Health promotion planning and evaluation in public health units in New Zealand

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Abstract

An ageing population, increasing rates of chronic disease, along with growing inequities in health status, and rising costs in health care and treatments are all placing a strain on the New Zealand health system. Combine these attendant issues with a work environment marked by funding constraints, prioritisation and high performance values, and the demands on health promoters to demonstrate evidence of effectiveness in planning and evaluation soon becomes evident.

This thesis explored the overarching question, ‘How do health promoters in public health units in New Zealand plan and evaluate their programmes?’ The study objectives were to understand best practice health promotion programme planning and evaluation, identify current health promotion programme planning and evaluation practice in public health units in New Zealand and finally, recommend improvements for health promotion planning and evaluation in public health units. I conducted semi-structured interviews with 17 health promoters (health promotion managers N=9; senior health promoters N=8) located in 10 of the country’s public health units. Interviews were thematically analysed using Braun and Clarke’s (2006) six-phase method.

My literature review supported the standpoint that no singular exemplar of best practice health promotion planning or evaluation can exist because of the context-dependent and multi-strategy nature of health promotion. Instead, a best practice approach that espouses a variety of principled and evidence informed approaches as they apply to different settings, circumstances, issues and populations is proposed. Interviews revealed that health promoters considered intersectoral action, collaborative partnerships and community engagement as important components of planning, with many reporting promising and effective examples of these in practice. Health promoters acknowledged that the practicality of incorporating these principles into practice was not without challenge. Participants were less confident discussing evaluation than they were planning and cited various barriers to conducting evaluation as these included financial constraints, short-term planning cycles, varying access to expertise, staff capacity, and the challenges entailed in evaluating complex programmes. Accordingly, a number of health promoters expressed a desire for operational and organisational support to strengthen evaluation capacity. There was a tacit expectation that Māori
Health promoters would act as cultural competency advisors and facilitate connections and networks in the community, adding another layer to their day-to-day responsibilities. Finally, the public health unit setting was perceived to facilitate as well as act as a barrier to health promoters’ ability to plan and evaluate.

Health promotion has an important role to play in reducing the burden of chronic disease and inequities in health status and access to health care. This thesis aimed to capture a snapshot of planning and evaluation practice in public health units in New Zealand and highlight the ever-present pressure on health promotion to demonstrate evidence of its effectiveness and strengthen its position in politically and socio-economically challenging times.
Acknowledgments

I began this thesis newly in grief at the loss of my father. This journey is reflected in the little Meyer lemon tree Dad sent me from Tauranga, the buds individually and tenderly wrapped in bubble-wrap for the journey. Unbeknown to me at the time, the tree would become his parting gift to me. The tree struggled through two Dunedin winters, nursed under frost cloth, midges squashed under thumb, to produce its first lemons this year. Out of the fog of grief, study and winters cold, the tree and I ‘survived.’ I dedicate this thesis to my mum and dad for their unfailing love and support.

To the health promoters who gave their time so generously to this study, thank you. I enjoyed the interviews immensely and appreciated your candidness, interest and enthusiasm. I felt a huge sense of respect and responsibility to you all in writing this thesis and only hope I have honoured your invaluable contribution.

To my supervisors, Richard Egan and Rose Richards, thank you for your support and wisdom. I always came away from our meetings with a fresh perspective and renewed enthusiasm. Thank you for gently nudging me to the finish line. Thank you too to my dear friend Charmaine for giving the thesis a final read.

To my beautiful boys, Kahu, Nikau and Felix, you give me such hope for the future, as you carve your own place in the world. You amaze me everyday, even on the ordinary days. I look forward to sharing some thesis-free waves with you this summer. How light and free I will feel on my boogie board.

And finally to Simon, thank you e hoa. You and I both know I couldn’t have done this without you and vice versa. We make a great team.
Table of contents

Abstract .................................................................................................................................................. 2
Acknowledgments .................................................................................................................................. 4
Table of contents .................................................................................................................................. 5
List of tables and figures ....................................................................................................................... 7
List of abbreviations and acronyms ...................................................................................................... 8
Glossary .................................................................................................................................................. 9

Chapter One: Introduction .................................................................................................................... 10
  Thesis aim and objectives .................................................................................................................. 10
  A guide to the thesis .......................................................................................................................... 10

Chapter Two: Background and context ................................................................................................ 12
  Overview of the public health unit setting ....................................................................................... 12

Chapter Three: Literature review ....................................................................................................... 16
  Introduction ......................................................................................................................................... 16
  Defining best practice ........................................................................................................................ 17
  Best practice planning ........................................................................................................................ 19
    Principles and values framed by the Ottawa Charter .................................................................... 19
    Treaty of Waitangi ............................................................................................................................ 22
    Determinants of health ..................................................................................................................... 23
    Participation and its relationship to equity and empowerment ..................................................... 26
    National and international core competencies .............................................................................. 29
    Models and frameworks to support planning .............................................................................. 30
    Reflective practice ........................................................................................................................... 32
    Problem analysis and needs assessment ....................................................................................... 32
    Evaluation in planning ..................................................................................................................... 33
  Best practice evaluation ..................................................................................................................... 34
    The task of identifying best practice evaluation .......................................................................... 34
    Defining evaluation .......................................................................................................................... 35
    Evaluation purpose and form .......................................................................................................... 36
    Principles and values ........................................................................................................................ 38
    The development of models and frameworks to support evaluation ....................................... 38
    Research methods and building an evidence base ....................................................................... 40
  Organisational factors and their impact on health promoters’ ability to conduct evaluation ................................................................. 46
  Building capacity and capability for evaluation ............................................................................. 49
  Summary ............................................................................................................................................. 50

Chapter Four: Methods .......................................................................................................................... 52
  Methodological approach .................................................................................................................. 52
  My positioning ................................................................................................................................... 54
  Overview of study .............................................................................................................................. 56
  Sample and recruitment ..................................................................................................................... 56
  Designing and conducting the interview ............................................................................................ 57
  Analysis ............................................................................................................................................. 59
    Phase 1. Familiarising yourself with the data ............................................................................... 61
    Phase 2. Generating initial codes .................................................................................................... 61
Appendix D

Chapter Five: Thematic analysis

Participant demographics
Thematic analysis
Chapter overview
Planning
Needs analysis and evidence gathering for programme planning
Overarching values, principles and models for planning
Equity considerations
Planning approaches and strategies
Collaboration and relationship building
Best practice programme planning examples
Summary
Evaluation
Introduction
Overview
Methods, approaches and tools
Equity considerations
Linkages with stakeholders and community
Support for evaluation
Challenges to evaluation
Results Based Accountability
Summary
Māori perspectives
Summary
The PHU setting
Summary
Success and aspirations

Chapter Six: Discussion

Planning
Evaluation
Māori perspectives
PHU setting - facilitators and barriers to planning and evaluation
Strengths and limitations

Chapter Seven: Recommendations and issues warranting closer investigation..
List of tables and figures

Table 1. Nowell et al. (2017) present an approach to thematic analysis that follows Braun and Clarke’s six phases of analysis and aims to establish trustworthiness at each phase using Lincoln and Guba’s (1985) trustworthiness criteria………………………… 60

Figure 1. Thematic overview showing planning and evaluation themes, associated sub-themes and two satellite themes ............................................................................................................ 67
# List of abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>CAQDA</td>
<td>Computer-assisted qualitative data analysis</td>
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<tr>
<td>CBD</td>
<td>Central business district</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>EBP</td>
<td>Evidence based practice</td>
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<tr>
<td>ERO</td>
<td>Education Review Office</td>
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<tr>
<td>FTE</td>
<td>Full time equivalent</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<tr>
<td>HEAT</td>
<td>Health Equity Assessment Tool</td>
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<tr>
<td>HEIA</td>
<td>Health Equity Impact Assessment</td>
</tr>
<tr>
<td>HIA</td>
<td>Health Impact Assessment</td>
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<tr>
<td>HPA</td>
<td>Health Promotion Agency</td>
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<tr>
<td>HPF</td>
<td>Health Promotion Forum</td>
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<tr>
<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
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<tr>
<td>LMC</td>
<td>Lead maternity carer</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSD</td>
<td>Ministry of Social Development</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NZ</td>
<td>New Zealand</td>
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<tr>
<td>NZPHD</td>
<td>New Zealand Public Health and Disability Act</td>
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<tr>
<td>PHO</td>
<td>Primary health organisation</td>
</tr>
<tr>
<td>PHU</td>
<td>Public health unit</td>
</tr>
<tr>
<td>PR</td>
<td>Public relations</td>
</tr>
<tr>
<td>RBA</td>
<td>Results Based Accountability</td>
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<tr>
<td>RCT</td>
<td>Randomised control trial</td>
</tr>
<tr>
<td>RE-AIM</td>
<td>Reach Effectiveness Adoption Implementation Maintenance</td>
</tr>
<tr>
<td>SHORE</td>
<td>Social and Health Outcomes Research and Evaluation</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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**Glossary**

Ata  Engagement principle: gently, slowly, carefully, clearly  
E hoa  Friend  
Hapū  Sub-tribe; pregnant  
Hauora  Health, spirit of life, vigour  
Iwi  Tribe  
Kaupapa Māori  Māori approach, Māori customary practice, Māori principles  
Koha  Gift, present, offering, contribution  
Kohanga reo  A Māori language pre-school  
Kura kaupapa  Māori based school  
Mahinga kai  Traditional sources of food  
Mahi tahi  To work together, collaborate, cooperate  
Mana  Rights, prestige, authority, control, power, influence  
Manaakitanga  Hospitality, nurturing relationships, care  
Manaaki  Showing care and helpfulness to others  
Mana whenua  Territorial land right holders  
Māori  Term used to describe the indigenous people of NZ  
Māoritanga  Being Māori  
Marae  The open area in front of the wharenui, where formal discussions and greetings take place, and surroundings  
Mātauranga Māori  Māori knowledge  
Ngai Tahu  South Island Māori tribe  
Pākehā  New Zealander of European descent or foreign  
Pōwhiri  To welcome, invite  
Rūnanga  Tribal administration headquarters  
Tautoko  Support, to agree  
Te ao Māori  The Māori world  
Te reo Māori  Māori language  
Tikanga  Māori values  
Tino rangatiratanga  The self-determination principle  
Waiata  Song  
Wairua  Spiritual strength and practice  
Whakapapa  Genealogy or lineage  
Whakawhanaungatanga  Process of establishing relationship  
Whānau  Family. Extended family structure  
Whanaungatanga  Active relationships  
Whānau Ora  Family health. An indigenous health initiative in New Zealand guided by Māori cultural values, aimed at empowering communities and extended families within a community context instead of an institutional context.  

Chapter One: Introduction

Thesis aim and objectives

This study aims to understand how health promoters in public health units (PHU) in New Zealand (NZ) plan and evaluate their programmes. The study objectives are to:

1. Understand best practice health promotion programme planning and evaluation;
2. Identify current health promotion programme planning and evaluation practices in PHUs in NZ;
3. Recommend improvements for health promotion programme planning and evaluation practice in PHUs.

A guide to the thesis

Chapter One presents the aims and objectives of the study, in addition to this guide to the thesis.

Background and context are briefly considered in Chapter Two. I provide an overview of the structure, function and organisation of PHUs in relation to the socio-economic and political environment that has shaped recent health promotion practice in NZ. This chapter is intended to provide context to study participants’ accounts of planning and evaluation as they apply to the PHU setting.

Chapter Three comprises my literature review, which sought to respond to the study objective ‘understanding best practice health promotion programme planning and evaluation.’ The first part of the review largely centres round a notion of best practice planning that embraces a variety of multi-strategy, context sensitive, principled approaches. The second part of the literature review reveals the methodological, conceptual, and organisational challenges that continue to define much of the evaluation literature.

In Chapter Four I describe the methodological approach that guided my research, and outline the research methods I used.

In Chapter Five I present my thematic analysis of semi-structured interviews with health promoters, and in doing so explore current health promotion programme
planning and evaluation practice in PHUs in NZ, covering the second of my study objectives.

**Chapter Six** presents a **discussion** of the results in connection to the literature with a focus on four key areas: planning, evaluation, Māori perspectives and finally, the PHU setting as both facilitator and barrier to planning and evaluation. I then identify the strengths and limitations of my research processes.

**Finally, in Chapter Seven** I consolidate the interview findings and literature review to make **recommendations** targeted at policy makers and PHUs¹ that I hope are practicable and achievable, in supporting health promoters to effectively plan and evaluate their health promotion programmes. I end this section with a final summary addressing the overarching research question, ‘how do health promoters in NZ plan and evaluate their programmes?’ This chapter addresses the third of my study objectives.

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¹ Some of the recommendations may be applicable to other health promotion organisations in NZ.
Chapter Two: Background and context

Overview of the public health unit setting

This section aims to provide an overview of the structure, function and organisation of PHUs in relation to the socio-economic and political environment that has shaped recent health promotion practice in NZ; giving context to study participants' accounts of planning and evaluation as they apply to the PHU workplace setting.

New Zealand has 12 district health board (DHB) owned PHUs that deliver regional public health services across the country. The focus of these Ministry of Health (MoH) funded units is environmental health, communicable disease control, tobacco control and health promotion, with an emphasis on communities. Each PHU is owned and governed by one DHB however there are fewer PHUs than DHBs, subsequently many of the PHUs are contracted by the MoH to deliver services on a geographical basis, thus spanning several DHB boundaries. For example, while Regional Public Health is a division of Hutt Valley DHB the unit also serves the greater Wellington region, and incorporates Hutt Valley and Wairarapa DHBs. Conversely, smaller PHUs like Tairawhiti are singularly responsible to one DHB (Health, 2018a).

PHU services and activities are expected to align with the NZ Health Strategy\(^2\) (New Zealand Ministry of Health, 2016), key government targets, policies, priorities and strategies (Ministry of Health, 2016a), He Korowai Oranga (New Zealand Ministry of Health, 2014), Ala Mo'ui (Ministry of Health, 2014a), DHB priorities, District Annual Plans, DHB Māori Health Plans and Public Health Service Specifications (Ministry of Health, 2014c, 2016b). Planning and funding teams within the DHBs use evidence-based research to assess population health needs, prioritise the activities and public health services of PHUs, and monitor, audit and evaluate service delivery (New Zealand Public Health Clinical Network, 2011).

\(^2\) “The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include: improving health and disability outcomes for all New Zealanders; reducing disparities by improving the health of Māori and other population groups; providing a community voice in personal health, public health, and disability support services; facilitating access to, and the dissemination of information for, the delivery of health and disability services in New Zealand.” (New Zealand Public Health and Disability Act 2000)
The mandatory Public Health Services Health Promotion Tier Two Service Specification for PHUs (Ministry of Health, 2016b) draws on the Ottawa Charter, 1986 to frame the different approaches and areas of action for planning health promotion programmes and services. The use of other established frameworks for planning, such as Te Pae Mahutonga (Durie, 1999) are also endorsed. In addition to adhering to the principles of equity and social justice, services are also expected to show a commitment to Te Tiriti o Waitangi. In alignment with an international shift from a health education model to an ecological approach (Green & Kreuter, 1999), health promoters are encouraged to focus less on activities that promote the development of personal skills in favour of activities more likely to influence the wider determinants of health and serve a larger population base (Ministry of Health, 2016b).

Other key principles and values guiding public health service delivery in NZ, as they apply to health promotion include: the formation of effective partnerships across the health, public and social sectors to achieve better socio-economic and health outcomes; the delivery of evidence-based practice grounded in government priorities and strategies, combined with the articulated needs of community; communities that are empowered through their active involvement in the planning, implementation and evaluation of projects; collaboration with a range of stakeholders in support of ‘health in all policies’ (HIAP); the prioritisation of health improvements and equitable outcomes for Māori; services that are attentive to cultural and other needs; and the reduction of inequitable health outcomes (Ministry of Health, 2014c, 2016b). While advocacy is identified as a key strategy in health promotion practice (World Health Organisation, 1986a), health promoters in PHUs are limited in their ability to advocate or lobby on issues which might compromise their “political neutrality” as public servants of the state (Ministry of Health, 2016b, p. 3).

With the primary aim of improving population health and equity, health promoters are encouraged to use equity tools such as the Health Equity Assessment Tool (HEAT) (Signal, Martin, Cram, & Robson, 2008), prioritisation frameworks, health impact assessments (HIA), the Whānau Ora Health Impact Assessment Tool (Ministry of Health, 2007b) and Equity of Health Care for Māori: A Framework (Ministry of Health, 2014b). Correspondingly, health promoters are expected to demonstrate in their annual planning how programmes intend to improve outcomes for vulnerable communities,
and detail the measures they will use to assess their contribution to improving equity (Ministry of Health, 2016a).

Across the globe, governments are demanding greater accountability and evidence of the effectiveness of health promotion initiatives (McQueen & Jones, 2007) and as such, systems and frameworks for measuring and reporting have been developed and integrated into public health organisations to capture the results and outcomes of programmes. New Zealand is no exception with the NZ Health Strategy, responsible for much of the recent strategic direction for health improvement in NZ, calling for a high-value, systematic, evidenced and performance based health system (New Zealand Ministry of Health, 2016, p. 27). An example of this demand for greater accountability is seen in the recent introduction of Results Based Accountability (RBA) as part of a larger Ministry process to develop “nationally consistent planning and reporting templates, and strengthen alignment of PHU/DHB planning and reporting processes” (Ministry of Health, 2016a, p. 4). After an initial transition period, health promoters are now expected to fully integrate RBA into their annual planning and reporting. In alignment with RBA processes, PHUs are expected to produce measures that will demonstrate performance accountability in the dimensions of: quantity and quality of effort and whether anyone is better off (Ministry of Health, 2016a).

Public health is allocated a small portion of the total health expenditure compared to that of personal health services, illustrated in the public health allocation across OECD countries, which sits between 2.5-7% of the total budget (Gauld, 2009). In NZ the 2017 projected expenditure estimate for the country's primary source of public health funding was 2.4% of the Vote Health (Government of New Zealand, 2017). Accordingly under the 2016/17 Annual Plan Guidance for PHUs (Ministry of Health, 2016a) health promoters are expected to operate within a “constrained funding environment” (p. 8), deliver “integrated and value-for-money services” (p. 4), and produce “good quality PHU service performance information” (p. 4). The reporting demands on PHUs further affirm this performance-based accountability approach to health improvement in so far as: PHUs must demonstrate financial accountability six-monthly, submit service performance-monitoring reports six monthly, submit an annual plan and annual planning budget in addition to completing 'Vital Few' RBA reports every six months (Ministry of Health, 2016a).
At the time of interviewing, health promoters in NZ were operating under a neo-liberal ideology with an emphasis on individual responsibility, financial constraint and the prioritisation of treatment services over preventive measures (Gauld, 2009; Lovell, Egan, Robertson, & Hicks, 2015) running counter to the values of equity, social justice and population health improvement. Compounding the challenges for health promoters today is an ageing population, increasing rates of chronic disease, growing inequities and the rising costs of medical treatments (Gauld, 2009; Health, 2017). Health promotion has an important role to play in reducing the burden of chronic disease and inequities in health care access and health status in these challenging times; subsequently the demand on health promoters to show evidence of effectiveness in tackling ‘wicked’ problems (Signal et al., 2013) has never been greater.

