives presented above, as well key overseas reports that look closely at factors shaping the effectiveness or “success” of intersectoral action for health.

Three overseas reports in particular have been useful for this.

The first is *Working Together: Intersectoral Action for Health*, a publication of the Australian Commonwealth Department of Human Services and Health (Harris et al. 1995). This aims to “give straightforward guidance to practitioners about the analysis of the complex factors that are crucial to the development of effective working relationships with other sectors” and to “identify some of the conditions that are critical to the success of intersectoral action” (ibid: 2). The report, which took over a year to complete, was prepared by a team of researchers from the University of Sydney, based on a review of literature and consultation with experienced practitioners in health promotion, community development and public health, both in Australia and other countries.

The second is *Intersectoral Action Towards Population Health*, prepared by Canada’s Federal-Provincial-Territorial Advisory Committee on Population Health (FPTAC 1999).

The third is *Effectiveness of Coalitions in Heart Health Promotion, Tobacco Use Reduction and Injury Prevention: A Systematic Review of the Literature 1990-98* (Kuhn et al. 1999). This report, which is widely cited in the recent international literature, was prepared by the University of Ottawa’s Community Health Research Unit (CHRU), funded by the Ontario Ministry of Health. It closely examines factors associated with the effectiveness of 20 community-based intersectoral initiatives (known as “coalitions” in Canada).

General framework

For ease of understanding, the information presented here is organised under six main headings. These headings correspond closely to the six over-arching requirements for effective intersectoral action for health identified in *Working Together: Intersectoral Action for Health*. The six requirements are:

- (1) sectors or organisations (including community groups) recognise the necessity to work together to achieve their goals
- (2) there is support in the wider community for action
- (3) the participating sectors or organisations each have the capacity to take action
- (4) relationships enabling action are defined and developed between the participating sectors or organisations
- (5) actions are planned and implemented to the satisfaction of each participating sector and organisation
- (6) systems are in place for demonstrating whether or not the expected outcomes are being achieved and sustained

Clear agreement exists on the necessity for intersectoral action

A key requirement for successful intersectoral action involving any kinds of organisations or groups is getting their agreement that working together is necessary and desirable. This includes securing agreement that the risks involved in working together are worth taking and that working together will be more effective and sustainable than working alone (Harris et al. 1995).

It must also be clearly apparent that working together will directly benefit each organisation or group by helping it achieve its core goals (Harris et al. 1995; Murphy and Thomas 1999).

Working Together notes that any organisation's goals, priorities and range of activities tend to be based on what it perceives to be its core business. Typically, engaging in intersectoral action for health will not be regarded as part of an organisation's core business, especially by people higher up in the organisation, who are more likely to be accountable for what an organisation does. They may perceive intersectoral working as potentially risky because it involves the loss of some freedom to act independently and the 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).

As we have seen, one factor contributing to the suspension of the Christchurch Healthy City project was 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 (Visser 2000, Richardson 1999).

For instance, in the Health Promoting Schools initiative, Northland and Auckland schools only had a very short time to decide whether or not 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 this (Wyllie et al. 2000).

Compatibility of partners

A crucial first step in this commitment building process is identifying and involving the key organisations and groups who it is hoped will work together on the initiative. Ideally these organisations and groups should have some compatibility in attitudes and social outlook, plus, if at all possible, a history of working together constructively in the past, as these have both been found to be factors conducive to more successful intersectoral working (FPTAC 1999).

In the Health Promoting School initiative, schools with an existing ethos consistent with Health Promoting School concept found it easier to introduce the scheme (Wyllie et al. 2000).

The literature also suggests that an organisation with a history of innovation and successful co-operative action is more likely to be a supportive partner in intersectoral action than one in which there is “low organisational morale or a history of failure” (Harris et al. 1995).

Alignment of purposes

Other work might include some kind of process for identifying and stimulating common underlying values and interests, and aligning purposes (FPTAC 1999; Angus 1999). Essentially this involves developing a shared vision of what the new initiative is aiming to do in terms of improving general health and other-related outcomes.

More particularly, it is important that the purpose of the intersectoral initiative is both clearly articulated and 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 offer a “win-win” situation where each participant plainly gains something from being involved. This is contrast to situations where the initiative simply represents an exercise in bureaucratic “imperialism”, with one sector aiming to persuade other sectors to help fulfil its agenda.

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 within the participating organisations (FPTAC 1999).

Partners not passengers

Working Together notes that in initiatives where the participating organisations do not all see benefits for themselves in working together, there is a risk that some organisations will become passengers in the intersectoral action. Although they may *seem* to be involved, in fact they do not contribute resources or show a high level of commitment. Instead they keep involved simply to make sure they do not lose resources, or to learn what other organisations are doing, or to gain reflected glory by having their name associated with an initiative.

Work In less risky areas first

In some cases the risks that organisations might see in working intersectorally can be minimised by starting out by working together in less risky areas. This can help build trust and understanding before working together on larger ventures involving greater interdependency.

Support exists in the wider community for action

Working Together identifies a second key determinant of successful intersectoral action - the presence in the wider community of factors that lend broad support to the overall direction and goals of the intersectoral action. All kinds of factors can be important here (Kuhn et al. 1999). Those singled out in *Working Together* include the political context, the economic context, organisational features, the sociocultural values of the community or population in which the initiative is being developed, and the timing or location of the intersectoral action.

High level political support

Working Together observes that intersectoral action for health is more likely to be sustained if it is high on the political agenda or mandated at different levels of government, in such things as national policies, reports and legislation (Harris et al. 1995). Getting politicians to stake out a commitment to the initiative and become involved in its development can be part of this (FPTAC 1999). Clear expressions of political support at the top level of central or local government can play an important function in stimulating and legitimating the actions of partners in an initiative.