Finally, PHUs are the largest employer of health promoters in NZ making the findings of this study significant to our understanding of planning and evaluation practice in NZ (Lovell et al., 2015).
Chapter Three: Literature review

Understanding best practice health promotion planning and evaluation

Introduction

This literature review primarily seeks to answer the study objective, to ‘understand best practice health promotion programme planning and evaluation.’ The review is structured in a way that planning and evaluation are treated as two separate entities though in recognition of their synergies or “cyclical and ongoing relationship” (Lobo, Petrich, & Burns, 2014, p. 1) I have tried to capture this intersection. Some issues and ideas are discussed discretely in relation to either planning or evaluation; this is not to preclude their relevance across both domains but rather stems from the desire to avoid repetition. For instance, while the values and principles that underpin health promotion are common to both planning and evaluation and are no less important to evaluation, I have placed them at the front end of the literature review to illustrate their overarching importance to health promotion programme planning, followed by only brief mention of them in the evaluation section. Similarly, because formative evaluation occurs early as part of planning and is used to inform programme design including the setting of goals, objectives and strategies I have situated it in the planning section, in relation to needs assessment (Nutbeam & Bauman, 2006). Likewise, the issue of health promotion capacity building, while pertinent to both planning and evaluation, is discussed largely in the evaluation section in acknowledgement of its critical contribution to creating a ‘culture of evaluation’ (Huckel, Milat, & Moore, 2016, p. 208), to guide programme improvement, grow the much needed evidence base to inform future programme planning, and convince policy makers and managers of its worth.

I begin the literature review with an examination of the concept of best practice, followed by a brief definition of health promotion before exploring the values and principles that shape planning, as they are framed by the Ottawa Charter. From here I consider the positioning of the Treaty of Waitangi as a living document (Barrett & Connolly-Stone, 1998) underpinning health promotion work in NZ, and discuss the determinants of health and their all-encompassing influence on health status and consequential relevance to health promotion practice. I subsequently explore the

3 Throughout the thesis I use the term ‘programme’ interchangeably with ‘project,’ ‘initiative’ and ‘intervention.’
principle of participation and its relationship to the processes of equity and empowerment, before surveying an international move towards the development of core competencies for practice, followed by an examination of the models and frameworks used to guide planning. Finally, I investigate the notion of reflective practice and end fittingly with a discussion of needs assessment and an acknowledgement of the function of evaluation in planning. In the ensuing chapter, I discuss the notion of best practice evaluation.

**Defining best practice**

Chief among the compelling reasons for adopting a best practices approach to health promotion is the increased likelihood that health promotion goals will be achieved, such as optimal health for all, social justice, and empowerment. (Kahan & Goodstadt, 2001, p. 47)

Green and Kreuter (1999) assert that the concept of best practice has greater applicability and relevance in a clinical or bio-medical setting where there is a degree of constancy in human biological processes compared to a public health context in which “human communities, organisations, and social behaviour are far more variable, making best practices less certain of working in the ecological situation at hand” (p.37). Today the debate continues around what comprises best practice in health promotion in the areas of planning, evaluation and evidence, illustrated in the innumerable articles and discussion pieces on theories, models, values, and evidence, not to mention tensions, elicited in the literature (Baum, 2015; Baum & Fisher, 2014; Francis & Smith, 2015; Glasgow, Vogt, & Boles, 1999; Green & Tones, 2010; Kahan, 2012; Nutbeam, 1996a; Smith, 2011; Smith & Petticrew, 2010). The more pertinent question might be to ask whether the pursuit of a concept of best practice with its typically prescriptive criteria is counterproductive or necessary to the development and reputation of health promotion as a profession and discipline? Kahan and Goodstadt (2001) warn that an organisational shift towards best practice approaches has the potential to undermine the core principles of health promotion, especially if best practice is prefaced on a limited interpretation of evidence or the underlying motive is “sociopolitical” (p. 47). For example fiscally motivated policy makers and funders might use best practice as a guise to impose austerity measures and exert control over programme decision-making.

Keeping these issues in sight we turn to definitions of best practice, of which the literature search revealed few that distinctly applied to health promotion, perhaps not
surprisingly given the complexities involved. Health Promotion Switzerland (Broesskamp-Stone & Ackermann, 2010) defines health promotion best practice as follows:

Best practice decisions, activities and interventions in the context of health promotion and disease prevention systematically take into account the values and principles of health promotion and public health, are supported by current scientific knowledge as well as knowledge from experts and derived from practice, observe the relevant context factors and achieve the intended positive effects whilst avoiding negative ones. (p. 7) [emphasis added]

Kahan and Goodstadt (2001) offer a similar definition:

Best practices in health promotion are those sets of processes and actions that are consistent with health promotion values, theories, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation. (p. 47) [emphasis added]

Together these definitions offer an appropriately broad and flexible view of best practice as opposed to a more prescriptive approach (Kahan & Goodstadt, 2001). They are both responsive to the multi-dimensional and context-dependent nature of health promotion and reflect the range of approaches to programme planning, implementation and evaluation, from the controlled and coordinated programme working at policy level through to the more quietly evolving community-level participatory based programme.

‘Context’ or ‘environment’ as it is might be applied to these definitions of best practice could refer to setting, target population group, behaviour, environment, as well as cultural, psychological, political and socio-economic factors (Kahan, 2012). These definitions thus embody a notion of best practice that emphasises: the development of programmes embedded in health promotion principles and values, planning and strategies grounded in theory and relevant evidence, an attentiveness to environmental and structural influences on health and behaviour, and the use of multi-levelled strategies in the pursuit of health promotion goals. Broesskamp-Stone and Ackermann (2010) in their definition additionally reference the ethically grounded principle of “do no harm” (Baum, 2015, p. 163), a central tenet of health promotion. My literature review broadly follows this construct of best practice, focusing on health promotion values, context and evidence and how they intersect in the pursuit of health promotion goals, ever mindful that no single exemplar of best practice can exist due to the multifarious approaches and context-bound nature of health promotion (Green, 2001;
Kahan, 2012). This literature review thus supports a broad and adaptable interpretation of best practice, one that espouses a variety of principle based and evidenced approaches, or “best processes” (Green, 2001, p. 165) and strategies as they apply to different settings, circumstances and population groups.

For the purpose of the literature review, I also expand on the notion of ‘context’ to include an examination of the organisational and interpersonal factors that impact on a health promoter’s ability to plan and evaluate on the basis that effective practice can only occur if these conditions are favourable. Thus best practice relies on organisational support to build workforce capacity, provide adequate resourcing and funding, create opportunities and time for relationship building and collaboration, and develop culturally responsive and equitable approaches to planning and evaluation. These organisational factors are discussed throughout the literature review and more specifically in the section, ‘Organisational factors and their impact on health promoters’ ability to conduct evaluation.’

**Best practice planning**

**Principles and values framed by the Ottawa Charter**

The significance of the Ottawa Charter lies in its longevity as a mouthpiece for the field of health promotion. It continues to confirm a vision, orient action, and underpin the values that comprise health promotion today. (Potvin & Jones, 2011)

This part of the literature review begins with a broad overview of health promotion, and its values and principles, as they are understood today within the context of the Ottawa Charter. Many of these principles and values are interwoven throughout the literature review as anchors for best practice health promotion planning and evaluation.

A bio-medical approach to health with its focus on disease and illness long dominated the health discourse (Baum, 2015; Green & Tones, 2010) before the advent of the Ottawa Charter⁴ and successive World Health Organisation (WHO) declarations, marking a departure from an individual behaviour and education-based model of health promotion to a “process of enabling people to increase control over, and to improve, their health” (World Health Organisation, 1986a) at a population level. Since then, the

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⁴ This is not to forsake the contribution of the Lalonde Report (1974) and the Alma Ata Declaration (1978) as pre-cursors to the Ottawa Charter, in establishing the concept of a new public health.
charter has overwhelmingly tenanted the role of determining the values and principles that shape health promotion planning and evaluation on an international stage (Green & Tones, 2010; Potvin & Jones, 2011). Subsequent WHO declarations, reports and charters have built and expanded on the Ottawa Charter, emphasising partnerships, health in all policies, and community participation, together with action targeting the determinants of health, with the aim of reducing inequities and building social capital (World Health Organisation, 1998b, 2005; World Health Organisation & Government of South Australia, 2010).

The values and principles embodied in the Ottawa Charter continue to scaffold much of health promotion practice, with some variation across countries and communities in consideration of unique cultural contexts and demographics. The Ottawa Charter for instance, sits alongside the Treaty of Waitangi in framing much of NZ’s public health service strategy development and contracting processes, including those for health promotion, laying testament to its influence and ongoing regard (Ministry of Health, 2014c, 2016b). Underpinning these values are equity and empowerment, followed by community, social justice, participation, partnerships, a socio-ecological model, holism, health as a right, voluntarism, sustainability, autonomy and non-maleficence (Green & Tones, 2010; Keleher, Murphy, & MacDougall, 2007; World Health Organisation, 1986a). Green and Tones (2010) go so far as to say, “It could be said that unless activity is consistent with these values, it should not be regarded as ‘health promotion” (p. 21).

Policy makers and researchers alike recommend health promoters apply an equity lens to their planning in an endeavour to reduce inequalities (Ministry of Health, 2016b; Potvin, Mantoura, & Ridde, 2007). The WHO defines equity as follows, “Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided” (World Health Organisation, 1986b). Four Steps to Equity, an Australian health promotion tool (2003), identifies community participation, advocacy, partnership and capacity building as crucial strategies for addressing equity. Programmes that lack an equity focus by either assuming a “one size fits all” (Signal & Ratima, 2015, p. 152) approach or neglect to use a range of strategies, focus on a single issue, favour the resourceful and privileged, or focus predominantly on individual behaviour change, risk exacerbating inequalities (Phelan, Link, & Tehranifar, 2010; Signal & Ratima, 2015). Various equity tools are available to guide health promoters in
their planning, including Health Impact Assessment (HIA) (Organisation, 2014; Public Health Advisory Committee, 2005) and HEAT (Signal et al., 2008).

The Ottawa Charter (1986a) proposes the use of advocacy, mediation and enabling as strategies to promote five areas of action: build health public policy, strengthen community action, develop personal skills, create supportive environments and reorient health services to focus on preventing disease and promoting health. These five points of action have become synonymous with the principles and practice of health promotion, signalling the shift to population level, multi-strategy approaches (Baum, 2015; Green & Kreuter, 1999; International Union for Health Promotion and Education (IUHPE), 2000; World Health Organisation, 1986a). Health promotion thus aims not only to strengthen the skills and capacity of both individuals and communities but also directs action at changing the social and environmental determinants of health to ameliorate their impact on population and individual health (Allegrante et al., 2009; Baum, 2015; Mittelmark, Kickbusch, Rootman, Scriven, & Tones; World Health Organisation, 1986a). The determinants of health are discussed in more detail later.

The CompHP consensus statement quoted below succinctly underscores the aspirations and ideals of health promotion best practice and signals the complexities of planning and evaluating programmes against a backdrop that calls for ethical and participatory approaches, an awareness of cultural difference and an appreciation of the impact of environmental and social factors on health:

The Consensus Statement reaffirms the core values and principles of health promotion, which provide a common basis for practice. These include: a social-ecologic model of health that takes into account the cultural, economic and social determinants of health; a commitment to equity, civil society and social justice; a respect for cultural diversity and sensitivity; a dedication to sustainable development; and a participatory approach to engaging the population in identifying needs, setting priorities, and planning, implementing and evaluating the practical and feasible health promotion solutions to address needs. (Barry, Allegrante, Lamarre, Auld, & Taub, 2009, p. 8)

With such multiple factors to consider and incorporate into planning and evaluation, it is of little surprise that researchers along with practitioners continue to be challenged by the notion of best practice or at least, a singular notion of best practice.
**Treaty of Waitangi**

Māori health promotion is “the process of enabling Māori to increase control over the determinants of their health and strengthen their identity as Māori.” (Ratima, 2010, p. 8)

New Zealand offers a unique cultural perspective to health promotion because the principles of the Treaty of Waitangi underpin the country’s public health system and legislation for improved health outcomes and reduced disparities for Māori (New Zealand Ministry of Health, 2014, 2016). This means PHUs as Crown entities are legally and ethically obligated to observe the principles of the Treaty when planning, implementing and developing programmes (Ministry of Health, 2014c, 2016b). Government policy maintains that all health promotion programmes be based on Treaty principles, as detailed here

1. **Partnership** – involves working with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services

2. **Participation** – requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services

3. **Protection** – involves the Government working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices

(Quoted from ”Treaty of Waitangi principles,” 2018)

He Korowai Oranga (2014), the MoH Māori Health Strategy, sets the strategic direction for achieving best health outcomes for Māori through the aims of: ensuring Māori inclusion in all facets of the health and disability sector; supporting whānau, hapū, iwi and community development; drawing on intersectoral approaches; providing high quality and culturally responsive health and disability health services; building a Māori research evidence base to inform effective planning and evaluation; strengthening the capacity of the Māori workforce; supporting Māori leadership; and finally, the ongoing collection of quality ethnicity data and health information to guide planning and resourcing. DHBs are expected to consider He Korowai Oranga in their planning.
The Health Promotion Forum (HPF) of New Zealand in its document a Treaty Understanding of Hauora in Aotearoa – New Zealand or TUHA-NZ (Health Promotion Forum of New Zealand, 2002) demonstrates its commitment to Te Tiriti o Waitangi by providing practitioners with a practical framework to apply te Tiriti values to their work. This recognition of Te Tiriti o Waitangi as a guiding tool for health promotion practice in NZ extends to the Health Promotion Competencies for Aotearoa New Zealand (Health Promotion Forum of New Zealand, 2012), discussed later in the literature review. Māori models (Durie, 1985; Durie, 1999) and frameworks (New Zealand Ministry of Research, 2007) help further lay the foundations for Māori health promotion and research in Aotearoa, NZ.

Ultimately, best practice planning for Māori might be described as that which allows Māori “to demonstrate a level of autonomy and self-determination in promoting their own health” while focusing on achieving the best outcomes for Māori health (Durie, 1999, p. 6). How these aspirations fit within our current health system model largely remains to be seen given the disparities in health status that persist between Māori and non-Māori (Berghan et al., 2017), though investment in initiatives like Whānau Ora (Kōkiri, 2010) show both promise and a commitment to Treaty principles (Wehipeihana, Were, Akroyd, & Lanumata, 2016).

From here, I turn to examine the significance of ‘context’ or ‘environment’ as it relates to the determinants of health and best practice approaches to health promotion.

**Determinants of health**

We hope that by tackling some of the material and social injustices, policy will not only improve health and well-being, but may also reduce a range of other social problems that flourish alongside ill health and are rooted in some of the same socioeconomic processes. (Wilkinson, Marmot, World Health Organization Regional Office for Europe, WHO Centre for Urban Health (Europe), & International Centre for Health and Society, 2003, p. 9)

At the heart of planning, particularly in striving to reduce inequalities, lies the need to consider the determinants of health and their impact on behaviour and health outcomes (Baum & Fisher, 2014; Green & Tones, 2010). A myriad of social and other environmental factors, including housing, community networks, access to health care services, employment, culture, stigma, education, historical injustices, colonisation income, and environmental hazards can all impact on health and behaviour (Commission of Social Determinants of Health, 2008; Howden-Chapman et al., 2011;
Marmot, Friel, Bell, Houweling, & Taylor, 2008; Marmot & Wilkinson, 2005; Oliver, Pierse, Stefanogiannis, Jackson, & Baker, 2017; Whitehead, 1992). The Commission on Social Determinants of Health (2008) identified the need to improve people’s general living conditions, and beyond that understand, measure and address the unequal distribution of social, economic, and political factors that influence health, and subsequently build workforce capacity in this domain. They recommend the use of Health Equity Impact Assessments (HEIA), intersectoral partnerships and a ‘health in all policies’ approach to equity. The World Conference on the Social Determinants of Health and the resulting declaration (World Health Organisation, 2011) affirm this intersectoral and ‘health in all policies’ approach to tackling the social determinants of health and the promotion of health equity on a global scale.

Health promotion planning necessitates an approach that prioritises equity and ethical perspectives to tackle chronic diseases and their associated risk behaviours because it is the socio-economically disadvantaged who carry the burden of disease (Baker et al., 2012; Blakely, Fawcett, Hunt, & Wilson, 2006; Blakely & New Zealand Ministry of Health, 2007; Marmot et al., 2008; New Zealand Medical Association, 2011; Oliver et al., 2017; Phelan et al., 2010; Simpson, Duncanson, Oben, Wicken, & Gallagher, 2016; Thomas, Briggs, Anderson, & Cunningham, 2008; Wilkinson et al., 2003). For instance, in NZ rates of diabetes are significantly higher among deprived and lower income people, and disproportionately higher for Māori, Pacific and South Asian populations (Blakely & Simmers, 2011). Another example of the “social gradient” (Wilkinson & Marmot, 1998, p. 10) at work is found in the incidence of rheumatic fever and inflammatory heart disease, and its association with poor housing and deprivation (Oliver et al., 2017). Such outcomes are counter-intuitive to a social justice perspective and therefore to health promotion.

Inequities can be enduring, persistent and intergenerational, emphasising the need for multi-strategy and innovative approaches that target the underserved (Marmot et al., 2008). For example, while NZ has attained considerable success with its multi-strategy, coordinated efforts to achieve Smokefree 2025 and a reduction in smoking rates to <5%, current smoking rates for Māori are still significantly higher than for non-Māori, highlighting the enduring health-related disparities and significant forces that determine health status (Ministry of Health, 2014d). Central to an equity approach is also the need to ensure that policy and programmes themselves do not exacerbate
inequalities (Hill, Blakely, Fawcett, & Howden-Chapman, 2005; Phelan et al., 2010). A thorough approach to planning that recognises the influence of socio-economic status on health and behaviour can help to ensure a proposed programme or policy change will benefit the target population irrespective of their circumstances (Phelan et al., 2010). Finally, an attitude of victim blaming contravenes a determinants view of health and is often a by-product of health education programmes that fail to recognise the external circumstances that shape health and behaviour and instead place responsibility solely on the individual (Baum & Fisher, 2014; Green & Tones, 2010; Jackson, Perkins, Khandor, Cordwell, & Hamann, 2006; Laverack, 2017).