This point is further developed by Angus (1999), drawing on his experience with the Strengthening Families initiative. He recommends that future intersectoral initiatives along these lines 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, etc).

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

Lack of political support at the central government level has been identified as a major dimension lacking in the NZ Healthy Cities projects

and probably an important reason why several of these projects folded (Randle and Hutt 1997).

At the local level, the presence of political support from elected officials such as Mayors and councillors can also be important. In Plymouth, UK, the commitment of local politicians to Area-Based Initiatives when the council changed from Labour to Conservative (Office for Public Management 2001).

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

One reason why the Kawerau Community Injury Prevention initiative was found to be less successful was 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, planning and staff development (Coggan et al. 1998c).

On the other hand, securing central or local government involvement and mandate for an initiative also has its attendant risks. In the UK's Health Action Zones, for example, central government directives have at times over-ridden local processes. When Health Action Zones were first set up, it was agreed that each Health Action Zone would identify their own priorities for action. However, Health Action Zones were subsequently all instructed by Government to ensure they focused their work on four specific issues (cardiovascular disease, cancer, mental health and waiting lists). This major shift in emphasis at the central government level led to a rapid undermining of the commitment, confidence and trust that Health Action Zones had established with local collaborating agencies (Bauld et al. 2001).

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

Another risk of securing central or local government support 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).

Even having initiative staff employed by, or based within, a local city council may be potentially problematic. For example, the most recent 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 identified a need for more explicit internal discussion within the Council about what the project co-ordinators could and could not say as Council employees.

More broadly, the success of intersectoral action for health has also been noted to be highly dependent on the existence of a public policy environment that facilitates collective action, rather than an environment in which the dominant ethos is towards individual freedoms and rights (FPTAC 1999).

Supportive economic circumstances

The broader economic context can also be another important factor that can work either for or against successful intersectoral action. According to *Working Together*, in environments where 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, the report adds, on a slightly more optimistic note, that scarcity may also encourage some organisations to try to work more closely together, to make the best use of the resources each has available.

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 paying attention to 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: 16).

Supportive organisational circumstances

According to Harris et al. (1995), another important element of the wider environment that can influence the success of intersectoral action is the organisational context – the ways in which organisations operate and the pressures they experience. If an organisation is under extreme pressure, constantly reactive rather than proactive, it is unlikely to be in a position to participate effectively in the regular rounds of meetings and other relationship building processes involved with intersectoral action.

This was evidenced in the Christchurch Healthy City project, where the introduction of new public sector management systems involving inflexible deadlines, budgetary constraints and cutbacks were 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 concluded that market-driven economic policies and retrenchments in public and private sectors had resulted in local agencies being less able to become involved in community action (Stewart and Conway 2000).

Beliefs and attitudes of target community

The values or beliefs of the people in the communities where the intersectoral action is planned can also be important “contextual” determinants of success. 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. If the core objectives of an intersectoral initiative can be linked in some way to the prevailing concerns or social movements in a community, this can be a positive step towards creating an effective initiative.

A key “success factor” in 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 (Moewaka Barnes et al. 1998a, Moewaka Barnes et al. 1998b, Pipi et al. 1994, Tunks et al. 1998).

Timing and location

Other contextual factors 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 can also be 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”. *Working Together* notes, for example, that intersectoral action may be easier to accomplish in rural or provincial centres, “where it is easier to see the impacts of issues, such as drunk driving, and to identify the stakeholders” (Harris et al. 1995). Evidence from the Safer Community Councils initiative supports this, with suggestions that it may be easier to publicise and build support for projects in smaller communities (Gray 1993).

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

Other issues to do with location 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 at the periphery (Ministry of Health 1997).

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).

Other contextual factors

The scope for successful intersectoral action can also be shaped by other contextual factors, such as accidental or opportunistic events (e.g. forest fires or the death of a prominent person), a marked growth in community concern about a particular issue, new knowledge about an effective intervention, new philosophies or changing community values or standards (e.g. acceptability of smoking in indoor environments, or the inspiration or commitment of a lone individual (Harris et al. 1995).

Capacity exists to carry through the planned action

Another key determinant of successful intersectoral action is that each of the sectors and organisations involved has the capacity to sustain the relationships and work needed. *Working Together* identifies three main dimensions of capacity: organisational support; resources; and skilful people (Harris et al. 1995).

Organisational support

This means support for the intersectoral initiative is provided by the people and organisational structures *within* a particular sector or organisation. *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.

Similarly, the World Health Organization identifies strengthened *intrasectoral* action within the health sector as a vital starting point for *intersectoral* 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) have 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 2000).

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 having 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 to be the good leadership shown by individuals within key agencies at many levels. 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 (Wyllie et al. 2000; Dowden and Kalafatelis 1999).

Clear decision-making processes

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

In the most recent evaluation of the Manukau Healthy City project, some respondents noted 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 they were regional or local managers of agencies, with their budgets controlled from Wellington (Hutt and Scott 2000).

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 in the case of 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 to be more compatible with managing the complexities of intersectoral working (Harris et al. 1995).

Capacity of the community sector

The literature generally 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 worthy goal, achieving it in practice can be difficult.

Evaluations of Health Action Zones, for example, 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).

Factors thought to be important in this include community members and organisations lacking the resources necessary to enable them to fully participate in intersectoral processes (Ministry of Social Policy 2000). This can be especially the situation in disadvantaged communities, where a higher proportion of people may be 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.

In some reports, lay people or community organisations complain of not being consulted enough, having little influence over decisions, and not being appreciated for their expertise and experience (Sullivan 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.

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

In the evaluation of the Manukau Healthy City project, participants noted difficulties associated with obtaining signatories and representations from Pacific Island people. Consultation in this area was regarded as “hard yards”, with the project not seen as particularly “well-known” amongst Pacific people.

The evaluation also concluded 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).

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

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

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

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 1999).

A recent 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).

Other studies highlight the importance of carefully assessing existing community capacity before embarking on intersectoral action (Simpson 1999).

Resources

A consistent message in the literature is that effective intersectoral action is heavily reliant on the capacity of participating organisations to devote meaningful resources to the process. *Working Together* defines these as *financial and human resources; information; skills; time; infrastructure; and leadership*. These resources are needed to support the development and maintenance of both the *conditions* that promote intersectoral working *as well as* running the actual community-based projects or programmes that arise out of this intersectoral working (Harris et al. 1995; Kuhn et al. 1999; FPTAC 1999).

Sufficient resources must be in place to enable people from the different organisations involved to meet and build intersectoral action together. Participating in a new intersectoral initiative usually involves extra work on top of what may already be very big workload for some people (Centre for Urban and Community Research 2001).

Resources are also needed for basic infrastructure such as ongoing staff positions, secretarial services and a place for organisational representatives and other participants to meet.

Most intersectoral initiatives involve the employment of at least one full or part-time co-ordinator (Kuhn et al. 1999). Casswell (2000) observes that having at least one paid position in the community is essential for successful community action. Using voluntary labour is thought to make it hard to sustain continuity and a strategic focus.

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).

The Waitakere community injury prevention programme was considered to have been a success partly because it had co-ordinators assigned to the three parts of the project (Māori, Pacific, general) (Coggan et al. 1998c). Appointing co-ordinators from the local community was also judged to be a key element of the success of the Turanganui a Kiwa and Ngati Porou community injury prevention programmes (Coggan and Simpson 1999). It was noted, though, that requiring the co-ordinators to do all their own administration as well as organise activities was detrimental to their performance (ibid).

Likewise, the evaluation of Safer Community Councils concluded 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 Safer Community Council 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).

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

Resources are also needed 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 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.

In general the literature concludes that intersectoral working and effective collaboration is more challenging and complex than working alone and that the level of resourcing provided by participating organisations must recognise this fact (Kuhn et al. 1999).

By the same token, providing realistic funding for a new initiative can sometimes cause resentment among existing services, making communication and collaboration with these agencies difficult for the new initiative (Kennedy 1994; Warren 2000).

Realistic timeframes

Closely linked to the topic of resourcing is the issue of the length of time required to develop and implement effective intersectoral action. A very commonly observed feature of intersectoral initiatives is that effective working relationships and joint action usually takes considerable time to develop, plan and implement (Harris et al. 1995; Kuhn et al. 1999; Casswell 2000). It cannot be expected to happen overnight, especially in situations where participating organisations or people have not worked together before, or where there are a large number of disparate organisations and groups involved.

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

In the case of Health Action Zones, relationship building that initially was expected to take only two or three months to complete has in many instances taken a year or more to achieve. This was particularly the case where there was little local experience of partners working together (Bauld et al. 2001).

HAZ partners also took considerable time to develop structures for services. For instance, the evaluation of HAZ cessation services noted that after one year's operation, in the seven studied HAZs, "some aspects of the service [were] not yet in place, strategies to reach particular target groups were still being formulated, and relationships with other key local agencies were still being developed" (Adams et al. 2000: 31).

The Health Action Zone evaluations also show that maintaining cohesiveness across differing agencies at the local level is reliant on staff putting considerable time into keeping other people in the loop, giving briefings, running planning sessions and generally communicating and sharing.

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 (Wyllie et al. 2000; Dowden and Kalafatelis 1999).

Overseas studies of intersectoral initiatives suggest that funding is required for at least three to five years for effective partnerships to develop. For instance, Sabel (1996) reviewed local partnerships that were operating in Ireland in the 1990s. Sabel cited an evaluation of the "LEADER" rural development programme which found that the main weakness of the (otherwise successful) programme (which ran from 1991-1994) was a lack of long-term funding and an assumption that "working partnerships could be created almost overnight" (ibid.: 8). As a result, Sabel states that the LEADER companies were often fully operational only during the last half or even one-third of their funding period.

Sabel (1996) also describes Ireland's "Operational Programme for Local, Urban and Rural Development" (1994-1999) which provided other initiatives, like Area-based Partnerships and County Enterprise Boards, with longer-term, more secure funding than the three-year agreements they had previously experienced. Sabel sees this as one of the main advantages of the Operational Programmes.

Another example, in the UK, is DETR's review of urban regeneration companies in Liverpool, Manchester and Sheffield (1999/2000). This study (DETR 2000b: 4) recommended that:

the companies should be placed on a longer-term footing as soon as possible and we recommend that the RDAs and English Partnerships be allowed to give that longer-term commitment. Five years would seem a financial minimum and it would be very helpful if the Companies were given revenue support budgets for that timescale.

A three-year evaluation (Geddes 1998, cited by the Ministry of Social Policy 2000), of 84 local partnerships located across Europe (30 of which were studied in depth) found that:

short-term funding (usually three to five years) [was] seldom sufficient to allow partnerships to develop and become effective. The research found that trust, collaboration and reciprocity needed for partnerships to work effectively took considerable time to develop, and could be undermined by insecure and short-term funding (ibid: 42).

This need for sufficient time to be given for intersectoral initiatives to evolve and mature has inevitable implications for organisational capacity and resourcing. As noted above, 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 (1999) observes based on his experience with the Strengthening Families initiative: “A serious foray into collaboration needs a long term commitment of resources, and is not to be undertaken lightly” (ibid: 5).