In recognising the sway of determinants on health that are largely beyond the control of the individual, health promotion must exercise a multi-faceted approach to programme planning and adopt a comprehensive raft of complementary strategies and intersectoral approaches (Baum & Fisher, 2014; Green & Tones, 2010; Jackson et al., 2006; Laverack, 2017; Signal et al., 2013). This underscores a shift from individual and risk behaviour models alone, which tend to target the more ably resourced (Baum & Fisher, 2014; Phelan et al., 2010; Signal & Ratima, 2015), to a multi-strategy approach that works at policy level, through to community development and individual level. Undertaking such a shift honours the principles of partnership, community participation and social justice among other health promotion values. Health promotion programmes that employ a variety of strategies and operate across multiple levels have been found more likely to institute change and promote inclusiveness, evidenced in a paper comprising a synthesis of reviews of health promotion initiatives dating back to 1999, produced for the WHO 6th Global Conference on Health Promotion (Jackson et al., 2006). The authors found that the development of healthy public policy was crucial to the effectiveness of a programme, and that the formation of supportive environments needed to occur across all levels from the individual through to organisational level. They were unable to determine the effectiveness of building community action, and the development of personal skills was viewed as effective only when used in combination with other strategies.

Overall, upstream approaches to planning are championed in the literature as the most likely to effect change and redress the power balance in favour of the underserved (Alvaro et al., 2011; Gore & Kothari, 2013; Marmot et al., 2008; VicHealth, 2015). Gore and Kothari (2013) in a review of both settings based and structural based initiatives
concluded that structural based initiatives were more likely to result in lasting social change, address inequalities and improve health outcomes than environment or settings based initiatives on the premise that "intermediary determinants are produced by structural determinants, and they will be maintained and reproduced as long as stratifying economic and political structures persist” (p. 53). Solar and Irwin (2010) in their conceptual framework for action similarly argue for interventions and policies that target the structural determinants, and support the use of intersectoral action to tackle inequities. Health promoters are encouraged to bear upstream approaches in mind when planning, particularly in the area of healthy public policy, and organisations are encouraged to build workforce capacity to operate at this level (Gore & Kothari, 2013; Green & Tones, 2010).

Instituting change at this level requires tremendous political motivation and resources and a universal commitment to a ‘health in all policies’ approach (Baum & Fisher, 2014; Marmot et al., 2008; World Health Organisation & Government of South Australia, 2010). New Zealand has identified the need for a whole-of-government approach to reducing inequities in health (Ministry of Health, 2014c; New Zealand Ministry of Health, 2002, 2016), and as such has been praised for its equity demographic data gathering systems (Marmot et al., 2008) and recognised for its regulatory policy and intersectoral approaches to issues like smoking and unhealthy homes. However, NZ’s efforts in tackling inequities must be viewed as a work in progress with current political structures falling well short of their intended goal of advancing population health (Duncanson et al., 2017).

**Participation and its relationship to equity and empowerment**

Health promotion programmes are most successful when linked to the normal daily life of communities, building on local traditions and led by community members. (McQueen, 2007, p. 202)

Globally, the terms *community, participation, empowerment* and *collaboration* have become virtual shorthand for health promotion. (Green & Kreuter, 1999, p. 63)

Participation and collaboration are important features of health promotion planning because the inclusion of individuals, groups and communities in decision-making processes encapsulates many of the core principles of health promotion such as empowerment, inclusiveness, social justice and equity (Barry et al., 2012; MacDonald &
Empowerment is described as “a process through which people gain greater control over decisions and actions affecting their health” (Nutbeam, 1998b, p. 6) and involves reciprocal decision-making, and the obtainment of knowledge and responsibility as a means of redefining the ‘power balance’ (Baum, 2015; Green & Tones, 2010; Signal & Ratima, 2015). In this way, a true community development approach is able to facilitate the processes of empowerment, autonomy and ethical responsiveness (Wallerstein, 2006). Empowerment processes can begin during needs assessment through consultation with community to understand their needs and should extend beyond the designing of programme activities to envelop policy making, evaluation and dissemination (Green & Tones, 2010; Marmot et al., 2008; Smith, Tang, & Nutbeam, 2006). There are varying levels of community engagement ranging from the community that plays an instrumental role in all decision making, with practitioners playing a secondary supportive role, to initiatives that involve community to a much lesser degree, and as a result are less likely to engage in empowerment processes (Signal & Ratima, 2015; Wallerstein, 2006). A true community-based participatory model is viewed as challenging to achieve (MacDonald & Mullett, 2008), perhaps particularly so for those health promoters who are accountable to the goals and targets set by their government employers. Researchers reiterate the view that true community based participatory research aims to be, “community-based and often community-directed, rather than merely community placed” (Minkler & Wallerstein, 2008, p. 3), emphasising the centrality of empowerment approaches and the active role of stakeholders in all stages of the planning process.

Health promoters and researchers alike have identified the fine balance involved in trying to accommodate the articulated needs and aspirations of stakeholders and community with the needs signalled by data and government targets (Baum, 2015; Green & Kreuter, 1999). Green and Kreuter (1999) describe it as the need to find “common ground” (p. 58). Baum (2015) similarly emphasises the need to be attuned to community perspectives and what is important to them, to inform planning. This sensitivity and respectfulness extends to different cultural perspectives, to counter the potential for disempowerment. It is widely acknowledged in the literature that community involvement should occur from the outset of a programme, not only as a means of capturing a community’s primary needs but also because a community is more likely to become involved and invested in a programme if their participation is actively
sought and valued from the beginning (Baum, 2015; Green & Kreuter, 1999), and the resulting programme is reflective and designed to meet their needs (Farquhar, Parker, Schulz, & Israel, 2006). As Baum (2015) states, subscribing to participatory approaches to determine community need through the use of qualitative methods is to “recognise that perspectives and solutions from within a community have a far greater chance of informing effective plans than those based on external perspectives” (p.231). Following a true participatory approach is to also accept that the goals and aspirations of community may be quite different to those of health promoters, their managers and funders (Baum, 2015).

Effective participatory approaches are built on mutual trust, courtesy, time, transparency, communication and respect (Cargo & Mercer, 2008; Green & Kreuter, 1999; Israel, Schulz, Parker, & Becker, 1998; Minkler & Wallerstein, 2008). Conversely, neglecting to consult and problem solve differences during programme planning and implementation can lead to mistrust, reticence or a breakdown in communication (Green & Kreuter, 1999). Researchers acknowledge the expertise community bring to the planning table alongside their experiential knowledge and insights into community priorities, concerns and existing support mechanisms (Cargo & Mercer, 2008; Gore & Kothari, 2013; Green & Tones, 2010). Over thirty years ago the South Australian Community Health Research Unit (1991) set guidelines for practitioners working with community that remain just as relevant today; in so far as consultation should be considered and deliberate, involve good listening skills, be inclusive of those in the community who are not always heard, connect with existing community networks and finally, results and information should be disseminated in a way that is appropriate and acceptable to community. Rootman, Goodstadt, Hyndman, et al. (2001) affirm the need to identify community champions and utilise existing networks and assets to build community capacity.

Meaningful participation in the planning process can also counter the potential for “coercion” (Green & Tones, 2010, p. 29) or inadvertent harm to occur during the course of a health promotion programme. Care is needed to ensure that community participation is broad, inclusive and representative of a range of different groups within a community though it is acknowledged that this is not always easily achieved (MacDonald & Mullett, 2008). There may be those within a community who do not have access to community resources and are excluded from the participatory process,
highlighting a core function of community development (Baum, 2015). Evaluation can play an important role in ascertaining the reach and representativeness of a programme and this is discussed in more detail later in the literature review.

Community participation, then, with its associated principles of communication and inclusiveness can be an empowering process, central to effective planning and equitable health outcomes.

**National and international core competencies**

Both internationally and nationally health promotion researchers and practitioners have responded to the need to construct a collective understanding of what knowledge and skills are necessary to plan and evaluate health promotion programmes through the development of core competencies (Allegrante et al., 2009; Australian Health Promotion Association, 2009; Barry et al., 2009; Dempsey, Barry, Battel-Kirk, & the CompHP Project Partners, 2010; Health Promotion Forum of New Zealand, 2012; Health Scotland, 2005). Not surprisingly, these competency frameworks share many of the same fundamental principles and include ‘planning’ as one of the core areas of action. Core competencies can be defined as “the minimum set of competencies that constitute a common baseline for all health promotion roles. They are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field” (Australian Health Promotion Association, 2009, p. 2). While competencies, as defined here are commonly understood to offer a ‘minimum’ or ‘baseline’ measure of competency some countries have attempted to expand on the measures to reflect graduated levels of practitioner expertise (Dempsey et al., 2010; Health Promotion Forum of New Zealand, 2012; Health Scotland, 2005).

A competency approach is not without criticism. Some researchers hold that competencies should encourage practitioners to strive for expertise, not simply a level of competence, while others consider the use of competencies might limit the potential for creativity or sensitivity in different contexts or complex situations (Dempsey et al., 2010). Yet others oppositely assert that a competency based approach can promote innovative practice, indicated here by the authors of the CompHP Project, “The work of the CompHP Project has created a new dimension in European health promotion by establishing the means and methods by which agreed core competencies and quality standards can be implemented to stimulate innovation and best practice” (Barry et al., 2012, p. 5).
The Health Promotion Competencies for Aotearoa – New Zealand\(^5\) (2012) created by the Health Promotion Forum (HPF) offer another level of competency in recognition of Te Tiriti o Waitangi. Similar to other competency frameworks, the NZ version endorses health promotion values and ethical practices, equity, community development and participation, multi-strategy approaches, workforce capacity building and acknowledges the social determinants of health. In a review of the original set of competencies health promoters reported them to be useful and informative in demarcating the skills and knowledge required for effective practice (Health Promotion Forum of New Zealand & Ministry of Health, 2004). The revised NZ competencies in their totality share a number of qualities with our broad understanding of health promotion best practice, particularly in regard to values, evidence informed theories and models, stakeholder engagement, and the recognition of equity and the social determinants of health (Barry et al., 2009; Marmot et al., 2008; World Health Organisation, 1986a). It is yet to be seen how these competencies might be fully realised or incorporated into NZ professional practice, prompting the need to look at the use of core competencies and accreditation systems internationally as a gauge of their potential. Health promotion practice in NZ is characterised by its diversity; the question is, would a competencies and accreditation system promote consistency of practice across the profession, or alternatively inhibit innovative practice?

**Models and frameworks to support planning**

There are numerous models, resources and frameworks to guide health promoters towards effective planning (Durie, 1999; Glasgow et al., 1999; Green & Tonks, 2010; Green & Kreuter, 1999; Jolley, Lawless, & Hurley; National Public Health Partnership, 2000; Public Health Ontario, 2015; Signal et al., 2008; Wren, 2006). It is not within the scope of this literature review to present a detailed overview of these various models and frameworks; platforms for this already exist in the literature (Glanz, Rimer, & Viswanath, 2015; Green & Tonks, 2010). Nor is it appropriate to make assumptions about the potential for effectiveness of individual models or frameworks because of the

\(^5\)A set of NZ health promotion competencies was established in 2000 (Health Promotion Forum of New, 2000), followed by the development of a set of competencies common to all public health roles (Public Health Association of New Zealand, 2007) . The HPF undertook a review of the original set of health promotion competencies, a process that involved wide consultation, research and a comparison of the original health promotion competencies with the generic set of public health competencies. The result was the Health Promotion Competencies for Aotearoa – New Zealand 2012 (Health Promotion Forum of New Zealand, 2012).
highly individualistic nature of health promotion initiatives and their context, though the preference shown in the literature for particular models infers their perceived usefulness in guiding planning (Glasgow et al., 1999; Green & Kreuter, 1999; King, Glasgow, & Leeman-Castillo, 2010; McKenzie, Naccarella, Stewart, & Thompson, 2007; Porter, 2016). Instead, I briefly touch on the breadth of models and frameworks available and determine some of the fundamental collective features that might contribute to effective planning.

Most planning frameworks share similar elements, with some variation, that reflect the following actions or patterns: identifying the population group, conducting a needs assessment of the target population and community context, defining the problem and its causes, conducting a literature scan, establishing clear goals and objectives, developing and implementing strategies, evaluating processes and outcomes and finally, disseminating results and outcomes (Farquhar et al., 2006; Green & Kreuter, 1999; Nutbeam & Bauman, 2006). Practitioners also draw on theoretical frameworks and models to make logical inferences or assumptions about proposed programme strategies and how they might contribute to behaviour change, policy or to overall goals and outcomes (Angeles, Dolovich, Kaczorowski, & Thabane, 2014; Creswell, Hanson, Clark Plano, & Morales, 2007; Wren, 2006). It should be noted, however, that some of these theories are directed at individual behaviour change or downstream approaches and as a consequence, they disregard the influence of environmental factors on behaviour. With the exception of behavioural change theories, many of these health promotion models, frameworks and guides espouse the importance of community and stakeholder involvement, cultural responsiveness, the use of broad approaches to address the determinants of health and equity issues, and lastly, programmes that are based on best evidence and knowledge (Integrated Health Promotion Team, 2003; Ministry of Health, 2016b). These features sit neatly alongside my conception of best practice.

More recently, some countries have developed platforms or forums, including online portals, to share evidence generated from interventions, to promote models of best-practice health promotion (Brug et al., 2010; Center for Community Health and Development (University of Kansas), 2018; Excellence, 2018; Infoxchange, 2018; Public Health Agency of Canada; Sims-Jones & Robinson, 2013; World Health Organisation, 2010a). These platforms are not without flaw in that some do not allow for the inclusion
of more complex interventions, or are inconsistent in quality, lack formal critique or tend to focus on single-issue, behaviour change interventions (Brug et al., 2010). In NZ there are currently no comprehensive or widely accessible platforms for the dissemination of practice-based evidence beyond peer-review journals (not always easily accessible) and public health conferences.

**Reflective practice**

Various ‘signposts’ ranging from checklists, planning templates, equity tools and logic models exist to support and encourage reflective practice during the planning process, enabling health promoters to identify the necessary adjustments for programme improvement. This process of reflection might be considered critical to an equity approach, particularly in assessing the reach and acceptability of a programme to its target population and the many factors that might influence a programme and its outcomes. The ability to reflect is dependent on an individual’s personal motivation, knowledge, training, the time available and the degree of collegiality or organisational support to initiate change (O’Connor-Fleming, Parker, Higgins, & Gould, 2006). Broesskamp-Stone and Ackermann (2010) present a reflection tool for everyday health promotion work that aims to increase the effectiveness of a programme and promote ethical practice in the belief that, “The implementation of best practice requires systematic, recurrent reflection by professionals or those responsible for health promotion and prevention when making decisions or when planning, implementing and evaluating activities to promote health” (p. 11). Baum (2015) similarly supports a reflective approach to practice. Formative and process evaluation can be viewed as tools aiding critical reflection, to be discussed later in the literature review.

**Problem analysis and needs assessment**

Stories have great potential as a way of engaging people in a needs assessment process. There is no better way of bringing home the reality of unmet needs than stories about a community’s or individual’s plight. Combined with relevant statistics and survey data, a full picture can be obtained. (Baum, 2015, p. 239)

Needs assessment is “a systematic procedure for determining the nature and extent of health needs in a population, the causes and contributing factors to those needs and the human, organisational and community resources which are available to respond to these” (World Health Organisation, 2006). Occurring early in the planning process needs assessment is often considered integral to the success of a programme (Green &
Tones, 2010; Green & Kreuter, 1999; Nutbeam & Bauman, 2006). There is “no set formula” (Baum, 2015, p. 232) dictating the shape and form of a needs assessment; much will depend on the size of a programme, the time and resources available, the nature and level of engagement with stakeholders and community, and the level of research skills health promoters demonstrate among other factors (Baum, 2015; O'Connor-Fleming et al., 2006). Conducting a needs assessment might be viewed as representing a responsive approach to a problem rather than a reactive, often politically motivated response to a topical issue.

Some of the elements viewed as important to needs assessment include: knowing the needs and priorities of the target population, understanding the determinants of health and their influence on the targeted health issue, identifying community capacity and strengths, investigating the cause and characteristics of the health issue and determining the extent and reach of the problem (Green & Tones, 2010; Nutbeam & Bauman, 2006; Waa, 1998). These factors help with the formulation of clear goals and objectives, as well as the best means to achieve them; both crucial to the development of effective health promotion programmes and later, evaluation (Green & Tones, 2010; O'Connor-Fleming et al., 2006). In alignment with the multi-disciplined and holistic nature of health promotion, the methods for gathering information for needs assessment are necessarily varied and broad (Green & Tones, 2010). Information can be gathered utilising existing data sets, health and environmental indicators, surveys, focus groups, interviews, government statistics as well as other means. Data can be qualitative or quantitative, or a mix of the two, with one often viewed as complementary to the other (Green & Kreuter, 1999).

**Evaluation in planning**

Evaluation anxiety “can be considerably diminished by attending to a systematic planning process that precedes the implementation and evaluation of the program.” (Green & Kreuter, 1999, p. 230)

Planning and evaluation might be considered a symbiotic or synergistic relationship. Researchers agree that evaluation should be integrated into planning early in the life of a health promotion programme and throughout its development (Green & Tones, 2010; National Public Health Partnership, 2000; Nutbeam & Bauman, 2006; O'Connor-Fleming et al., 2006; Waa, 1998). Perceived benefits of doing so include: a greater likelihood of resources being allocated specifically for evaluation, an evaluation that links more
closely to the programme as a whole, and the ability to gather comparative baseline data and apply performance indicators from start to finish (Huckel et al., 2016; Wilson, Magarey, Dollman, Jones, & Mastersson, 2010). The goals and objectives established in the planning stage of a programme will inevitably drive the direction of evaluation (Farquhar et al., 2006) moreover, if objectives are well planned and strategies are “sound and targeted to those objectives, [a programme] should lend itself easily to an evaluation that will detect the changes implicit in the objectives” (Green & Kreuter, 1999, p. 230). Conversely, evaluation is equally important to the iterative process of planning in that it allows for strategies and methods to be tested and can help determine the reach of a programme and the necessary modifications required for programme improvement (Green & Tones, 2010). The literature review now shifts to best practice evaluation.

**Best practice evaluation**

**The task of identifying best practice evaluation**

The objective of this section of the literature review is to lead to a greater understanding of best practice health promotion evaluation. I began the task of identifying what constitutes best practice evaluation in health promotion with a degree of naivety, almost with the expectation that I would be led by national and international health policy and the literature to a definitive and widely accepted understanding of best practice approaches and strategies for evaluation. It soon became abundantly clear this was not to be the case. Instead what I discovered was a raft of literature spanning the course of over twenty years covering a complexity of conceptual, methodological and organisational issues related to evaluation (Bauman, King, & Nutbeam, 2014; Datta & Petticrew, 2013; Francis & Smith, 2015; Lobo, McManus, Brown, Hildebrand, & Maycock, 2010; Nutbeam, 1996b, 1998a; O’Connor-Fleming et al., 2006; Smith & Petticrew, 2010; Wise & Signal, 2000). Health promotion’s “slowly at best” (Smith, 2011, p. 165) progress and inability to articulate clear terms of practice in evaluation and develop a comprehensive evidence base continues to hamper its maturation and potential to instil faith in policy makers, funders and the wider health sector (McQueen, 2001; McQueen & Jones, 2007).