Implications of funding instability

A lack of stable, long-term funding can be detrimental in several ways. When funding is committed for only relatively short timeframes (say 1-3 years), this can increase the pressure to concentrate on achieving shorter-term or perhaps more limited goals, in order to prove “effectiveness” and secure further funding (Bauld et al. 2001). This can overwhelm the work aimed at achieving longer-term goals.

A lack of stable funding can also undermine the confidence of workers and other collaborating agencies. Part of the difficulty in attracting skilled case managers was attributed to the fact that the South Auckland pilot Wraparound service had a relatively short time frame (2¼ years) (Warren 2000).

Funding uncertainties can also result in staff spending most of their time fund-raising, rather than getting on with their core tasks (Bauld et al. 2001).

In the United Kingdom, one destabilising feature of Health Action Zones is said to be the fact that they are persistently labelled as “pilots” or “trials” rather than being “mainstreamed” and accepted as a core programme with a solid future (ibid).

These kinds of issues have 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).

Personal skills

The personal attributes of the individuals involved at the front-line of the development of intersectoral action are recognised to be another important determinant of success. *Working Together* concludes that 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 (accessing and packaging information, briefing appropriate people, handling publicity and media, etc.) (Harris et al. 1995).

Individuals representing organisations in intersectoral action should also understand the issues involved and the wider context in which they are working, including the community and community interests (Harris et al. 1995: 95). A good strategic and operational knowledge of existing community infrastructures is important, too (Henderson 2001)

Training opportunities, or management practices that encourage and reward expertise in working intersectorally, can be useful for fostering these skills in an organisation or group.

The Christchurch Healthy City project’s lack of success has been 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).

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 (Wyllie et al. 2000; Dowden and Kalafatelis 1999).

A key success factor identified in the Turanganui a Kiwa community injury prevention programme was 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 Māori (Moewaka Barnes et al. 1998a, Moewaka Barnes et al. 1998b, Pipi et al. 1994, Tunks et al. 1998)

Relationships enabling action are defined and developed

Another crucial determinant for effective intersectoral action is clearly defining the nature of the relationships between the participating organisations. These relationships must be appropriate to the goals of the proposed action. Relationships should 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 (Harris et al. 1995; Kuhn et al. 1999).

Clearly defining the nature of relationships is particularly important for intersectoral initiatives because of the many different organisations involved, and their diverse cultures, philosophies and ways of doing things (Bauld and Judge 1999; FPTAC 1999). *Working Together* notes, for example, that hierarchical organisations typically find it challenging working 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).

Building relationships for joint action with the health sector can also be potentially challenging or threatening for some organisations. They may worry that the extensive power and size of the health sector will be used to control what happens during an intersectoral initiative. They may also be concerned, for example, about the health sector’s emphasis on scientific evidence, often narrowly defined, which can “devalue the basis on which many organisations work” (Harris et al. 1995: 70).

Trust and respect

Mutual trust and respect are widely acknowledged to be the foundations on which agreements about the nature of relationships between participating organisations should be built (FPTAC 1999; Blaiklock 1997; Kuhn et al. 1999; WHO 1997; Angus 1999). Trust and respect need to be consolidated as initiatives progress. Ideally, 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 or not (Murphy and Thomas 1999).

The success of the TU BADD drink driving campaign was found to be influenced by the high degree of close collaborative working achieved

between community, police, councils, marae, education, justice and sports organisations (Moewaka Barnes 2000).

By contrast, 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 (Warren 2000).

Defining relationships

Working Together notes that the more a group of 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 organisations should be (Harris et al. 1995).

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

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 (Wyllie et al. 2000; Dowden and Kalafatelis 1999).

Possible types or styles of relationship that could be developed between participants in an intersectoral initiative are listed earlier in this report (pp 2-3). Just some of the options include networking to share information; providing technical support, information and training; developing joint policies; and co-ordinating the delivery of services and programmes. The literature contains numerous examples of initiatives where these and other different types of relationships have been developed. However, the review articles examined for this report do not single out any particular types of relationship that could be expected to be generally applicable, successful or effective across a wide range of different kinds of initiatives. This is probably not surprising given the complexity and diversity of intersectoral initiatives, which mitigates against making general 'one-size fits all' prescriptions regarding suitable relationship types.

Agreed actions are planned and implemented

Another key determinant of effective intersectoral action is that the participating sectors and organisations reach agreement on the range and types of actions to be taken and then implement them (Harris et al. 1995). This is necessary because there are potentially many different actions that could be taken to address a particular health issue.

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).

Part of this process could include preparing a formal action plan or clear statement of agreed actions. This would clearly state why all participating organisations regard it as important to work together on an issue, how they see the issue and its solutions, the actions required, and the contribution each organisation will make to implementing these actions. As well, the action plan would state how the interests of each participating organisation will be met by the initiative.

The plan also would indicate the level and kinds of resources that each participating organisation will commit to the initiative (e.g. for establishing staff or for providing equipment). Actions or goals specified in the plan should be achievable within a given time period and a given level of resources.

Working Together adds that there should 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).

Similar points are made by the FPTAC. They, too, highlight the importance of having a planning phase where partners develop a consensus about such issues as “desired outcomes, measures of success, leadership, operating processes, contribution of resources, methods of resolving conflicts, recognition and rewards” (FPTAC 1999: 19). A key goal of this process is to ensure that the contributions to be made by the respective partnership members are defined clearly and unambiguously.

Putting effort into clearly agreeing on the actions to be implemented is likely to be crucial in situations when participating organisations have

different planning, budgeting and accountability requirements (FPTAC 1999), as was the case in the Family Service Centre pilot initiatives. It is also likely to be crucial in situations where organisations work to different timetables, or do not serve clientele within the same or similar geographic boundaries, as occurs in many Health Action Zones (Bauld and Judge 1999; Office for Public Management 2001).

The FPTAC also emphasise the importance of initiatives keeping a strong action orientation, focusing on concrete action and specific, visible deliverables that can be achieved in the short term. They argue this is more likely to motivate and sustain intersectoral action than attempts to “meet laudable but vague goals” (FPTAC 1999: 19).

An evaluation of the Nelson Healthy City project concluded 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).

The FPTAC also suggest aiming to keep co-ordinating structures and decision making processes as simple as possible. A review of New Zealand’s Healthy City projects once noted that projects can be compromised if they are dependent on a “myriad of planning cycles and bureaucratic processes” (Health Promotion Forum 1994)

The experience from Health Action Zones is that initiatives should try to avoid setting too broad an agenda or excessively high expectations at the beginning (Bauld et al. 2001). Others note that securing short-term quick wins can be helpful in “gaining legitimacy and support for more complex, long-term goals during the early stages of partnership development” (Mitchell and Shortell 2000: 261).

Similar advice was given to the Manukau Healthy City initiative following an evaluation early in its development. It was 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 would help demonstrate to participating organisations and groups that the initiative could produce outcomes and was working.

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).

Accountability processes

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 being shared, as well as the recognition and rewards for success (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 in intersectoral action need to devise some kind of system by which they can exert pressure on each other to ensure that collective decisions are honoured (Office for Public Management 2001). Writing in 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).

Outcomes are monitored

Monitoring and evaluating how well an initiative is working, and its impact, is the final key ingredient for successful (and enduring) intersectoral action. If there is sound evidence emerging that an initiative is running well and achieving meaningful results, this can be highly influential in shaping the decisions of participating organisations about their future level of commitment (including resourcing) to the initiative.

A key question regularly raised throughout the literature on intersectoral action is how can the success or otherwise of an initiative be reliably monitored and evaluated, particularly its impact on the broader health status of a community or people?

In New Zealand, evaluations of community-based intersectoral health initiatives have concentrated mainly on assessing the quality of the processes involved in setting up and running an initiative – so-called “formative” or “process” orientated evaluations. These focus on issues such as the extent to which partners in an intersectoral project have developed suitable working relationships with one another, and the factors that have been important in shaping the nature of these relationships. Evidence in these evaluations is likely to be drawn from data collected from face-to-face interviews or surveys, reviews of project documents, or direct observations in the field or at meetings.

Evaluations have also given some attention to cataloguing what might be called the *intermediate* outcomes or activities (programmes or projects) resulting from work done as part of intersectoral relationships (such as purchasing and running a community house, or setting up free school-lunches for children in disadvantaged areas, or an increase in awareness in the community about drink-drive enforcement campaigns). In most cases it is not hard to see that these outcomes are directly a result of the intersectoral initiative and probably would not have occurred without it. Again, evaluation evidence related to these intermediate outcomes tends to be derived from face-to-face interviews or surveys, reviewing project documents, or direct observation in the field or at meetings. In some cases, too, before-and-after type research methodologies have been used to track changes in dimensions such as community awareness or knowledge, or self-reported alcohol consumption.

It is relatively uncommon, though, for New Zealand evaluations of community-based intersectoral action to devote a large amount of project funding to measuring broader outcomes from an initiative, such

as the downstream impact on measures of health status. To some extent at least, this reflects the real difficulties in many cases of measuring the downstream impact on health of these initiatives (see further discussion below).

Measuring outcomes

Studies attempting to measure health status outcomes are more common in other countries, especially the United States. For example, a major review by Ontario's Community Health Research Unit examined 20 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: 3). Most of the initiatives covered were undertaken in the United States in the last decade.

Of the 20 projects, six injury prevention projects and three heart health projects demonstrated statistically significant changes in health status (e.g. head injuries in children; drownings; 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, significant increases in self-reported regular physical activity, reductions in smoking-prevalence) and health-related knowledge and attitudes (e.g. changes in attitudes towards smoking).

This 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 whole communities. However, the reviewers' endorsement of the effectiveness of community-based intersectoral action remained, 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).

In addition, they note the absence of any studies estimating the overall costs (human and financial) involved in forming or maintaining coalitions, or of studies comparing the effectiveness of a strategy implemented with a coalition compared to one without a coalition.

Obstacles to measuring broader outcomes

There are probably two important reasons why New Zealand evaluations of community-based intersectoral initiatives have tended to give little emphasis to trying to identify broader health status or health-risk behaviour outcomes.

One is the non-availability of suitable research data or tools to do this. This, of course, is not a problem peculiar to intersectoral action. Measuring the effects of many other kinds of health programmes or interventions with any reliability is also challenging (Harris et al. 1995).

Another is the expense and time, as well as potential disruption to the actual programme activities, involved in collecting and processing reliable data to measure health-related outcomes (presuming it is possible to do so).

These issues, and issues related to them, have been touched on by the evaluators in several of the case studies reviewed earlier.

For example, Casswell notes in relation to community action research, "... the use of more naturalistic approaches to evaluation is an acknowledgment that experimental design may not be feasible or scientifically appropriate for the evaluation of community action projects" (Casswell 2000: 55). Experiences in the early years of community alcohol action research in New Zealand lent support this conclusion.

Outcome evaluation should only be considered where there has been adequate formative evaluation of the programme, there is a reasonable reason to believe that the programme will achieve its objectives, and there is clear new significant contributions to knowledge to be obtained by the evaluation (Duignan and Casswell 1992).

In the Family Service Centre pilots, much effort was put into attempting to get centre staff to collect detailed quantitative data directly from participating families, to try to gauge some impressions about the impact of the pilots. 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). As well, funders may have placed too much emphasis on determining health and social outcomes when pilot centres were in the midst of being established and still very much finding their feet.