Despite the wealth of literature on health promotion evaluation and numerous discussion papers, frameworks and models that have been developed and adapted to guide practice (Davies & Sherriff, 2014; Glasgow et al., 1999; Goodman, 1998; Green &
Kreuter, 1999; Jolley et al., 2008; Nutbeam, 1998a; Nutbeam & Bauman, 2006; 2001), no one single model has emerged as an exemplar of best practice evaluation, nor is consensus on what actually characterises best practice evaluation likely, given the complexity and context-dependent, multi-strategy nature of health promotion programmes (McQueen, 2001; Nutbeam & Bauman, 2006). Moreover, Francis and Smith (2015) recently observed there have “been few formal investigations of evaluation practices in the field of health promotion” (p. 716), a finding supported by Lobo et al. (2014). It should be noted this section of the review is largely built on the premise that in order to understand what best practice evaluation might look like we must in addition observe the various challenges and barriers that are perceived to impede its development (discussed later in the chapter).

I begin this section of the literature review with a definition of evaluation before exploring the different purposes and forms of evaluation. From here, I briefly discuss the underpinning principles and values of evaluation, and the development of models and frameworks to support the evaluation of health promotion programmes. Following this I investigate research methods and the building of an evidence-base and the various issues this entails, before examining organisational factors such as funding and capacity building and their impact on health promoters’ ability to conduct evaluation. Best practice in accordance with our earlier definition here, relates to principles, values, context, and perhaps most importantly, evidence as it applies to practice.

**Defining evaluation**

The generation and use of a diverse range of data and information sources will generally provide more illuminating, relevant and sensitive evidence of effects than a single ‘definitive’ study. (Nutbeam, 1998a, p. 41)

Evaluation is variously defined in the literature nonetheless there are commonalities to these conceptualisations around information sharing and the assessment of programme processes and outcomes (Nutbeam & Bauman, 2006; Rootman, Goodstadt, Hyndman, et al., 2001; World Health Organisation, 1998a). WHO in an often cited definition, describe evaluation as:

The systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness. (World Health Organisation, 1998a, p. 3)
Comparatively, Nutbeam and Bauman (2006) assert that:

In health promotion, an evaluation will determine the extent a programme has achieved its desired health outcomes, and will assess the contribution of the different processes that are used to achieve these outcomes. (p. ix)

While Waa (2015) says of evaluation:

Evaluation is a knowledge-building and, ideally, a knowledge-sharing exercise. Domains of knowledge include understanding a problem (formative), the best mix of actions to go about addressing it (process), and whether a meaningful change in the problem will result from implementing an intervention (outcome). (p. 111)

And finally, Baum’s (2015) contribution to a definition of evaluation:

Evaluation assists sense-making about policies and programs through the conduct of systematic enquiry that describes and explains the policies’ and programs’ operations, effects, justifications, and social implications. (p. 243)

In these definitions and others, evaluation is not simply concerned with outcomes, but also programme processes and how these mediate and contribute to outcomes (Nutbeam, 1998a; Nutbeam & Bauman, 2006). This hybrid view of evaluation, which places equal value on both processes and outcomes, sits squarely with the Ottawa Charter, which defines health promotion as a “process of enabling people to increase control over, and to improve, their health” (World Health Organisation, 1998a, p. 3). Baum (2015) similarly recognises the centrality of people, participation and empowerment to the evaluation process when she states, “Evaluation of community development and healthy settings projects is as much about partnerships and community participation as the projects themselves” (p. 244). Last but not least, evaluation is instrumental to programme development and improvement and plays an important role in establishing an evidence base to inform future health promotion practice.

**Evaluation purpose and form**

Evaluation has multiple purposes: to assess the appropriateness of a programme in obtaining its goals and objectives, to ascertain the reach of a programme, identify the gaps and strengths of a programme and its delivery, contribute to the evidence base for future programme planning, show accountability, guide programme development, assess stakeholder involvement and acceptability, provide evidence to influence policy
making, and fulfil ethical requirements (Chambers, Murphy, & Kolbe, 2015; Francis & Smith, 2015; Nutbeam & Bauman, 2006; O'Connor-Fleming et al., 2006; Patton, 2002; Pettman et al., 2012; Rootman, Goodstadt, Hyndman, et al., 2001; Waa, 1998).

Despite calls for evaluation not to be used simply as a means to “justify funding, but also to determine effectiveness and compare standards of practice” (Durie cited in Moewaka Barnes, 2009, p. 9) the literature shows that evaluation is often used for the primary purpose of demonstrating accountability to funders, policy makers and management (Chambers et al., 2015; Dunne, Scriven, & Furlong, 2012; Green & Tones, 2010; Patton, 2002). In an Australian study, Lobo et al. (2014) found that easily collected data or that which was used for the purpose of fulfilling organisational requirements was more likely to be gathered, while all participants in Brug, Tak and Te Velde’s (2011) study cited accountability as an important reason for conducting evaluation.

Nutbeam and Bauman (2006) describe evaluation as the “formal process of judging the ‘value’ of something” (p. ix). Inevitably this value will be constructed differently according to an individual or organisation’s role in a programme and whether they are a funder, practitioner, manager, policy maker, the community, or outlier (Baum, 2015; Moewaka Barnes, 2009; Nutbeam & Bauman, 2006; O’Connor-Fleming et al., 2006; Waa, 1998). Green and Tones (2010) note “there is often substantial variation in the views of stakeholders about what would constitute success, and indeed, about the purpose of the evaluation enterprise itself,” (p. 470) reminding us of the need to approach planning for evaluation with clear purpose and goals, inclusivity and transparency. Moreover, the power of funders and management to assert influence on the evaluation research agenda must be anticipated and cannot be underestimated (Green & Tones, 2010).

Evaluation is inherently context-bound, meaning that the targeted population group, scope, scale, setting, (Nutbeam & Bauman, 2006; Rychetnik, Frommer, Hawe, & Shiell, 2002) and cultural circumstances (Fotu et al., 2011) in which an intervention operates can all ultimately influence the form, purpose and outcomes of a programme. Add to this the complexities of individual health behaviour together with socio-economic and political contextual factors and we begin to appreciate the intricacies and complexities involved in conducting evaluation. O’Connor-Fleming et al. (2006) venture that given the complex nature of health promotion “there may not be an ideal evaluation design or definitive measure” (p. 66) that can be applied to a programme, a claim which finds support in Nutbeam and Bauman’s (2006) statement that, “The best approach in health
promotion program evaluation will vary, depending on the context and setting of the program, the resources and time available, and the expressed needs of stakeholders for evidence of program effectiveness” (p. 83). What is evident is the need to enter the evaluation process with clear purpose and context in sight with an end view to how the results might be practicably applied to programme improvement or contribute to the evidence base.

**Principles and values**

As we have already established, the values and principles embodied in the Ottawa Charter largely guide health promotion practice and this is certainly true of evaluation (MacDonald & Mullett, 2008; Tones, 2002). The WHO European Working Group on Health Promotion Evaluation (2001) devised four principle-based features to guide evaluation as these include: broad and inclusive participation; build the capacity of individuals, communities, organisations and governments to tackle health promotion issues; use a range of information gathering methods and multi-disciplined approaches; and finally, be appropriate to the complexities of health promotion initiatives. Meanwhile Green (2006) offers a practical set of principles for evaluating public health interventions based on the Ottawa Charter, as such: ensure evaluation has a clear purpose, assess both processes and outcomes, consider the impact of environmental factors, draw on a range of methods to collect information, engage with and be inclusive of stakeholders’ views, and acknowledge the power dynamic between practitioner and community. Underlying these and other evaluation tools or frameworks sit the principles of equity, empowerment and participation. MacDonald and Mullett (2008) argue that evaluation that is tied more closely to health promotion principles is more likely to be ethically sound, more inclusive of community and attuned to good research processes.

**The development of models and frameworks to support evaluation**

Numerous models, resources and frameworks exist to guide health promoters towards effective evaluation (Coen & Wills, 2007; Craig et al., 2013; Craig et al., 2008; Cunningham, Signal, & Bowers, 2011; Glasgow et al., 1999; Hawe, 1990; Jolley et al.; Nutbeam & Bauman, 2006; O’Connor-Fleming et al., 2006; Rootman, Goodstadt, Hyndman, et al., 2001; Round, 2005; Rychetnik et al., 2002; Saunders, Evans, & Joshi, 2005; Social Policy Evaluation and Research Unit (SUPERU), 2017; Waa, 1998). In accepting that “evaluations have to be tailored to suit the activity and circumstances of
individual programs - no single method or design can be ‘right’ for all programs” (Nutbeam & Bauman, 2006, p. 32) we are effectively acknowledging that there is no one model or framework that exemplifies best practice evaluation beyond one that is underpinned by health promotion principles.

Most frameworks or models generally embrace three or four phases of evaluation, with some variation in terms\(^6\), beginning with formative and process evaluation, followed by impact and lastly, outcome (Nutbeam & Bauman, 2006; O’Connor-Fleming et al., 2006). Formative evaluation involves the gathering of information and baseline data in order to define the issue, identify the target group, plan, develop and improve a programme, including the setting of goals, objectives and strategies (Anderson, 2008; Nutbeam & Bauman, 2006; Schoster, Altpeter, Meier, & Callahan, 2012; Waa, 1998). Process evaluation is focused on the reach and acceptability of a programme, and whether it has been implemented as was intended. Process evaluation is also used to assess the strengths and weaknesses of a programme and as such, is instrumental to programme development and improvement (Craig et al., 2008; O’Connor-Fleming et al., 2006; Pettman et al., 2012; Saunders et al., 2005; Waa, 1998). Impact evaluation is concerned with the immediate impacts of a programme while outcome evaluation investigates the longer-term effects of a programme, as these relate to a programme’s objectives (Craig et al., 2008; O’Connor-Fleming et al., 2006). While there is an emphasis on programmes following a logical or linear progression beginning with problem identification and ending with evaluation (Green & Tones, 2010; Nutbeam & Bauman, 2006) the reality means that this is not always possible nor appropriate; rather a programme is more likely to follow a cyclic pattern of development.

A number of evaluation tools and frameworks have been custom-designed for specific settings or populations, including workplace and school initiatives (Dunet et al.; Lee, Cheng, & St Leger, 2005), those targeting single issues like alcohol control and policy (Duignan & Casswell, 1992), tools designed to evaluate community change (Scott & Proescholdbell, 2009), partnerships and organisational development (Fotu et al., 2011) as well as indigenous models (Moewaka Barnes, 2009). Other popular models and frameworks like RE-AIM, developed by Glasgow et al. (1999) have experienced various iterations in different settings and contexts, such as King et al. (2010) who applied a

\(^6\) The evaluation literature reveals variations in definitions, for example the terms ‘impact’ and ‘outcome’ are sometimes used interchangeably
revised RE-AIM model to programmes targeted at built environment interventions to promote healthy eating and active living.

Research methods and building an evidence base

Given the need to evaluate public health initiatives to maximise health benefits, minimise harms, avoid exacerbation of health inequities, and maximise the value of resources, the question of what constitutes evidence of effectiveness is critical. (Sanson-Fisher, D’Este, Carey, Noble, & Paul, 2014, p. 11)

The debate around what constitutes evidence in health promotion reveals that the “spectrum of opinion is broad and diverse” (McQueen, 2001, p. 261; O’Connor-Fleming et al., 2006; Raphael, 2000) if not contentious. The challenges of attributing causality between a programme and its outcomes, gaps in practice-based evidence, question marks around appropriate measures, divergent opinion on what constitutes evidence and a lack of acceptance of alternative evaluation methods have all dominated much of the discourse on health promotion evaluation (McQueen, 2012; Raphael, 2000; Smith, 2011; South & Tilford, 2000) over the last two decades. Indeed, it seems the divide or awkward “fit between research [evidence] and practice” (Nutbeam, 1996a, p. 317) is still largely to be reconciled.

To be considered effective programmes are expected to be grounded in evidence, however health promoters and researchers continue to find practice-based evidence wanting (Francis & Smith, 2015; Nutbeam, 1996a). While examples of comprehensively reported evaluation can be found in the literature (Fotu et al., 2011; Petticrew, Kearns, Mason, & Hoy, 2009; Schoster et al., 2012; Wilson et al., 2010), researchers have petitioned for a stronger evidence base, arguing that there remains a lack of quality published studies coupled with a lack of appropriate measurement tools to guide programme evaluation (Chambers et al., 2015; Francis & Smith, 2015; Smith, 2011; Wilson et al., 2010). The extent to which a practice-borne evidence base can be developed additionally requires a shift from evaluation for accountability’s sake to one that seeks to contribute to the development and improvement of current programmes as well as inform future initiatives (Francis & Smith, 2015; Jolley, Lawless, Baum, Hurley, & Fry, 2007). This is no enviable task for practitioners who are contract-bound to deliver high performance, cost-value programmes within short time frames (Ministry of Health, 2016a).
The literature proposes that a more comprehensive and accessible evidence base would enable health promotion to demonstrate its effectiveness to the wider health sector and policy makers, help identify quality practice, and support practitioners in their planning, and programme development (McQueen, 2012). Published evaluations are a valuable source of information for health promoters wanting to plan programmes in comparable contexts or circumstances (Dooris, 2006; Francis & Smith, 2015; Jolley, 2014), however smaller community based initiatives or setting-specific programmes are often not published (McQueen, 2001; Pettman et al., 2012; Round, 2005) or are only be found in the grey literature, which is not always easily accessible nor reported comprehensively (Francis & Smith, 2015; Round, 2005). Over twenty years ago Nutbeam (1996b) invoked a discussion about what he described as a lack of “transfer of knowledge between researchers and practitioners” (p. 317) in the field of health promotion, an issue that still endures today (Francis & Smith, 2015). In a mixed-methods study examining the factors that assist or hinder evaluation performance, a number of health promotion practitioners reported on the difficulties of accessing academic literature and the dearth of published evaluations to guide practice, that impacted on their ability to evaluate projects effectively (Francis & Smith, 2015). Participants in this study, and in previous studies have identified a palpable gap between academia and health promotion practice, and as such have expressed a desire for more formalised networks to bridge the research-to-practice gap (Brug et al., 2011; Francis & Smith, 2015; South & Tilford, 2000). Meanwhile, indigenous worldviews have not readily qualified as evidence in the canon of academic literature (Moewaka Barnes, 2009), posing a challenge when what is regarded as evidence is predicated on published literature. In NZ more autonomous platforms and networks are being developed, permitting greater dissemination of indigenous research, in recognition of uniquely Māori notions of evidence and mātauranga (www.communityresearch.org.nz; New Zealand Ministry of Research, 2007; www.journal.mai.ac.nz; www.maramatanga.co.nz).

In a climate espousing high-value, performance based programmes there has been a growing expectation that health promoters produce evidence of effectiveness based on experimental scientific approaches or evidence-based methods (Dooris, 2006; Jolley, 2014; Ministry of Health, 2016a; New Zealand Ministry of Health, 2016). However, the “complex relationship between context and behaviour, and the need to influence systems and structures as well as individuals to support change” (Speller, Wimbush, & Morgan, 2005, p. 15) that defines health promotion, limits the use of experimental based
methods in this setting compared with its use in a bio-medical setting (Baum, 2015; Dooris, 2006; Hepworth, 1997; Kahan & Goodstadt, 2001; Sanson-Fisher et al., 2014; Speller et al., 2005). The strict and controlled conditions dictated by traditionally lauded methods like that of the ‘gold standard’ randomised controlled trial (RCT) and other experimental designs largely sit outside the province of health promotion with its participatory and multi-sectoral approaches (Dunne et al., 2012; McQueen, 2001; Moewaka Barnes, 2009; Nutbeam, 1998a; Pettman et al., 2012; Raphael, 2000; Round, 2005; Speller et al., 2005; Wilson et al., 2010). Randomised controlled trials and other experimental designs are often not practical (Commission of Social Determinants of Health, 2008; Francis & Smith, 2015), nor always translatable to different populations or settings (Chambers et al., 2015; Nutbeam & Bauman, 2006; Rychetnik et al., 2012), are often single-issue based (Nutbeam, 1998a), are not always ethically appropriate (Brug et al., 2011; Francis & Smith, 2015; South & Tilford, 2000) or process focused (Dunne et al., 2012), nor do they capture the voice of individuals or perceive change at population level or over a long time period (Dunne et al., 2012). Pawson and Tilley (in Green & Tones, 2010) conceive that “true experimental design effectively strips away the context and yields results that are valid only in other contextless situations” (p. 481). Kahan and Goodstadt (2001) heed warning that if policy makers and funders limit definitions of best practice to narrow interpretations of evidence they are less likely to encounter examples of effective health promotion practice.

Researchers affirm the need to utilise a range of alternative methods in evaluation and explore their potential for rigor and quality in evaluating initiatives against the limitations of RCTs (Abma, 2005; Green & Tones, 2010; Green & Kreuter, 1999; Hepworth, 1997; Nutbeam & Bauman, 2006; Sanson-Fisher et al., 2014).

“Methodological pluralism” (Baum, 2015, p. 155) is proposed as a means of capturing the complexities that abound in health promotion as they relate to equity, environmental factors, individual behaviour and community (Abma, 2005; Green & Tones, 2010; Green & Kreuter, 1999). It soon becomes evident that information gathering ought to not only incorporate a range of methods but also a range of sources, in a nod to participatory approaches and intersectoral partnerships (Abma, 2005; Green & Kreuter, 1999; Nutbeam, 1998a). Alternative methods of assessing evidence have been developed, including indigenous and community development models. For example, Labonte, Feather, and Hills (1999) developed a story-telling/dialogue method aimed at redressing the knowledge and power balance between institutions,
professionals and communities whose knowledge has often been overshadowed in favour of ‘expert’ knowledge and theorising.

Qualitative methods have previously been “undervalued” (Nutbeam, 1998a, p. 38) and underutilised because of a hierarchy that positioned quantitative experimental research methods above qualitative (Nutbeam, 1998a; Nutbeam & Bauman, 2006). Recognition and support for the latter has only transpired over the last two decades (Abma, 2005; Baum, 2015). Qualitative methods were previously associated with a “perceived weakness” (Abma, 2005, p. 395) or viewed as a “soft” (Labonte & Robertson, 1996; Nutbeam, 1998a; Nutbeam & Bauman, 2006, p. 30) form of research. In truth however, the use of qualitative methods “can provide depth and insight into people’s experiences and the social contexts that strengthen, support or diminish health” (Nutbeam, 1998a, p. 38), and in doing so, embody the principles of equity, social justice and participation (Abma, 2005; Baum, 2015; Farquhar et al., 2006; World Health Organisation, 1986a). Abma (2005) states, “Qualitative data are more than just ‘mere opinions’ when generated in a systematic way and according to internal verification and validation strategies” (p. 395). Qualitative data can be used for advocacy purposes, as a persuasive tool to engage policy makers in the lived experiences of a community.