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

The evaluators of the Northern Region Health Promoting Schools initiative determined that measuring long term health status outcomes would be inappropriate. Instead it was decided that 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).

Evaluators for the Waitakere community injury programme tried to set up an injury monitoring system using data from a variety of sources (e.g. emergency departments, NZ Health Information Service hospitalisation data) but were largely unsuccessful because data were either 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)

In the case of Health Action Zones, evaluators have noted the difficulty of identifying whether positive outcomes are being achieved by a new initiative when the initiative is being integrated or “mainstreamed” into an agency’s normal working (Sullivan 1999). Even if improved health outcomes were detected, it would be hard, if not impossible, to “disentangle” changes due to HAZ from changes due to other factors (Office for Public Management 2001).

To try to gauge if nutrition messages are being translated into action, evaluations in community nutrition initiatives have focused on people’s eating behaviour, awareness of nutrition issues, marae menus, and what children take for school lunches (Moewaka Barnes et al. 1998a, Moewaka Barnes et al. 1998b, Pipi et al. 1994, Tunks et al. 1998).

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

As a model for future best practice, they point to well-regarded Canadian evaluations of Healthy City projects in Canada, where the focus was on assessing success in terms of broad concepts, such as “coherence of objectives”, “citizen participation” and “intersectoral action”. These evaluations used primarily quantitative social science methods such as interviews, reviews of documents, field observations and expert panels.

Others experienced in the practicalities of implementing broad intersectoral action 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).

This same commentator adds that intersectoral collaboration is justifiable simply because it makes *intuitive* sense.

Choosing evaluation methods

Working Together concludes that, when assessing the “success” or “effectiveness” of an intersectoral initiative, a key requirement is that the monitoring and evaluation strategy used, and the quality of evidence it provides, should be *acceptable* to all participating sectors and organisations.

On top of this, the monitoring and evaluation strategy should reflect the size, amount of funding and outcomes expected from the initiative. The evaluation should not overpower the actual initiative and be the dominant driver of the process.

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).

Chapter Four

Implications for Future Initiatives

Introduction

To end the report, we now consider the implications of the information reviewed for future community-based intersectoral health initiatives in New Zealand. We do this by answering the research questions specified in Chapter One. This includes suggesting ways the Ministry of Health, District Health Boards and local authorities, could assist in improving the effectiveness of intersectoral action, given the current state of knowledge in this area.

Aims and approaches of the initiatives

Community-based intersectoral health initiatives are essentially aiming to improve the health of the people in a particular locality or area, and by so doing help to reduce broader health and social inequalities. In our view these objectives are appropriate, given the inequalities that exist between different geographic, ethnic and socio-economic groups within New Zealand.

The fact that these initiatives are using intersectoral approaches also seems appropriate, given that the determinants of health are themselves multi-dimensional and “cross-sectoral”.

Some of the reviewed initiatives have used population-based approaches (including community development). Others have worked primarily with individual clients using cross-sectoral approaches such as case management. Both approaches have had their successes and problems and it is not obvious from our readings whether one is likely to be more “successful” than the other.

Effectiveness of community-based intersectoral health initiatives

One possible criterion, (although not the only criterion) for judging the “success” or “effectiveness” of intersectoral initiatives is whether or not they achieved the health-related outcomes they aimed to achieve.

In the New Zealand initiatives reviewed here, it was comparatively rare for evaluators to attempt to measure broader health status outcomes (such as morbidity and mortality) produced by the initiative. As we have seen, reasons for this included the methodological difficulties and costs involved in collecting or accessing suitable data, plus difficulties in interpreting results (such as whether health gains occurred because of the initiative or because of other factors). While these same difficulties arise when attempting to assess the impact of other kinds of health initiatives, the difficulties may be greater for intersectoral programmes, especially because of their structural complexity and often broad ranging objectives.

Changes in health status

That said, there are indications that 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 these programme may also be easier to demonstrate).

Overseas, some studies of Safe Communities, as well as other injury-prevention coalitions, have shown improvements in injury outcomes (although other studies have not). In New Zealand, the Waitakere injury prevention programme attempted to measure injury outcomes but encountered problems relating to the availability and timeliness of injury data. This led to an analysis of hospitalisation data for a two-year period that showed insignificant changes, or in some cases slight *increases* in injuries.

Overseas research also suggests that some intersectoral heart-health programmes can contribute to improvements in cholesterol levels and decreased hospitalisation for blood pressure problems.

Changes in health-related knowledge, attitudes and behaviour

When it comes to assessing impacts, evaluations of community-based intersectoral initiatives are more likely to focus on assessing changes in people’s health-related knowledge, attitudes and behaviour. Examples of changes in these types of intermediate outcomes attributed to the initiatives reviewed here include:

- improved nutrition-related knowledge and provision of healthier food (*community nutrition programmes for Māori*)
- 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*)
- perceived improvements in outcomes for families (Strengthening Families Collaborative Case Management initiative).

Changes in the environment

As well as influencing personal determinants of health, community-based intersectoral initiatives have been found to led to changes in various aspects of the environment such as:

- 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 (*Waitakare community injury prevention programme*)

Level and quality of initiatives' contact with the public

Along with the above changes in “outcomes”, the effectiveness of initiatives depends on whether they reached the intended recipients, and were acceptable and appropriate for these people.

The intersectoral initiatives reviewed in this report showed various levels of achievement in these areas. Many initiatives reached their planned number and type of target audiences or clients. These people were usually satisfied, or very satisfied, with the services and activities provided. However, other initiatives were less successful in making the general public aware of their presence and getting them to participate in their activities.