Many researchers endorse a mixed methods approach to evaluation that embraces both qualitative and quantitative methods, arguing that it is better to draw on more than one approach to show evidence of a programme’s effectiveness (Anderson, 2008; Farquhar et al., 2006; Hepworth, 1997; Kelly, Hoehner, Baker, Brennan Ramirez, & Brownson, 2006; Marmot et al., 2008; McCreary et al., 2012; Nutbeam & Bauman, 2006; Wilson et al., 2010). Qualitative and quantitative methods might be viewed as balancing one another; quantitative methods are used to describe an issue and its extent while qualitative methods offer contextual information and first-hand insight from a community perspective and can reveal the acceptability of a programme (Anderson, 2008; Baum, 2015; Farquhar et al., 2006; Nutbeam, 1998a). Kelly et al. (2006) in recognising the combined value of quantitative and qualitative measures proposes that we view the issue as “how can we use the benefits of each to overcome the weaknesses of each. Combined they allow us to assess the context as well as what the population within this context perceives as most important” (p. 290).

In response to the shortcomings of using experimental methods in health promotion O’Connor-Fleming et al. (2006) extoll the need to “adopt a broader view of evidence that
acknowledges the complexity of health promotion and embraces broader indicators of success like equity, community development, empowerment and social mobilisation” (p. 62) as indicators of health promotion processes and outcomes. However the challenges involved in evaluating intangible principles like participation and empowerment and their contribution to outcomes, are well documented (Berry, Murphy, & Coser, 2014; Brandstetter, McCool, Wise, & Loss, 2012), perhaps offering some insight into why these principles do not commonly appear in evaluation reports (Jolley et al., 2007). Health promotion values and concepts are not always understood or valued by management, programme partners and funders, perhaps further foretelling their absence in evaluation reporting (Brandstetter et al., 2012). Jolley et al. (2007) identified the need for tools to evaluate the key components of community participation, collaborative partnerships and equity, to determine their contribution to outcomes.

Attributing a causal link between the impact of a complex health promotion programme and change in behaviour, health status or the environment is considered difficult because changes that occur over a long period are often difficult to detect or measure because of the multiple environmental, behavioural and social factors that can all bear on health and decision making (Datta & Petticrew, 2013; McQueen & Jones, 2007; Nutbeam, 1998a). Many researchers expound the use of logic modelling or theory based evaluation as a means of making plausible connections between programme activities, outcomes and context (Connell & Kubisch, 1998; Craig et al., 2012; Rootman, Goodstadt, Hyndman, et al., 2001; Wren, 2006). Baum (2015) claims “causality is not established through statistical tests of correlations but by a ‘burden of evidence’ that supports logically coherent chains of relations that emerge through the contrasting and comparing of findings from many forms of evidence” (p. 247), hence the need for both qualitative and quantitative methods. Capturing baseline data is considered important to this process, as is the use of appropriate indicators throughout the course of a programme as points of comparison, and process evaluation (Nutbeam & Bauman, 2006; Swinburn et al., 2007).

We have already established health promotion is concerned with processes (Butterfoss, 2006; Nutbeam & Bauman, 2006; World Health Organisation, 1986a) and accordingly researchers opine the importance of conducting process evaluation (Abma, 2005; Dooris, 2006) for programme development and refinement as well as “to determine whether there are plausible pathways linking interventions and outcomes” (Butterfoss,
Furthermore, the reporting of process evaluation allows practitioners to provide context and assess the applicability of a programme to another programme in a similar setting or context (Pettman et al., 2012; Swinburn et al., 2007). Researchers assessing the quality of evaluation reporting have revealed gaps in information about context and implementation processes, particularly for complex initiatives (Butterfoss, 2006; Datta & Petticrew, 2013; Pettman et al., 2012; Rychetnik et al., 2002; Swinburn et al., 2007), making it difficult to compare interventions or assess their applicability to another setting. Researchers reiterate that “over and above establishing what works, it is important that such evidence provides insight into how interventions work and under what conditions and in what contexts they succeed or fail” (Glasgow et al., 1999; Green & Tones, 2010, p. 469). This might include the reach of a programme, details about the intervention and how it was delivered, the costs involved, barriers and facilitators, negative outcomes, and how the theory worked (Pettman et al., 2012). With this in mind, process evaluation would appear vital to the principle of equity. There are examples of process evaluation in the literature, adding to the evidence base (Fotu et al., 2011; Wilson et al., 2010).

The literature repeatedly emphasises the importance of ensuring that methods, tools and indicators used to evaluate interventions are “reliable and valid” (Kelly et al., 2006, p. 280; Pettman et al., 2012; Stolp et al., 2017) as an antidote to the gaps in data collection and the “poor definition and measurement of anticipated outcomes to health promotion activities has long been considered a stumbling block to progress” (Kelly et al., 2006; Nutbeam, 1998a, p. 28). Challenges include the need to ensure data is collected consistently and at multiple points, that indicators used to measure outcomes are appropriate to evaluation questions and acceptable to the target group, the potential for recall bias is mediated, sampling is representative of a community or a group, confidentiality and anonymity are preserved and, questionnaire designs demonstrate rigor and validity (Kelly et al., 2006). Studies of health promotion organisations have illustrated the various shortcomings experienced in developing appropriate measures, particularly to measure complex initiatives, and in the reporting of data for evaluation purposes (Brandstetter et al., 2012; Datta & Petticrew, 2013; Francis & Smith, 2015; Nutbeam, 1998a). For example, in a mixed-methods study examining the quality of evaluations conducted in community health services in Australia, researchers expressed concerns about the validity of the data and findings (Jolley et al., 2007). Evaluation reports were found to be lacking detailed analysis and information about response rates,
few had engaged in theory, nearly a third of reports described only one method of data collection, and there was little consideration of long term outcomes or community participation. Overall, evaluation reports generally failed to inform planning and policy decisions. It should be noted most of the reports reviewed were intended for internal use only so this may in part explain the omissions. In a study by Napp, Gibbs, Jolly, Westover, and Uhl (2002), many practitioners expressed concern about the validity of evaluation measures, some questioned the honesty of their clients’ self-reported responses, and a number demonstrated a lack of confidence in their ability to evaluate programme outcomes accurately. Interestingly, over half of practitioners did not consider the data they had gathered useful. One way to increase validity is through triangulation using multiple evaluation methods, both quantitative and qualitative to ascertain points of convergence and divergence (Baum, 2015; Nutbeam & Bauman, 2006; Patton, 2002).

Clearly, health promotion continues to face a host of largely unresolved issues related to evaluation. A more developed and widely accepted evidence base would allow health promotion to demonstrate its effectiveness, assist in identifying health promotion best practice, and support practitioners in their day to day practice (McQueen, 2012).

**Organisational factors and their impact on health promoters’ ability to conduct evaluation**

Capacity building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organisations, and; the development of cohesiveness and partnerships for health in communities. (World Health Organisation, 2006)

As already mentioned, effective practice can only occur if the conditions are favourable. Various organisational and structural factors are perceived to impede health promoters’ ability to evaluate, as these apply to budgetary constraints, short term-funding cycles, time pressures, competing demands, a focus on accountability instead of improvement, gaps in technical expertise and staff capacity, prioritisation of planning over evaluation and the perennial tension of operating within a bio-medical domain (Brug et al., 2011; Francis & Smith, 2015; Huckle et al., 2016; Jolley et al., 2007; Lobo et al., 2010; McQueen, 2001; O’Connor-Fleming et al., 2006; Reupert, McHugh, Maybery, & Mitchell, 2012; South & Tilford, 2000). Some practitioners support a regulated or standardised
approach to evaluation as a means of diminishing practitioners’ lack of confidence around conducting evaluation (Huckel et al., 2016) though such prescribed approaches are not without their criticism (Dempsey et al., 2010). A number of studies go a step further and point to the need to instil a ‘culture of evaluation' into the fabric of an organisation to maximise evaluation effectiveness (Huckel et al., 2016; Jolley et al., 2007; South & Tilford, 2000). Huckel et al. (2016) describe a ‘culture of evaluation’ as one that integrates evaluation into all areas of decision-making, including programme design, implementation, funding and resourcing. Francis and Smith (2015) and Lobo et al. (2014) similarly identify the need to build evaluation capacity across all levels of operation; at the system, organisational and personal level.

Various studies highlight some of these impediments to evaluation. Napp et al. (2002), in a qualitative study of 61 community-based organisations, found that staff attitude was most frequently reported as acting as both barrier and mediator to programme evaluation, with management perceived as playing a contributing role. Some health promoters regarded themselves as service providers foremost, respectively; evaluation was viewed as a diminution of resources and time, secondary to the purpose of planning. Further, when evaluation was viewed simply as a funder-imposed auditing requirement its purpose became devalued. The level of evaluation expertise present in an organisation was also perceived to impact on practitioners’ ability to conduct evaluation. In Jolley et al. (2007) study, practitioners similarly found organisational support for evaluation wanting. Barriers to evaluation included time and resource constraints, lack of an evaluation culture, limited access to specialist skills and external evaluation. On the flipside, skills and training, a culture of evaluation, a workable framework, review processes, access to expertise, support and appropriate evaluation tools and data sources were all perceived to be facilitators of evaluation. Meanwhile, in a study of state-funded health promotion agencies in Australia (Francis & Smith, 2015), the reporting and administrative requirements set by funders were reported as significantly challenging to evaluation as were budgetary constraints, inexperienced staff, reduced training opportunities, and limited resources to develop measurement tools. In addition, a number of practitioners reported difficulty in accessing tools and resources like academic journals, to guide and develop their own evaluation practice. Brug et al. (2011), in a qualitative study of government funded health promotion organisations in the Netherlands, present a similar story of limited resources, time and expertise dedicated to evaluation, often resulting in limited research designs. Health
promoters reported a lack of support for evaluation from management and a
demonstrable reluctance to dedicate funds to evaluation because it was not considered
central to their role. Other barriers to evaluation were perceived to be time pressures,
short planning cycles and difficulties in identifying measurable outcomes.

Time or more specifically, lack of time, as a barrier to effective evaluation performance
is a recurrent theme in the health promotion literature (Huckel et al., 2016; Jolley et al.,
2007; O’Connor-Fleming et al., 2006; Reupert et al., 2012; Social Policy Evaluation and
Research Unit, 2016; South & Tilford, 2000). In a recent qualitative study (Huckel et al.,
2016) of senior health policy makers and evaluation researchers, issues related to time
were cited most often as affecting evaluation. Some of the time-related issues raised by
study participants included the fact evaluations were often initiated late, thus the
opportunity to gather baseline data was lost or funding was depleted. Other issues
identified were lack of time for data collection and analysis, an inability to conduct
complex analysis because of the short-term nature of programmes and funding cycles,
and the difficulty of balancing the demands of day-to-day operations with the time
required to execute carefully considered evaluation plans.

One of the paradoxical challenges of operating in a financially constrained and
performance-based environment comes the expectation that to secure ongoing funding
and influence policy, health promoters must show evidence of effectiveness; the paradox
being that the funding required to evaluate and show evidence of effectiveness is often
lacking (Dunne et al., 2012; Francis & Smith, 2015). This issue is further compounded
when politically motivated policy makers desire evaluation results in a much shorter
time frame than is realistically feasible for community development and settings based
initiatives (Baum, 2015). A number of researchers have commented on the lack of
financial investment in programme evaluation as a major hurdle to conducting quality
complex evaluation (Brug et al., 2011; Jolley et al., 2007; Lobo et al., 2010; Napp et al.,
2002; O’Connor-Fleming et al., 2006; South & Tilford, 2000; Wilson et al., 2010). For
example, in Napp et al. (2002) qualitative study of community based organisations,
participants perceived insufficient funding and short funding cycles as barriers to
evaluation; the latter because there was little time to plan, conduct and evaluate a
programme, let alone find measurable change in a population over such a short time
frame.
Building capacity and capability for evaluation

Evaluation capacity building is about growing the knowledge, skills, and attitudes of individuals, while developing the structures, systems, resources and leadership within organisations to embed learning into everyday practice and enable health promoters to learn how to achieve evaluation goals (Lobo et al., 2014; Preskill & Boyle, 2008; World Health Organisation, 2006). Researchers have identified workforce capacity as a limiting factor to effective evaluation and much has been conveyed in the literature about the need to improve evaluation capacity through training (Lobo et al., 2014; Pettman et al., 2012). However, it is widely opined that the acquisition of knowledge and learning needs to be coupled with wider organisational change to create environments conducive to evaluation and capacity building efforts (Francis & Smith, 2015; Keleher, Round, Marshall, & Murphy, 2005; Lobo et al., 2014). The New South Wales Health Capacity Building framework emphasises five key areas for capacity building action: organisational change, workforce development, resource allocation, partnership and leadership (New South Wales Health Department, 2001). Huckel et al. (2016) share a similar comprehensive view of the challenges to capacity, in recognising that action is required at the micro (individual), meso (organisational) and macro (context and system) level.

Lobo et al. (2014) in a review article offer a range of strategies to increase evaluation capacity, namely the use of multi-levelled approaches, mentoring, leadership that places value on evaluation, and the forging of partnerships with researchers to add credibility and opportunities for publishing. The review also cites examples of coordinated capacity building projects in Australia aimed at improving the quality of programme planning and evaluation through intersectoral partnerships between practitioners, researchers, policy makers and funders, though evidence of their potential value is yet to be fully collected. Evidence shows that workforce development and mentoring can improve health promoters’ evaluation knowledge, confidence and practice (Reupert et al., 2012). In Reupert et al. (2012) study however, participants who reacted negatively to the workshops and mentoring were those who were not working on a programme at the time, to which they could apply their knowledge, supporting a previously held belief that hands on, experiential learning is most effective for evaluation training.

Even staff with a background in public health or health promotion may not understand evaluation well, or may view it as requiring specialist skills or assistance (Francis &
Smith, 2015; Hanusaik, O’Loughlin, Kishchuk, Paradis, & Cameron, 2010; Huckel et al., 2016; Lobo et al., 2010; Napp et al., 2002). Joss and Keleher (2007), in a US study, found that staff skills, knowledge and commitment alone were unlikely to determine the extent to which quality evaluation occurred in an organisation. Health promoters recruited in the project were enthusiastic about receiving training in research and evaluation methods, however, the demands of their day to day responsibilities soon took priority over the tasks involved in conducting research and evaluation. Similarly, in an evidence based practice (EBP) train-the-trainer programme to build workforce capacity, participants reported significant improvement in their EBP skills and knowledge, however, they also experienced barriers to evaluation as these related to resourcing, staffing, organisational factors and a lack of confidence (Lloyd, Rychetnik, Maxwell, & Nove, 2009). In Huckel et al. (2016) study, staff motivation, the championing of evaluation and the level of skills and experience demonstrated by staff were viewed as key factors in making evaluation an accepted organisational practice. Where resources and opportunities for staff development were not so available, the quality of evaluation was viewed as compromised. High turnover of staff was viewed as a barrier as was the level of knowledge and interest, or lack of, that staff demonstrated. Ultimately these studies demonstrate that while training and skills acquisition in evaluation is useful it is further strengthened when an organisation is equipped to foster and support a sustainable research culture, and can provide the necessary time, resources and managerial support for staff (Keleher et al., 2005).

The development of staff capacity in evaluation might be viewed as extending beyond the imparting of knowledge and the acquisition of technical skills, to the valuing and nurturing of attributes such as integrity, trust, relationship-building skills and communication skills (Preskill & Boyle, 2008). Moewaka Barnes (2009) describes evaluation as a “craft” (p.12) that is learned experientially over time with support from others both formally and informally.

**Summary**

This review proposes a necessarily broad and flexible understanding of best practice as it applies to different contexts, environmental factors and population groups. It finds support in programme planning that is multi-dimensional, principle-based and context sensitive. Best practice planning involves reflection, attention to processes, relationships, intersectoral partnerships and upstream measures. While there is general
consensus around the values and goals of health promotion planning there is less agreement around evaluation and what constitutes evidence; a key factor perceived to be hampering health promotion's ability to progress and prove its effectiveness. Until the issue of growing a workable evidence base and organisational barriers are resolved, health promotion will not reach its potential.
Chapter Four: Methods

Methodological approach

I subscribe to a constructivist paradigm based on the premise that research is not “value free” (Guba & Lincoln, 1994, p. 114; Labonte & Robertson, 1996, p. 435; Lincoln & Guba, 2005) in so far as how we understand and interpret meaning is influenced by historical, political and social processes (Green, 2014). Correspondingly, Guba and Lincoln (1994) assert the need to acknowledge the significant role values play in research processes; a stance they contend is preferable to the misguided belief that methodology prevents the intrusion of values in research. Juxtaposing this view is a positivist paradigm, which recognises objective knowledge and a single reality that can be measured, “uncluttered by values or biases” (Guba, 1989; Labonte & Robertson, 1996, p. 434).

My constructivist research approach supports a perspective of reality that is sensitive to diverse perspectives, based on the premise that “truth is not absolute or immutable but rather is understood as the best informed and most sophisticated truth we might construct at any given time” (Labonte & Robertson, 1996, p. 435; Patton, 2002). Thus my theoretical position aligns with the capturing and study of “multiple realities constructed by people and the implications of those constructions for their lives and interactions with others” (Patton, 2002, p. 96). With this position in sight, I sought to gather health promoters’ varying perspectives and experiences of planning and evaluation within an institutional and organisational context, with the aim of drawing on this constructed knowledge to propose recommendations for future health promotion practice. In conducting the literature review and comparing and contrasting my findings with the literature in the discussion section, I was able to find consensus as well as divergence across the different research parts, and as such, capture and reflect on the complexity of socially constructed multiple realities and viewpoints.

Labonte (1996) positions the researcher as “part of the reality that is being researched, such that the research findings are a creation of the inquiry process itself rather than a collection of external, already existing facts” (p. 434). Giacomini (2010) affirms this view of the researcher, who in the process of constructing knowledge “can neither stand apart to take an objective view, nor refrain from affecting that which they study” (p. 133). The qualitative researcher thus acknowledges their active role in the research process and accepts that they cannot dissociate themselves from the results of their
research (Baum, 2015; Braun & Clarke, 2006; Guba & Lincoln, 1994). In doing so, the researcher acknowledges their research limitations, describes their own position and stance within the research process, and deploys methods to ensure the views of study participants remain fundamental to the study (Kuper, Reeves, & Levinson, 2008). The detailing of these processes and perspectives then allows the reader to determine how these factors might have influenced the research (Kuper, Reeves, et al., 2008). In consideration of this approach I have outlined my research processes and perspectives both here and in the ‘strengths and limitations’ section, to include: my personal positioning, choice of affirming interview questions, the use of data and researcher triangulation (Liamputtong, 2013), researcher reflection, journaling, iterative analysis among other research processes (Braun & Clarke, 2006).