Effectiveness for disadvantaged people

Many of the intersectoral initiatives reviewed here appear to have worked well for disadvantaged people, at least when “effectiveness” is judged in terms of the kinds of intermediate outcomes achieved.

For instance, evaluations of the Strengthening Families case-management programmes found that the programmes achieved high levels of client satisfaction and successfully engaged socio-economically disadvantaged and “at risk” individuals and families.

Some issues-based initiatives like injury prevention and nutrition programmes targeting Māori also seemed to be effective, particularly if they were endorsed by the local Māori community; run and developed by Māori in a way consistent with tikanga Māori; and used existing Māori networks (like iwi organisations, marae, and kohanga reo).

However, it is less clear how much some of the overarching, area or settings-based initiatives have benefited disadvantaged people. Partly this is because evaluations of these initiatives have tended to concentrate on looking at the functioning of the initiative as a whole, rather than at specific projects or programmes within the initiative. As well, there has been focus on assessing organisational processes rather than outcomes for individuals. It is clear, however, that these types of initiatives have had some problems achieving a good level of participation from the “grassroots” community, including disadvantaged people. This fits with the experience from other countries where, generally speaking, socio-economically disadvantaged people are less likely than others to participate in community activities (Baum et al. 2000).

Effective ways of implementing community-based intersectoral health initiatives

The case studies and review articles presented earlier highlight a range of important ingredients for producing a “successful” or “effective” intersectoral initiative. These ingredients can be summarised under six headings:

1. All partners agree on the necessity for intersectoral action

- all partners (government agencies, non-government agencies, community groups, etc.) agree they should work together

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- the intersectoral action presents a “win-win” situation where all partners benefit
 - all partners have a shared vision of what they want to achieve
 - all partners give their full support and mandate to the intersectoral action and accept it as part of their core business

2. Support exists in the wider community

- high-level political support (central or local government)
- appropriate legislative environment (e.g. ability to share budgets)
- a supportive economic environment (there is economic growth and resources are not too scarce)
- the prevailing public policy environment facilitates collective action rather than individualism
- a supportive organisational environment
- the initiative is consistent with the socio-cultural beliefs, current concerns and attitudes of the target community, including their priorities for action
- the timing is right
- the location for the intersectoral action is appropriate (e.g. other sectors have to be available to collaborate with)

3. Capacity exists to carry through the planned action

Partner organisations

- there is widespread support among all levels of staff within partner organisations
- activities associated with the initiative are part of staff’s job descriptions
- staff involved in intersectoral planning and management groups are able to make decisions on behalf of their organisations (and it is clear who is able to do so)
- the power to make decisions rests at the local, rather than national level

Community participation

- existing community organisations (like NGOs, voluntary agencies, businesses, Māori organisations) are involved in partnerships rather than *ad hoc* groups of “grassroots” individuals” with no existing networks
- Māori initiatives use existing Māori networks such as marae and kohanga reo and have “buy in” from the local Māori community
- the current literature review did not find any evidence concerning conditions that are favourable to Pacific peoples’ participation in intersectoral initiatives for health.

Resources

- all partners (including community representatives) have enough resources and support to participate in the initiative
- extra staff time for collaboration and extra resources for infrastructure and administration are allocated (although financial savings may also be made in some instances)
- at least one full-time local co-ordinator is employed, as well as regional and / or national co-ordinators for initiatives that are located more widely
- administrative assistance is provided to co-ordinators
- long-term funding is assured so initiatives can be properly developed, infrastructures are built and projects have time to “work” (this usually takes several years because of the time it takes to establish partnerships and work collaboratively)
- long-term funding so that skilled staff are attracted and do not have to spend too much time fund-raising rather than facilitating the initiative’s activities
- long-term funding so that partners do not become disillusioned and mistrustful (e.g. where one partner is the funder)

Personal skills

- staff employed on the initiative (e.g. co-ordinators) have a wide range of skills, knowledge and experience in areas such as community development, health promotion, communication, negotiation, management
- front-line initiative staff are locals
- training is given early on to staff in areas they are less familiar with

4. Relationships enabling action are defined and developed

- the roles of, and relationships between, partners are agreed and clearly defined
- there is trust and respect between partners
- well-resourced systems are in place for collaborative working
- systems are in place to enable relationships to be regularly reviewed and renegotiated if necessary

5. Agreed actions are planned and implemented

- a planning and development phase is undertaken, including an assessment of the local community's needs and existing services and programmes
- strategies and action plans are agreed and, ideally, put in writing (e.g. in a memorandum of understanding)
- a manageable number of activities are undertaken so success is achieved, as well as working on building community and organisational infrastructure
- the responsibilities of each partner are defined with regard to what actions they will undertake
- partners share accountability for programme successes and failures

6. Outcomes are monitored

- progress is monitored so that partners can make decisions about their future support
- initiatives are given time to "succeed".

Prioritising proposals for new initiatives

In selecting proposals for new community-based intersectoral health initiatives, the above criteria suggest that priority could be given to proposals that:

- demonstrate there is clear agreement between the partners on the necessity to work together
- show there is support in the wider community, including central and local government, for the type of initiative envisaged
- demonstrate that the partners each have the capacity to contribute to and carry out the initiative
- recognise that the relationships between the partners need to be clearly defined and nurtured on an ongoing basis
- state the intention to develop a clear, strategic plan of action to meet the assessed needs of the local community
- recognise the value of monitoring and evaluating the progress of the initiative.

Role of the Ministry of Health and District Health Boards

As the New Zealand case studies presented earlier in this report have shown, in the past the Ministry of Health, Health Funding Authority, Public Health Commission, Area Health Boards and Crown Health Enterprises have been partners in intersectoral initiatives. In the new, restructured health system it seems therefore appropriate for the Ministry and District Health Boards (DHBs) to take on these roles. There are potentially several ways that the Ministry of Health and DHBs could support the development of community-based intersectoral initiatives. These are discussed below.