Guba and Lincoln describe the constructivist approach to research as one that “begins with issues and/or concerns of participants and unfolds through a ‘dialectic’ of iteration, analysis, critique, reiteration, reanalysis, and so on” (Lincoln & Guba, 2005, p. 243), much like the research processes I adhered to in my thematic analysis. Moreover, the thematic analysis (Braun & Clarke, 2006) I utilised was responsive to researcher perspectives and allowed me to engage in the data in a flexible, iterative and reflective manner, consistent with the constructivist approach (Lincoln & Guba, 2005). Further synergy was found in Labonte’s identification of the “congruence of a constructivist paradigm with the health promotion principles of empowerment and community participation” (Labonte & Robertson, 1996, p. 431); tenets a number of health promoters in my study ascribed or aspired to, not to mention grappled with, in their planning and evaluation and that was to become a theme I subsequently engaged with in my thesis. Perhaps more relevantly, Labonte (1996) submits that a constructivist research paradigm “has the potential to resolve some of the tensions between research and practice in health promotion” (p. 431), a central theme identified in my literature review relaying the challenge of developing a workable evidence base to inform evaluation and programme development. Finally, in the same way a constructivist viewpoint recognises the social, economic, political, historical and cultural influences on people’s constructions of ‘reality,’ so a determinants approach to health promotion recognises the social, economic, political, historical and cultural influences on health outcomes and health behaviour (Marmot et al., 2008; Phelan et al., 2010; Wilkinson et al., 2003).
My positioning

The issue of subjectivity in qualitative research requires the researcher to engage in a process of self-reflection to examine how their personal experiences and the social and cultural conditions they inhabit might influence the analytic process (Green, 2014; Kuper, Lingard, & Levinson, 2008; Liamputtong, 2013; Lincoln & Guba, 2005). It is likely the various perspectives I brought to this project informed its development, both consciously and subconsciously. By situating myself in the research, the reader becomes empowered to decide how such perspectives might have influenced the research.

I come from a privileged Pākehā background; as a child I lived rurally, in a state-funded schoolhouse. My father was the headmaster of a two-teacher school, my mother assisted at the school and kept home life in order, and we had the run of the school and its surrounding paddocks. It was a simple, free-range life. In later life Dad recalled that one of the drivers for moving the family to the city, ten years into my life, came when he realised he was a lone voice against the proposed 1981 Springbok tour, at his local rugby club. Things were not necessarily more enlightened in the city; on marching downtown in protest of the forth-coming tour my father was spat on. Further gestures of protest followed in the form of written submissions opposing the proposed Aramoana smelter and other ‘think big’ projects. This was the socio-political context of my childhood.

On entering into a relationship with my partner who identifies as Ngāi Tahu I had to grapple with my place in his Māori world. Time and my children have brought me some ease – my children wear their Ngāi Tahu whakapapa comfortably and proudly – though there are still moments of discomfort and awkwardness for me, when I step onto the marae, or the niggling regret that I did not enrol in a te reo class earlier to help grow the language in our home. It is from this position I questioned and reflected on my role as researcher and felt the responsibility that came with interviewing Māori health promoters for this project, particularly in the knowledge that my project was borne of a Western construct. In response, I tried my best to approach interviews with the notion of respect, a listening ear, time, reciprocity and reflection about my outsider status. Mead’s words also resonated with me throughout the research process, “Processes, procedures and consultation need to be correct so that in the end everyone who is connected with the research project is enriched, empowered, enlightened and glad to have been part of it” (Mead, 2003, p. 318). While it was beyond the scope of my project
to elicit empowerment and participatory action research processes, a number of participants nonetheless expressed gratitude at the end of the interview for the opportunity to articulate and reflect on their practice.

Entering into secondary school teaching at the age of 21 I was completely under prepared and resourced to mediate the discrepancies in educational opportunities for indigenous and socio-economically disadvantaged students. I worked hard to support my students and sometimes found myself playing the role of counsellor despite my lack of training, but my naivety, inexperience and innate inclination to follow the ‘system’ restricted and frustrated my ability to meaningfully make a difference for some students. Long before I formally learned about the determinants of health in my post-graduate public health course, I witnessed them at work on my students’ learning and wellbeing in ways beyond my capabilities and capacity to change. These were the stories of poverty, hardship and inequity in a low-decile school. From this experience comes my privileged and outsider understanding of inequalities, and herein my interest in the inextricable links between health, the wider determinants of health and education. Together these links drive and motivate my interest in health promotion and feed into this project.

My love of words led me to an English undergraduate degree before becoming a secondary school teacher of English, at which time I became cognisant of the inequalities in literacy and educational attainment. To wander down the aisles of any secondary school English book room during that time there was a notable absence of books relevant to the lives and experiences of many students. In an education system that elevates the role of literacy and numeracy (ERO, 2011), how to build students’ literacy skills and grow a love of books when words are prone to the weight of social, economic and cultural inequalities? It is from this standpoint that I am interested in literacy and educational attainment as a predictor of health literacy and the broader implications of health literacy on health status and health promoting behaviour (Bo, Friis, Osborne, & Maindal, 2014; Friis, Vind, Simmons, & Maindal, 2016).

To summarise my research position, the constructivist researcher does not deny their influence on the research process, but instead responsibly takes steps to mediate their role in this process in the belief that “different perspectives lead to diverse meaningful interpretations of social phenomena” (Giacomini in Bourgeault et al., 2010, p. 133). In this way I have clearly detailed my role and stance in the research process with the aim
of capturing the varying perspectives of health promoters on which to base recommendations for future planning and evaluation practice.

**Overview of study**

Face-to-face and telephone interviews were conducted with health promoters working in PHUs to find out about their planning and evaluation practice. Interviews were audio recorded, transcribed, coded, and thematically analysed. The project was reviewed and approved by the University of Otago Human Ethics Committee (Appendix A, ref D16/015) and Māori consultation was carried out via the University of Otago’s Ngāi Tahu Research Consultation Committee process (ref 5681-18576).

This part of the study relates to objectives 2 and 3 of my study (Chapter 2, p. 10).

**Sample and recruitment**

I aimed to invite 18 health promoters from nine PHUs to take part in my study, that is one health promotion manager and one senior health promoter each, from nine purposefully selected PHUs (Liamputtong, 2013; Patton, 2002). I chose the nine units on the basis that collectively they represented diversity in provincial and urban, small and large, and spanned the length and width of the country. One of my supervisors (RE) approved the selection of units. The first step in recruitment involved contacting the nine PHU health promotion managers via telephone to introduce myself, deliver a brief outline of the project along with an invitation to participate. I followed up the phone call with an introductory email and attached the consent form (Appendix C), information sheet (Appendix B) along with the interview schedule (Appendix D) to allow participants prior consideration of the questions before the interview. I also listed some dates and times I was available to conduct the interview, and from there scheduled a date with health promoters. I emailed participants a reminder the day before their interview and confirmed the phone number to ring. At this initial stage of recruitment, I also asked health promotion managers to give some thought to nominating a senior health promoter from their unit who might be willing to be involved in the project. All but one of the managers, pre or post interview, supplied me with the name and email address of a senior health promoter. I subsequently contacted the nominated senior health promoters via email and invited them to participate. In the email I introduced myself and attached the consent form, information sheet and interview schedule as I had done earlier with health promotion managers.
Of the original 18 individuals invited to participate, all except two health promoters agreed to participate. One health promotion manager declined on the basis of work commitments, though they were able to recommend a senior health promoter from their unit whom I later interviewed. The other person who chose not to participate was a senior health promoter who, after receiving my initial introductory email made a general request for additional information about the project but did not respond to my subsequent phone message and follow up email. I did not pursue recruitment of this individual beyond this point. To supplement numbers, one more PHU was added in from which I recruited a final health promoter. In total, I interviewed nine managers and eight senior health promoters from 10 PHUs.

**Designing and conducting the interview**

While this study bears little resemblance to an appreciative inquiry or assets based approach (Coghlan, Preskill, & Tzararas Catsambas, 2003; Cram, 2010), I did make the conscious decision to ensure questions were largely affirming and framed around participants’ personal experiences of planning and evaluation. For example, participants were asked to discuss examples of good or innovative planning and evaluation they had been involved in and identify the best support or training they had received, while the back end of the interview asked participants to consider their aspirations for planning and evaluation (Appendix D). I followed this approach because my intention was for health promoters to come away from the interview feeling rewarded and positive about the experience and this was demonstrated at the end when a number of health promoters appraised the opportunity to share their experiences and contribute to the overall objectives of the study. Kvale (2007) speaks of the importance of making sure qualitative research is a positive experience for participants. The interview questions were also formulated on the premise that while there was a leaning towards more affirming aspects of practice, problems and issues would still be implicitly raised, and this was later confirmed to be the case in my study (Coghlan et al., 2003; Cram, 2010). The interview schedule was informed by a preliminary literature review and was organised according to nine key areas: needs analysis; planning; partnerships, relationships and collaboration; responding to the Treaty of Waitangi; evaluation; support and training; reporting and administrative matters; political influences; aspirations for planning and evaluation.
After discussion with my supervisors it was agreed that the use of a semi-structured open-ended interview format would assist me in the management of an anticipated large volume of data and make the location and retrieval of data easier for later analysis while still allowing me some flexibility to raise questions as they arose in the immediate context of the interview (Bryman, 2008). According to Patton (2002) the use of pre-determined interview questions “facilitates organisation and analysis of data” (p. 349). I also hoped that following this format would engender health promoters to give careful thought and consideration to the interview schedule prior to the interview. As a relatively inexperienced interviewer with limited knowledge of health promotion planning and evaluation, the semi-structured approach would also to a degree allow me the confidence to focus on the words of participants during the interview instead of becoming distracted by upcoming questions. A semi-structured approach still enabled me the flexibility to explore and expand on new ideas and perspectives with participants (Patton, 2002). For instance, while the interview format was largely structured I took the approach that participants would guide me, so if a participant segued into another issue I would naturally follow their lead instead of adhering to a strict sequence of questions. Similarly, if a participant raised a new idea or discussed an issue that deviated from the interview schedule I would explore it with them further. After several health promoters indicated their desire for greater sharing of resources and ideas across units, for instance, I added a corresponding question to the schedule, thus following the iterative processes of qualitative research (Kuper, Lingard, et al., 2008). Probing questions that sat outside the interview schedule were also used to encourage participants to elaborate on their answers. In addition, the open-ended nature of questions also encouraged participants to express their own understandings of planning and evaluation. Finally, at the end of the interview participants were asked if they would like to add anything to the conversation. From these more flexible approaches, several new areas of inquiry that were not anticipated emerged such as, the PHU setting acting as facilitator and barrier to planning and evaluation, and the desire for greater sharing of ideas across units.

Before finalising the interview schedule (Appendix D), I conducted a face-to-face pilot interview with a health promotion manager to check the acceptability, timing and appropriateness of the interview schedule. The health promoter was responsive to the format and did not suggest any changes. Data from this interview was used in the final data analysis. Fifteen of the interviews took place by telephone and the remaining two
were face-to-face, one with a health promotion manager (the aforementioned pilot interview) and the other with a senior health promoter. All of the interviews bar one were audio-recorded and transcribed with participants’ permission. One health promoter declined to be audio-recorded but did agree to me taking notes throughout the interview. Before the interview began, this particular participant recalled a negative experience in which a colleague’s anonymity had been compromised as a result of their involvement in a research project. To alleviate any concerns they might have and as a token of trust, I offered to email the health promoter a copy of my notes for them to member check. Immediately after the interview, I reviewed and wrote up my notes before emailing them to the participant, with queries marked in the margin where I wanted to make sure I had recorded their words accurately. They approved the interview with nominal changes. Interviews were conducted between May-Aug 2016.

In my original research proposal I sought to conduct 18 interviews but restricted time frames and funding resulted in 17 interviews in total (Patton, 2002). Patton (2002) asserts the insight garnered from qualitative research and the analytical skills of the researcher are more relevant than sample size, which is dependent on many factors including what can be achieved within the time and resources available. While saturation was not reached on all questions few new ideas or topics arose during the latter interviews and variation of response was achieved (Baum, 2015).

**Analysis**

I conducted thematic analysis, which follows an iterative process and is “a method for identifying, analysing, organising, describing and reporting themes found within a data set” (Nowell, Norris, White, & Moules, 2017, p. 2 referencing Braun and Clarke, 2006). Thematic analysis largely followed Braun and Clarke’s (2006) six-phase method and was guided by Nowell et al. (2017, p. 4) (Table 1) framework for establishing trustworthiness at each phase of analysis, modeled on Lincoln and Guba’s trustworthiness criteria (1985). Thematic analysis is independent of any particular theory but according to Braun and Clarke (2006) it is adaptable to the constructivist approach I chose for this study. Further, the semi-structured interview is viewed as the customary approach of constructivists.
Table 1. Nowell et al. (2017) present an approach to thematic analysis that follows Braun and Clarke’s six phases of analysis and aims to establish trustworthiness at each phase using Lincoln and Guba’s (1985) trustworthiness criteria.

<table>
<thead>
<tr>
<th>Phases of Thematic Analysis</th>
<th>Means of Establishing Trustworthiness</th>
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<tbody>
<tr>
<td>Phase 1: Familiarising yourself with your data</td>
<td>Prolong engagement with data</td>
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<td></td>
<td>Triangulate different data collection modes</td>
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<td></td>
<td>Document theoretical and reflective thoughts</td>
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<td></td>
<td>Document thoughts about potential codes/themes</td>
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<td></td>
<td>Store raw data in well-organised archives</td>
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<td></td>
<td>Keep records of all data field notes, transcripts, and reflexive journals</td>
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<tr>
<td>Phase 2: Generating initial codes</td>
<td>Peer debriefing</td>
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<td>Researcher triangulation</td>
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<td></td>
<td>Reflexive journaling</td>
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<td>Use of a coding framework</td>
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<td>Audit trail of code generation</td>
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<td></td>
<td>Documentation of all team meeting and peer debriefings</td>
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<tr>
<td>Phase 3: Searching for themes</td>
<td>Researcher triangulation</td>
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<td></td>
<td>Diagramming to make sense of theme connections</td>
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<td></td>
<td>Keep detailed notes about development and hierarchies of concepts and themes</td>
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<td>Phase 4: Reviewing Themes</td>
<td>Researcher triangulation</td>
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<td>Themes and subthemes vetted by team members</td>
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<td>Test for referential adequacy by returning to raw data</td>
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<td>Phase 5: Defining and naming themes</td>
<td>Researcher triangulation</td>
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<td>Peer debriefing</td>
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<td>Team consensus on themes</td>
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<td>Documentation of team meetings regarding themes</td>
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<td>Documentation of theme naming</td>
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<td>Phase 6: Producing the report</td>
<td>Member checking</td>
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<td></td>
<td>Peer debriefing</td>
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<td></td>
<td>Describing process of coding and analysis in sufficient details</td>
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<td>Thick descriptions of context</td>
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<td>Description of the audit trail</td>
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<td></td>
<td>Report on reasons for theoretical, methodological, and analytical choices throughout the entire study</td>
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</tbody>
</table>

The analysis section below is organised to align with Braun and Clarke’s (2006) six-phase thematic analysis.
Phase 1. Familiarising yourself with the data

After each interview I wrote journal reflections detailing my general feelings during the interview, my perceived performance and rapport with participants, as well as any ideas and questions that were raised during the interview. Patton (2002) describes the “period after an interview or observation as [is] a critical time of reflection and elaboration (p. 384). Lincoln, Lynham, and Guba (2011) describe this reflexivity process as “reflecting critically on the self as researcher.” Further self-reflection processes are documented in the 'methodological approach' and 'my position' sections of this chapter.

It is often considered preferable that researchers conduct some or all of their own interview transcriptions (Liamputtong, 2013; Patton, 2002) but given the number and length of interviews, the scope of the project and limited time frames this was not possible in my study. I did however transcribe the pilot interview within a day of the interview while it was still fresh, to familiarise myself with the data. In so doing, I was also able to check whether interview questions had been worded appropriately before I proceeded with the remaining interviews. I employed a professional transcription agency to transcribe the other interviews verbatim, as is recommended (Liamputtong, 2013), after first receiving confirmation of the company’s confidentiality policy. On receipt of each completed transcription I conducted a word-for-word check for accuracy against the audio files and reread the transcripts several times to immerse myself in the data prior to undertaking formal analysis, as indicated in Braun and Clarke’s model (2006). Patton (2002) asserts that at the least, “checking [transcriptions] by listening to the tapes as you read them, can be quite different from just working off transcripts done by someone else” (p. 441). During this stage of the research process I kept notes of emergent ideas, questions, patterns and insights as is recommended (Tuckett, 2005).

Phase 2. Generating initial codes

I initially intended to use NVivo software to organise and assist with the coding of data but after some training and trialling of the software I decided to code transcripts manually, primarily for two reasons. First, I generally prefer to work ‘old school,’ directly on paper and two, I surmised manual coding would allow me to become more immersed in the data, to and fro between transcripts, and would involve numerous readings of the data, which proved to be the case. Researchers are encouraged to immerse themselves in the data through repeated readings of the data in the search for “patterns of meaning and issues of potential interest” (Braun & Clarke, 2006, p. 86).
Critics of computer-assisted qualitative data analysis (CAQDAS) have identified the potential for “fragmentation” of the narrative to occur as a result of the “code-and-retrieve process” and have suggested that researchers can in a general sense become removed or disconnected from the data (Liamputtong, 2013, p. 260). I was able to “familiarise [myself] with the depth and breadth of the content” (Braun & Clarke, 2006, p. 16), and work intimately with the data throughout the coding process, using pen and paper and later, the cut and paste function in Word.

To initiate the coding process my supervisors and I systematically coded two interview transcriptions independently before meeting on two occasions to discuss discrepancies and commonalities in our coding. I took notes during these meetings, revised and finalised the codes, after which time I submitted a coding framework to my supervisors for review. On receiving their approval, I coded the remaining transcripts on my own. In keeping with the theory that credibility is improved when data is analysed by more than one researcher (Lincoln, 1985), I drew on researcher triangulation with my supervisors throughout the coding and theme development phases. I reviewed, edited and refined the codes several times before I was satisfied with the final coding framework.

**Phases 3 & 4. Searching for and reviewing themes**

Once this data had been initially coded and collated, the next phase involved systematically organising all of the relevant coded data into potential themes (Braun & Clarke, 2006; Thomas, 2006). At this point, I checked to make sure the themes worked in relation to the coded extracts and the data as a whole and used diagrams to visualise the connections between themes. I analysed the data both deductively using the literature themes as a framework as well as inductively, to gauge participants’ experiences and identify patterns and themes as they emerged through analysis of the raw data (Patton, 2002). Many studies similarly utilise a combination of inductive and deductive analysis (Thomas, 2006). The value of inductive analysis was revealed in the themes that emerged that I had not encountered during my initial literature search, such as those related to the dual-responsibility felt by Māori health promoters.

**Phase 5. Defining and naming themes**

I met with my supervisors again to discuss the themes before developing a thematic framework, which underwent several iterations before becoming the basis for my
findings chapter. Patton’s (2002) description of this process is “figuring out what things fit together... by looking for reoccurring regularities in the data” (p.465). During the process of theme development and refinement, I collected multiple quotations from the data to exemplify each theme and reinforce their relevance, though in the final write up I reduced the number of quotations in an attempt to meet the word count. Liamputtong (2013) calls this process source triangulation. Throughout this phase and well into the final write up I frequently crosschecked the raw data against my findings to make sure the themes were grounded in the data (Lincoln, 1985). My supervisors acted as ‘peer debriefers’ throughout the research process to support and question my interpretations of the data (Lincoln, 1985).

**Phase 6. Producing the report**

The final phase involved writing up the findings once I had established the themes (Braun & Clarke, 2006). This section underwent oral and written peer-review by my supervisors and amendments were made. Braun and Clarke (2006) contend that analysis is a “recursive process, where you move back and forth as needed, throughout the phases” and that “writing is an integral part of analysis” (p. 16) across the life course of the research process. This was the case in my project from the journaling during interviewing, right through to the final write-up. The inclusion of direct quotations from participants is considered vital in qualitative report writing as a means of illustrating and reinforcing the validity and value of the analysis undertaken (Braun & Clarke, 2006; King, 2004), thus I embedded quotes throughout my analysis. On a personal level, the inclusion of quotations was also my way of honouring the contribution of participants who had given their time so generously.

Nowell et al. (2017) in table 1 presents a checklist of ways to establish ‘trustworthiness’ (Lincoln and Guba, 1985 in Nowell et al., 2017, p. 4) at each phase of thematic analysis, drawing on Braun and Clarke’s 6-phase model and using Lincoln and Guba’s ‘trustworthiness’ criteria as a framework to establish research credibility. I employed many of these tools and methods throughout the course of the study, such as: repeated readings of data, researcher triangulation (Denzin, 1989), supervisor debriefing, an audit trail of researcher notes and summaries of meetings with supervisors, securely stored data, post-interview reflections, documentation of coding and theme development, use of a coding framework, source triangulation, themes checked and peer-reviewed by supervisors, and frequent cross-checking of raw data against themes
and findings. Finally, a friend who works in public health research reviewed the final manuscript.

**Privacy, confidentiality and anonymity**

It was anticipated that confidentiality might pose a concern for health promoters at a personal and organisational level so utmost care was taken to protect the identities of health promoters and their associated PHUs. Diener (1978) identifies three dimensions of privacy: sensitivity of information, setting, and dissemination of information, which became considerations in my study. Several steps were taken to protect the identity of individuals: participants’ names were removed from the write-up and replaced with numbers, and any other sources of identifiable information such as unit names, titles, place names or regions were either replaced with a generic descriptor or removed from the thesis altogether (Frankfort-Nachmias, 1992). Written consent was obtained from each participant (Appendix C). Both the information sheet and the consent form included clauses outlining that participants could withdraw from the project at any point or decline to answer any question that made them feel uncomfortable, without disadvantage (Appendix B & C). Prior to commencing each interview I reiterated participants’ right to withdraw from the study and/or decline to answer questions. One health promoter shared some potentially sensitive information during the interview so I emailed them the parts of the analysis and discussion that related to the issue and sought their permission to include it in the final write up. They approved its inclusion with small changes (Kuper, Lingard, et al., 2008). Basic demographic information was recorded, specifically gender, ethnicity, age and health promoters’ duration in the current role and length of time they had worked in health promotion per se. In the final write up I elected to write a general summary of participant demographics instead of adhering to the usual table format because I felt the latter could compromise participants’ anonymity (see ‘Participant demographics’). Data including the transcripts and all accompanying field notes are currently securely stored in a locked drawer at the university and on my computer, which is password-protected. Only my supervisors and I have access to the transcriptions. Any personal identifying information such as contact details and the audiotapes will be destroyed at the conclusion of the project but any data on which the results of the project depend will be retained for 10 years in secure storage. The setting in which the interviews occurred was integral to ensuring privacy, and participants chose a location in which they could speak comfortably and uninterrupted. I conducted the phone interviews from a designated interview room at
the university to ensure privacy and confidentiality were observed at my end. As added insurance I asked my supervisors to check all participant quotations in their final reading of the thesis to ensure health promoters’ anonymity had been preserved.
Chapter Five: Thematic analysis

Participant demographics

I originally presented participant demographic information in a table as is commonplace but it became evident this format might compromise anonymity, so I chose instead to summarise participant demographics. Of the 17 participants I interviewed in total, there were 14 women and three men, and of these, nine were health promotion managers and eight were senior health promoters. There was a range of ages: with one participant in the 20-30 year-old age bracket, four participants in the 41-50 year-old age bracket, eight participants in the 51-60 year-old age bracket and four participants in the 61+ year-old age bracket. Two health promotion managers and one senior health promoter self-identified as Māori while one participant identified as international. The other 13 participants self-identified as Pākehā/NZ European/Scottish New Zealander/European. Seven of the interviews with health promotion managers corresponded with interviews with seven senior health promoters from the same unit, the remaining two health promotion managers and one senior health promoter each came from different units. The number of years that health promoters had been in the role at the time of interview ranged from just under 1 year to 16 years.

Thematic analysis

This chapter forms a thematic analysis of the interviews conducted with 17 health promoters to investigate how health promoters in PHUs in NZ plan and evaluate their programmes. Sub-themes are organised under the main themes of ‘Planning’ and ‘Evaluation,’ with two satellite themes, ‘Māori perspectives’ and ‘The PHU setting’ (Figure 1. Thematic overview showing planning and evaluation themes, associated sub-themes and two satellite themes). In addition to their inclusion in ‘The PHU setting’ section, organisational factors are interwoven throughout the literature review, as and where they are shown to impact on planning and evaluation. This part of the study addresses objective 2 and will inform objective 3 of my study (Chapter 2, p. 10).

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7 Care has been taken to ensure that quotes are accurate. I have made minor adjustments in the wording of some quotes to add readability and all additions are signaled by square brackets. Any omissions or deletions are indicated by ellipses. Numbers replace participants’ names to preserve their anonymity. Place names and any other potential markers of identity have also been removed and replaced with a generic descriptor in square brackets, as a further step to preserve anonymity.
Figure 1. Thematic overview showing planning and evaluation themes, associated sub-themes and two satellite themes.
Themes were inductively and deductively developed from interviews with health promoters (see 'Methods' section). The overarching themes of ‘planning’ and ‘evaluation’ stemmed from the main research question, while underpinning sub-themes like ‘equity’ and ‘collaboration and relationship building’ grew from a process of thematic analysis (Braun & Clarke, 2006), duly informed by the preliminary literature review.

**Chapter overview**

The chapter begins with an overview of participants’ views of planning, before exploring needs analysis and evidence gathering, followed by a discussion of values, principles and models, including a detailed profile of equity as an overarching principle of health promotion planning. The chapter then looks at strategies and approaches, before examining the centrality of collaboration and relationships to programme planning, followed by two examples of practitioner best practice planning that have relationship building at their core. The chapter then pursues evaluation practice, beginning with a brief introduction, followed by a discussion of methods, approaches and tools, before exploring equity issues, linkages with stakeholders, and support for, and challenges to evaluation, before finishing with a response to RBA. The focus of the chapter then turns to ‘Māori perspectives’ and ‘The PHU setting’ and how these directly and indirectly impact on health promoters’ planning and evaluation practice.

The findings are predominantly directed at programme level planning, rather than strategic planning.

**Planning**

**Needs analysis** and evidence gathering for programme planning

Health promoters were asked how they undertook needs analysis (Appendix D).

A large number of health promoters acceded that the identification and prioritisation of health issues was largely driven by DHB contractual obligations, MoH specifications and to a lesser degree, regional needs assessment reports. Nevertheless, a small number affirmed the importance of starting with the needs and priorities of community foremost before finding alignment with government priorities. The majority of health...
promoters reported taking an integrated approach to needs analysis, coalescing community need with MoH directive:

*It’s fairly prescribed, so we have our public health unit packages and guidelines that come out each year. And so in there it outlines the sort of work that the Ministry want to engage us with, or engage from us and so in that, that regard you know it’s a little bit prescriptive but there’s always room in there to tailor it locally.*  
(P3, manager)

*From a community development approach so the issue needs to be identified by the setting as a priority to them…but it also needs to align with the health strategy and priorities from Government.*  
(P13, manager)

*It’s always with community and always with their focus in mind.*  
(P7, manager)

It was recognised by some health promoters that balancing the articulated needs of community with government priorities was not always an easy fit:

*Sometimes...we’re obliged to achieve the goals set by our funder who generally speaking is the Ministry of Health...sometimes we’re doing a marriage in the middle so we know we’ve got to create, reach the outcomes that are set out in the service specifications for us but we try and work the way the goals and the outcomes fit into that, in a way that allows both to line up, our funder’s requirements and our community requirements.*  
(P1, manager)

*Communities will identify that their needs can be quite different from what the national statistics might tell government.*  
(P13, manager)

Health promoters reported that data collection often comprised a combination of qualitative or self-reported sources of information from stakeholders and community alongside existing quantitative data sets. Health promoters drew on a wide range of sources of information from: Māori health providers, Statistics New Zealand, Primary Health Organisations (PHO), iwi, MoH, non-government organisations (NGOs), territorial authorities, Ministry of Social Development (MSD), Lead Maternity Carers (LMC), Housing New Zealand, university researchers, national health promotion agencies, alliance partners, Whānau Ora collectives, the internet, DHBs, educational institutions, Accident Compensation Corporation (ACC) and the community itself.

A coalition led by a senior health promoter consciously chose not to seek self-reported information for a needs analysis in favour of a stocktake of existing data sets in the belief it would provide more robust evidence for strategic planning and goal setting in their systems approach to planning:
So that was sort of an agreement made that rather than trying to, you know, do their own survey or do something that you know wasn’t sort of reputable that they would use data sets publicly available and already being collected...was based on a whole range of indicators that came from all the different organisations so things from Statistics New Zealand, [name of city] Council, [name of transport agency]. (P14, senior)

They went on to question the use of self-reporting methods, implying they could be tokenistic, “We sometimes kind of do these soft evaluations to make us tick the box.” (P14, senior)

Heath promoters from several PHUs described needs analysis as sometimes following a fairly “informal” (P10, manager) or “organic” (P3, manager) process; one that relied on health promoters’ common sense and experience, linkages with stakeholders and the community, tied together with data prepared by the DHB funding and planning team or a research analyst. Needs analysis in this instance was not necessarily written up formally nor did it follow a formalised consultation process:

If you wanted to put it [needs assessment] under a spotlight you might have some question marks around it but I think if you married the two, like a technically sound process but also drawing on those networks and those relationships and those experiences that health promoters have then I think you’d be pretty close to the mark. (P3, manager)

A number of health promoters reported there was ample data available for needs assessment, while some commented on the challenges of obtaining comprehensive baseline data. For instance, one DHB had not updated its regional equity report to reflect changing demographics in the region and another PHU reported not having full access to a regional population health survey. One health promoter described these regional reports as helping to shape the “targets and key areas that we want to work on” (P1, manager) especially in terms of equity areas. Another spoke of the difficulty of extrapolating regional data from national data. A health promoter working in the area of tobacco control spoke of the need for research and evidence to be responsive to current issues, recently spotlighted by the contentious debate around the viability and promotion of electronic cigarettes as a tool to help people to quit smoking:

I think there’s a plethora of data out there. And it’s using that, whether it’s from census data or DHB or council info…” (P16, manager)

You know with housing, there are massive holes in that data, to work out how many homes are insulated or how many people are homeless. (P1, manager)
Some health promoters noted the importance of seeking locally relevant information and evidence, as a counterbalance to national data, in the belief that programmes should be developed according to local priorities and need. Accordingly, some health promoters felt they were more likely to garner support from council if proposals were informed by local data:

*A good community survey, for example, on alcohol, views around alcohol...and the community’s views can’t really be argued with when you’re presenting that to councils and others around local alcohol policies and bylaws.* (P12, senior)

*Local data which means stuff that’s coming through the hospitals, our GP practices per se, our LMCs...so we have that localised data available to us and I guess to a point that anecdotal stuff that comes from, once again from our community stakeholder groups.* (P4, senior)

Several health promoters commented on the importance of identifying early in the needs assessment what resources and programmes already exist in the community to avoid unnecessary duplication. Duplication could undermine another organisation’s efforts, dilute the impact of a prospective programme or result in inefficient use of resources:

*I certainly look to make sure that no one else is doing it, so if you’re thinking about a health promotion project, you want to make sure that it fills a niche that someone else isn’t doing and we usually identify that by other partnership organisations or other regions.* (P2, senior)

Health promoters consulted with community in a variety of ways including survey, hui, focus groups and interviews. One health promoter spoke of a programme in which an agricultural contractor had conducted their own version of a needs analysis in response to concerns about the health and risk-taking behaviour of their employees before initiating contact with a Māori NGO, who in turn contacted the PHU, resulting in a collaborative approach to the problem.

A number of health promoters spoke of sometimes being one-step removed from community which meant they were reliant on partnering organisations to assess the needs of their clients, consumers and community:

*We didn’t directly go to into the community but our organisations have links to...so it’s sort of linked through our partner organisations.* (P14, senior)
Needs analysis as a process allowed health promoters to; describe the target population, draw on best practice models and how these might be applied to local settings, explore equity issues, conduct a stocktake of existing programmes and resources related to the issue, identify gaps in service delivery, gather an evidence base to secure DHB support and funding, find funding partners, investigate whether the prioritised issue was likely to meet the needs of the target population, explore the factors that might facilitate or act as pitfalls to a programme’s success and reach, and finally, develop relationships with programme partners and community to ascertain their needs, priorities and capacity:

So, we look at the resources available, whether someone else is doing it, whether there’s any funding internally or in partnership with other organisations. (P2, senior)

There was general consensus among participants that DHB analysts played an invaluable role in assisting health promoters with needs analysis, namely conducting literature reviews, compiling, analysing and publishing data:

Quite a lot of support is from our analyst team. So we’ve got a business unit, so for example with that [names project] approach, we have one of the analysts working closely with us and so that’s been very valuable. (P16, manager)

Lean on them to be the critics they are, programme planning processes... robust... they provide evidence, numbers, trend data... credibility to our work. (P8, senior)

However, access to analysts and internal research expertise appeared uneven, with some health promoters having onsite or readily available access while others did not. Further, health promoters from two PHUs discussed how restructuring and resourcing constraints within their DHB planning and funding departments had impacted on their ability to make use of analysts to assist with needs analysis and general research. One health promoter felt particularly stretched in their role because they had been expected to take on the role of surrogate analyst in the absence of an on site analyst:

I’d really love the resources to help support me to actually do the evaluation, you know, do the needs assessments and those sorts of things without myself having to be an analyst. You know I’m really good at interpreting numbers and data but I’m not a particularly good analyst and trying to teach myself database programmes is a real struggle. (P9, senior)

The following example highlights the importance of consultation when undertaking needs analysis, to identify both the facilitators and barriers to a new programme.
Consultation about a proposed smokefree programme in an early childcare setting revealed teachers were concerned that if they initiated conversations about smoking with parents and caregivers, it might imply judgement on their part and compromise the relationship. In this case, the health promotion team were able to alleviate these concerns and make the intervention more acceptable to teachers, parents and caregivers.

Census data proved useful for targeting specific areas or settings to undertake programmes. For example, health promoters reported using census data to indicate the ethnic distribution across different workplace settings and to identify smoking rates in high deprivation areas. Census data also provided health promoters with baseline data that could be used later for evaluation purposes:

*Ideally we want to target work places and you know, low wage, high Māori, high Pasifika and so we did some analysis based off the back of the census data looking at you know, occupations in [name of region] versus you know, level of income and stuff and then siphoned that down.* (P1, manager)

One health promotion manager spoke enthusiastically about a successful collaborative needs analysis that involved an external facilitator partnering with a health promoter from within the unit. The external facilitator was able to approach the need analysis impartially while the onsite health promoter acted as a conduit to the community, scaffolding the relationship between facilitator and community:

*Facilitating the hui alongside the external facilitator that was brought on board...So even though there was an external facilitator we, we wanted to be involved right along in the whole process and we thought it was important because the external facilitator didn’t have the relationships but we did and they needed to have those relationships. We’re the key to it and so that’s where our local health promoter came in, was involved in bridging between what the external facilitator could bring. Yeah and just ensuring that you know there weren’t any barriers, relationship barriers involved that might have hampered the process.* (P3, manager)

**Overarching values, principles and models for planning**

Values and principles intrinsically underpin health promotion models, thus they are discussed conjointly in the first part of this section, as they apply at an individual, programme planning and organisational level. Health promotion principles and values lay the foundation for much of the structure of this thematic analysis.
Health promoters identified the fundamental qualities and values they considered typified a person entering the health promotion profession to include “humility and kindness” (P13), a sense of “fairness” (P3), alongside a “passion for health and well being” (P2). Together, these qualities might be considered essential to understanding fundamental health promotion values like equity and community development. There was a general consensus among health promoters that they were attracted to the role in a desire “to make a bit of a difference” (P7):

*I guess there are some fundamental values that most people bring to their role if they’re in health promotion. You know it attracts a certain type of person. And it’s about having, you know, fair outcomes, equitable access...It’s a passion.*

(P12, senior)

*So it’s that person that has arohanui ki te tangata, manaakitanga you know. Has time for people, takes time for people and listens to them and helps, tries to find ways of moving forward.* (P7, manager)

In accordance with MoH specifications the two most commonly cited models health promoters reported utilising in their planning were the Ottawa Charter and Te Pae Mahutonga (Ministry of Health, 2016b). Models were reportedly chosen for their ease of use, reflective qualities, or relevance to a particular issue or programme. They were used flexibly, as a prompt to ensure strategies were aligned with goals and principles. Some health promoters employed a mix of these models and others to inform their planning. In addition, some health promoters reported employing national or global action models like Smokefree 2025 and the WHO Global Strategy to Reduce the Harmful Use of Alcohol (2010b) to shape programmes:

*A lot of those models have been used as a checkpoint, do your strategies align to health promotion principles? You know, so there might be some flexibility in the beginning of people just scoping something out but then there’s like a check in point of well, how does this inform this model you know like going back and checking have I missed something that’s key from say the Ottawa Charter or from Te Pae Mahutonga?* (P14, senior)

Health promoters unanimously stressed the importance of equity as a guiding principle in planning. The majority reported using HEAT, followed by DHB regional equity analysis reports while a small number reported using Health Impact Assessment (HIA):

*Māori identity, collective autonomy, social justice and equity.* (P8, senior)
You’re always going to want something like an equity lens or Whānau Ora tools to come into it because they play a big part in how you’re conceptualising that planning. (P16, manager)

The principles of the Treaty of Waitangi were also referred to as important to planning though interviews also revealed programme gaps in provision for Māori, suggesting a dissonance between principle and practice:

And of course coming back to our Treaty responsibilities. If you pull those principles and then add both a focus on reducing inequalities. (P10, manager)

Health promoters reported using Māori models of health in response to Māori population demographics in their region and as a means of bringing equity and markers of cultural competency into focus. For Māori health promoters, using Māori models appeared fundamental to their own core values, discussed later in ‘Māori perspectives.’