Funding initiatives

As funders of demonstration or pilot initiatives, the Ministry and DHBs could ensure that the funding provided is sufficient to enable initiatives to develop and sustain appropriate infrastructures for intersectoral working (including collaborative relationships, co-ordinator roles and administrative functions).

As well, stable funding should be provided for a sufficient length of time to enable initiatives to effectively implement sustained activities such as community development, health promotion, and case-management services.

Most experienced practitioners observe that intersectoral action generally takes more time and resources than *intrasectoral* action because of the time it takes to establish partnerships with other organisations. For community-based projects it also takes time to build partnerships with community groups and to encourage good levels of community participation.

There are instances where programme designers have called for five, seven or even ten-year time frames for the development of intersectoral initiatives. There is also some research evidence that intersectoral initiatives should be funded for at least 3-5 years (or even longer) to enable effective partnerships and service structures to be developed. However, it is hard to generalise about appropriate timeframes for intersectoral initiatives, given their diverse goals and activities.

While it is possible intersectoral initiatives may eventually produce long-term savings due to efficiencies associated with reducing duplication between agencies, the current literature review has found no evidence that this is the case.

It also seems appropriate for the Ministry and DHBs to fund evaluations of pilot or demonstration initiatives.

Supporting initiatives

As well as financial support, the Ministry and DHBs could take leadership roles in supporting community-based intersectoral action for health. This could include emphasising their commitment to new initiatives so that other organisations are encouraged to participate in them. Additionally, it could include securing high level political support for the initiatives. As we have seen, supporting intersectoral initiatives is consistent with the Ministry's new health and disability strategies and guidance to District Health Boards.

Being a partner amongst partners

While community-based intersectoral health initiatives benefit from political *support* from central government, problems can occur if Ministers or central government start trying to set the priorities and agendas for community-based action. One of the fundamental tenets of community development is that planning should be locally-based and activities tailored to the needs of the local population. If the funding agency "changes the rules" midway through an initiative (by directing local initiatives to follow national agendas), trust between local partners can be undermined and the viability of an initiative can be seriously threatened, as has apparently occurred for Health Action Zones.

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

Developing guidelines

The Ministry and / or District Health Boards could also develop and promulgate guidelines to assist organisations thinking of setting up community-based intersectoral initiatives for health. The focus would be on recommending suitable processes and examples of "best practice" rather than requiring that certain priority outcomes are addressed. The guidelines should also be flexible enough to accommodate a wide variety of initiatives and local contexts. Again, the list of "success" factors presented above could be a useful start for this. We also recommend *Working Together: Intersectoral Action for Health* (Harris et al. 1995) as a key resource.

Role of other organisations and the community

The evidence from this review suggests that local authorities have the potential to play an important role as supportive partners in community-based initiatives, both as funders and providers. However, this support may not be forthcoming if the local authority is not experienced in working collaboratively or does not accept that it has a role in promoting health.

Some locally-based health and social agencies, as well as other organisations that deal with aspects of the human and physical environments, will also be in good positions to become partners in intersectoral initiatives. Especially helpful are existing networks and working relationships with other agencies that can be used and built upon. Agencies without existing networks and appropriate structures will have to work hard to establish new relationships with one another - a process that takes time and resources, and may be hampered by past rivalries and competition.

“Community participation” is frequently identified as a key goal of community-based intersectoral initiatives for health, and of community development in general. However, this is one goal that some initiatives have found hard to achieve.

In general, initiatives that have aimed to engage existing local organisations as partners (or funders), including the voluntary sector, local businesses, Māori organisations (such as runanga and marae committees), 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 “grassroots” 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 “ordinary” community members, especially if they are socially disadvantaged in some way.

Evaluation

Many of the methodological issues that need to be taken into account when evaluating community-based intersectoral health initiatives are the same as for any other kind of programme evaluation, and are well-documented elsewhere (e.g. Patton 1981; Waa et al. 1998).

Our review indicates that naturalistic (as opposed to quasi-experimental) research techniques are generally the ones most favoured in New Zealand evaluations of intersectoral action. The advantage of these techniques (which include interviews, focus groups, first-hand observation and the analysis of written records) is that they enable details of the sometimes complex processes involved in implementing an initiative to be thoroughly documented, analysed and, where necessary, critiqued.

Depending on the nature of an initiative, as well as the evaluation resources available, it is also often possible to measure certain intermediate outcomes. These could include levels of public awareness, self-reported behaviour change, or client satisfaction with a particular service or campaign activity.

Assessing whether ultimate health goals or objectives have been reached (such as improvements in health status or health gains) may also be possible for some intersectoral initiatives. This is especially where robust statistical information is available and easily accessible. However, even where changes in indicators are detected, attributing causality to the particular initiative is still likely to be a matter of judgement, since other factors, both known and unknown, may also have had an effect.

There are also several distinctive features of community-based intersectoral health initiatives that evaluators need to note. They include:

- the diversity of the initiatives, which mean that making comparisons between initiatives can be quite difficult
- the complexity of partner relationships
- the extra time, resources, infrastructure, activities and “transparency” agencies need to develop and support collaborative partnerships, meaning that evaluations also may take longer to do
- the large number and scope of different activities often undertaken as part of an intersectoral initiative
- the existing 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.

Further details of models and techniques for evaluating complex community-based intersectoral health initiatives are discussed in several recent publications (e.g. Bauld and Judge 1999; Judge et al. 1999; Judge and Bauld 2001; Meyrick and Sinkler c. 1999).

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