We always look to the Ottawa Charter but we align Māori models of health...it’s imperative that we use a model that our whānau can engage with and so the Ottawa Charter or as well as Te Pae Mahutonga and then there’s Te Whare Tapa Whā as well. (P4, senior)

Several health promoters commented on ideological differences in values between PHU and DHB management and the subsequent challenges that arose from having to accommodate both sets of values in their planning. One health promoter manager described these differences as management taking a patient centred approach with an emphasis on “faster, sooner, better” (P10, manager) treatment compared to a population based, long-term preventive view of health. They felt there was a degree of willingness shown by management to support public health however overall their priorities lay with managing treatment. Another health promoter manager spoke of management setting unrealistic timeframes to meet targets because of a lack of understanding of health promotion processes. Two health promoters considered there was ample support for regulatory and health protection work compared to that of health promotion. Several health promoters expressed the desire for greater recognition from management of the value of health promotion per se:

I think that more recognition needs to go into the health promotion world. This is general acceptance for what health promoters do. Getting out there, making things happen and working with the community because they’re often the eyes and ears of the community, nobody else is. The Board wouldn’t have a clue what was going on in their community but go to the health promotion team and they can normally tell you. So I think there needs to be recognition and I don’t
necessarily mean money, I don’t mean status, I just mean we often get, ‘our health promotion doesn’t do anything, you can’t give us numbers, you’re not meeting your targets.’ (P11, manager)

You have our clinicians with different views on you know taking a service into a community. (P4, senior)

They see themselves as a provider arm, they’re focused on treatment, treatment of patients. (P10, manager)

Several health promoters discussed the fact that intersectoral partners and other stakeholders did not necessarily understand health promotion concepts which meant responsibility for ensuring programmes were founded on health promotion principles often lay primarily with the health promoter. Consequently, health promoters sometimes found themselves in the role of expert, educating and apprising partners of health promotion principles and approaches. Furthermore, health promoters spoke about the need to take care with the language or terminology they used to articulate models and principles so as not to confound or alienate stakeholders:

Where we ‘live, learn, work and play’ is the language that we find resonates most with our community and with also organisations like territorial local authorities when we’re doing submissions. They can get that. Talk about the social determinants of health and there’s a glazing. (P10, manager)

A good example of that is the equity focus that [name of PHU] tries to take on every piece of work. We’ve put it into the project plans but there’s regional organisations working across [name of city] and so sometimes you know we’re trying to say ‘what about equity in the planning?’ But it’s a newer concept for some people and so, you know, working where you can work and sort of trying to slowly make changes. (P14, senior)

Equity considerations

Described as a goal and “linchpin for sustainable development” (Becerra-Posada, 2015), participants unanimously identified equity as a key principle informing their work.

All of the health promoters interviewed showed big heart and best intention in their approach to programme planning for equitable participation and outcomes. However, some also spoke of programmes that inadvertently targeted the privileged or ‘low hanging fruit’ or were focused on individual behaviour change and other downstream measures. Some health promoters perceived these programmes by design, were not “hitting the mark” (P7, manager) in terms of reach and intended outcomes. This was especially noted for programmes designed to be inclusive of Māori:
And improve Māori breast feeding rates. They’re still on red and we’ve been looking at health promotion breastfeeding promotion here for eleven years and I’ve had to say to the team, since when does change tables at cafes and marae impact and increase Māori breastfeeding rates? I’m sorry we’re not hitting the mark. (P7, manager)

A pharmacy-based smoking-cessation programme aimed at pregnant women: We knew when we started that a number of our target audience may not have a pregnancy test, or would choose a supermarket one rather than a pharmacy one. And the question is how do you manage that appropriately and the answer is that it’s very difficult. (P10, manager)

We’ve got to try and do something different. We can’t do the same. It’s not working (P7, manager).

Some health promoters commented on the need to address the wider determinants of health by way of integrated partnerships with other social development and territorial organisations to wield influence on policy and issues collectively. This is touched on further in the section ‘collaboration and relationship building:’

So bringing in MSD, bringing in Ministry of Māori Development and Ministry of Education, so having a regional group that provides oversight to the social and wellbeing, health and social wellbeing of the region. (P4, senior)

Among the programme planning examples health promoters discussed, community development, whānau ora, intersectoral action and settings based approaches are perhaps the models most consistent with the ideology of equity. Intersectoral action for its recognition of ‘health in all policies’ and its potential to influence change at policy level through collective impact; community development for its ability to empower communities to identify and prioritise their own needs and aspirations; whānau ora for its cultural integrity and commitment to whānau and community based capacity building and finally; a settings based approach as a means of capturing and prioritising low socio-economic or vulnerable communities within a defined and supportive setting whilst drawing on multi-disciplined approaches. Examples, some aspirational, of each of these models as they relate to equity follow:

Whānau ora:

So take the planning into Māori settings and you know have the planning happen in a kaupapa Māori way. You know too often our planning is done, you know, in our offices and in our buildings and so on and so forth but you know take the planning out amongst the people. (P3, manager)
Community development:

Public health without any walls and taking our expertise that we have around water quality, around community development out in communities for them to build their expertise not ours. You know so shifting it all around the, empowering who has power here and we want to empower community and give them voice and help them with their plans and their aspirations for the future. (P7, manager)

Intersectoral action:

Our first health equity report came out two years ago, a big statement that we put out with that report was this is the health status of our population but actually we can’t do this by ourselves. This is not just a health problem. This is a problem for all of us…the DHB, the health sector in the region cannot do this alone. We cannot improve health outcomes in our communities as a DHB in isolation. (P1, manager)

Settings based:

When it comes to say health promoting schools and early childhood and other education programmes and some of our other programmes, we’ll basically look at the targeting criteria because I think the equitable or accessibility of the project is one thing that is factored into the planning right at the beginning. So I guess part of the evaluation would be looking at whether you’re actually meeting the targets that you set yourself out to achieve in terms of the priority groups you’re reaching. I’ll give you an example of health promoting schools. We’ve got a national target of reaching 75% of all decile one to four schools in our region so as part of that evaluation we will be keeping an eye on our recruitment. (P5, senior)

Several health promoters talked about the difficulty of accessing the hard to reach or at risk in a community. When planning and evaluating settings based approaches it may be pertinent to ask ‘who might be excluded from this setting?’ and ‘what are the determinants that exclude them from this setting?’

How do we reach the really marginal to make a difference and in the really marginal communities I think everybody [referring to health promoters] struggles. (P9, senior)

One health promoter had grappled with their insufficiency to reach and facilitate equitable outcomes for Māori despite consideration of equity issues during planning. Others similarly highlighted the dissonance between theory in planning and reality in practice when it came to planning for the reduction of health inequalities and designing and implementing programmes that were inclusive. Several health promoters
commented on health literacy as a barrier to obtaining equitable access to programmes, services and outcomes, especially for Māori:

Well what I struggle with around planning and evaluation is how best we can actually reach the population that we verbally say we prioritise or we should be reaching because many times I find myself thinking we’re quite PC about mentioning Māori and how our programmes will be responsive to Māori but when it comes to actually cracking it and getting into Māori settings...it’s not as easy as on paper. The reality is we’re not even in that space a lot of the time but our projects mention those as our priority groups...so I think that’s one thing I really struggle with. (P5, senior)

It’s about health literacy. It’s around how do, how do you engage effectively with Māori community? Do you feel you can engage with Māori, do you think you are? Well between you and me, Sarah, and this is probably not new news to you is that we’ve been tasked by the Ministry...we’re not meeting Māori outcome, Māori health outcomes. (P4, senior)

One senior Māori health promoter spoke of clinicians whose values did not accord with health promotion or cultural values. For example, in an initiative designed to engage pregnant Māori women in a smoking cessation programme, clinical staff had proposed “the intervention should be with radiology because that’s like the place where they’re likely to get told this is when baby is due” (P4). However, research shows that such a view does not recognise the inequalities that persist in Māori experiences of, and access to, maternity services (Ratima & Crengle, 2013). In this case, the Māori health promoter felt a tikanga-based programme would have been a more appropriate means of engaging pregnant Māori women:

This is where we come to that kind of like hard basket discussion with our clinical staff. We need to be looking at tikanga based approaches...we just need to have a programme, an antenatal programme specific to our hapū mama, and it will bring that whole tikanga and you know the whānau aspect and all lead into it. (P4, senior)

Several health promoters argued that a more targeted approach in high deprivation areas was a more effective means of tackling inequalities without spreading themselves too thinly. Some PHUs were moving more towards a community development model that would allow them a more targeted approach. However, some also relayed the challenge of serving all DHBs in their jurisdiction equally and having to work across a wide geographic area. One PHU’s solution was to take a wider, regional focus aimed at policy level as described here:
Yeah, we need to be...and you know, [names areas within their region] has some of the main disparities, health equity issues so you could argue that most of our energy should go there but then in terms of being seen to support all [cites a number] DHBs, we need to be working regionally. And a lot of our scale stuff when we sort of say actually how do make a difference for the city, it does really change, there’s a lot of things, if you’re working with changing Council process that has impact for the whole city regardless, so kind of, it’s a sensible place for us to be moving to. (P6, manager)

That’s certainly what we’re doing in terms of those equity areas so the smoke, the tobacco strategy for example identified you know [names five areas in the region] are our big areas to target for smoking cessation support and smoke free messaging...We’ve got the settings work happening across the portfolio priority areas. Happening in certain communities because we realise that we can’t be all things to all people in our community because that’s actually not going to give us a good return. (P12, senior)

The MoH has recognised the need to address health inequalities as “a major priority requiring ongoing commitment across the sector” (New Zealand Ministry of Health, 2000). Health promoters identified the importance of linking up with other health service providers within the sector, and some had actively developed these relationships. A small number of health promoters reported the challenge of maintaining relationships and communication across the sector, particularly when seeking information to inform programme planning. One PHU was involved in a whole of service approach to address equity and initiate culturally safe practices across hospital services. This PHU had aligned its values and goals with the DHB Māori Health Strategy and was also looking to align itself more closely with the Māori NGO they predominantly worked with in the spirit of “mahi tahi” (P7, manager) or working collectively. Relationships with PHOs were mixed, with several health promoters reporting they did not have any connection with their local PHO. The potential to grow a more integrated relationship between PHOs and PHUs to improve services for more equitable outcomes is an area for further exploration:

I think the challenge is what they hear and what they know about, how do you feed that into the wider organisation. It’s like our public health nurses sit in another group but they’re very, very much in touch with what’s happening within school communities and that kind of information is useful for all of us whereas I think you can get very, you’re busy enough, how do you find the time, the mechanisms to share that so that others can get involved. (P16, manager)

But like our health promoters were called into oncology to look at ways of helping out in there because of a lot of, some Māori were passing away and so there’s been a HEAT tool that’s been placed over there...Yeah and we couldn’t
very well go out to community. We have to get our, sort of try and get our backyard a little bit sorted. (P7, Manager)

Planning approaches and strategies

Health promoters are encouraged to plan in collaboration intra and intersectorally, across the health sector, iwi, local and central government, NGOs as well as the education and social sectors, in a move towards more integrated and sustainable practice. As such, many health promoters cited examples of collaborative planning:

Without collective vision and drive, you have nothing...only sustainably, people who will desire to see collectively, improvement. (P8, senior)

A number of health promoters indicated there had been a shift in planning from a health education model to a more strategic approach with health promoters often taking the lead or a coordination role alongside other organisations, services and the community to plan and deliver integrated programmes. Nevertheless, several health promoters still alluded to downstream approaches such as health education campaigns and initiatives that were singularly focused on the development of personal skills or behaviour change. It should be noted that it was beyond the scope of this project to ascertain the extent to which these approaches might have been part of a broader multi-levelled health promotion programme. Some health promoters voiced concerns about programmes that continued to either place responsibility for change on the individual or did not permit a more holistic, population based approach:

Old school health promotion puts a burden of change back on the community that is also experiencing the challenges of the issue. (P6, manager)

Some five years ago now our team here was still going out into the community and having health promotion days and I thought, oh that’s, ah well you know things have changed...That is not our role. Our role is strategic. We need to be working with the likes of the councils to get smoke free CBDs, to get fizzes out of the supermarkets, to reduce the number of gambling outlets, to reduce the number of fast food outlets. That is where our strength is and you know what, Sarah? We still have a long way to go here. (P4, senior)

Some health promoters extended discussion beyond traditional health promotion tools and methods to the use of business models, skills and project management tools that could be applied at the systems change, policy or advocacy level. One health promotion manager had consciously recruited staff from disciplines other than health promotion to accommodate the breadth of skills they sought to implement a systems change
approach. They viewed this shift in direction as one that corresponded with the “professionalisation” (P6, Manager) of health promotion. They also questioned whether the title ‘health promoter’ was relevant today in light of its association with a more “grass roots” (P6, manager) approach to health promotion:

> Even if you look across the Ottawa Charter you need sort of adult educators and facilitators and policy writers and all of the breadth of communication expertise, we need HR advice at times so actually in a way, this idea of a health promoter is something we’ve been questioning. (P6, manager)

Health promoters commented on the need to be opportunistic and flexible in their planning, especially when invited into a community, working with stakeholders or responding to a topical issue. Accompanying this approach, several health promoters discussed the valued notion of voluntarism, identified as an important factor in gaining acceptability in a particular community:

> You need to be flexible and so I could say yeah, this will be an outcome and this will be an outcome but it doesn’t quite fit into that model, health promotion because it really relies on the person, the health courier having initiative, seeing opportunities, relationships, collaboration... (P2, senior)

> We’ve worked in like iwi, we work with schools, we work in kohanga reo, we work in wherever we’re invited to work. (P7, manager)

Some health promoters acknowledged the need for multi-strategy approaches to planning in response to the five actions outlined in the Ottawa Charter:

> I try and make sure that when people are putting a health promotion activity in place, that the five principles are being covered, that we are doing work around policy, individual behaviours, you know like all of that stuff is ticked off so that it is a genuine health promotion rather than a health education or a community development or an advocacy type activity. (P1, manager)

Some units were combining their compliance and regulatory work in alcohol and tobacco with their health promotion work in these areas with the aim of reducing the availability of these products:

> We’re trying to break down a little bit of our silos between compliance and health promotion so we’ve sort of said for alcohol that actually our objective is again around the decisions that are being made on alcohol availability...for Smokefree, it’s the number of public places that are free from smokes and the density of retailers near schools...so actually how we’re using our compliance and health promotion expertise to reach those goals. (P6, manager)
Units variously operated under issues-based portfolios like tobacco control and alcohol harm minimisation, settings-based approaches, intersectoral action, systems change and community development models. Many units were subsequently employing a mixed-models approach, conflating existing portfolios with aforementioned approaches. Planning was leveraged at different levels of action and included policy change, advocacy, inter-disciplinary and community linkages, environment change and the development of personal skills:

*We’ve encouraged our team in the past three or four years to engage in the policy level, influencing at the policy level...in the settings, obviously physical, kura kaupapa, a little bit of our marae settings and our iwi settings.* (P3, manager)

*It’s a big shift, you know this team, for more than a decade, has worked on portfolios so there’s always been somebody who’s done sexual health and there’s always been somebody who’s done tobacco and there’s always been somebody who’s done alcohol harm reduction...I think, that was one of the reasons for moving to a settings based approach because it really makes you focus on the determinants, you know people have to have good quality housing.* (P1, manager)

The literature has long recognised that upstream approaches are more complex than downstream approaches. Here a health promotion manager talks about the challenge of working at policy level and having to rely on staff skills and ability to work at this level:

*It’s not always easy. It depends really, really it comes to how, how well engaged your staff you’ve got on board are around that area. You know we’re kind of lucky. We’ve got on board a couple of good staff that have come on board and so and they’re climbing into it really well.* (P3, manager)

Several PHUs had expanded their predominantly issues-based portfolios to include a more community development model with the aim of including community voice in setting goals. It was beyond the scope of this project to establish how close these approaches were to being truly participatory or community-motivated. How achievable a true community development approach is in an environment of accountability and government priorities remains to be seen. (Ministry of Health, 2014c, 2016b)

*Trying to start off with what matters for them and recognising that the communities have aspirations, they’ve got solutions, they’re experts about their own life in their community.* (P16, manager)
Here two health promotion managers describe their units’ mixed-strategy approach to planning:

*I think there’s a mix really. I think some of our planning is really around the system level initiatives and other things are very community based.* (P16, manager)

*And we’ve also got in through our councils and the team I work also write all the submissions for the DHB. So we enter all the submission stuff, which is whatever is going on, long term plans and all this sort of stuff. So yeah we would target health and wellbeing issues in those plans. And so, and we also do all our position statements for the DHB like the Smoke Free, Alcohol Free Harm Reduction. So basically yes we’re working at that level right through to the hands-on type work.* (P11, manager)

Some health promoters reported using project templates as a practical tool for planning, while others spoke of programmes undergoing some form of peer-review, albeit informally in some instances:

*If you want to get down to the nuts and bolts, we have a project template that has been approved for us to work and within that, you have to come up with your rationale, your time line, your resources, your fiscal availability, any Ministry of Health requirements, your objectives and your time frame so that’s at a real practical point how we do planning.* (P2, senior)

Health promotion managers at two PHUs commented on the challenge of balancing a systems based approach with community need and aspirations. One unit reported receiving some positive feedback from health promotion academics in regards to their shift to a systems change model, however they were not without their critics who questioned the absence of community voice, illustrated below:

*I’ve got a couple of colleagues in academia who have mixed views because they’re probably more champions of community development...they have questions around the integrity of that, of you know where’s the community voice in our process?* (P6, manager)

*Every now and then it feels a little uncomfortable because community action has been at the heart of health promotion for so long and there are questions about authenticity and mandate...you know we have been challenging ourselves and the team hold the Treaty and equity pretty much at the heart of most of what they do so I think they do kind of keep it honest.* (P6, manager)

A large number of units used settings based approaches, and had programmes operating within a range of different settings including schools, workplaces, kohanga reo, marae, churches and early childcare centres
We tend to work in settings so a health promoter will go, they’re engaged in a setting, it could be a marae, it could be a church, it could be a school, whatever and they have a relationships with that setting. (P13, manager)

Some health promoters were planning and operating at policy level; both at the macro level in partnership with territorial authorities as well as the meso level, developing healthy policy in schools, kohanga reo, sports clubs, the workplace and other social settings:

I can work at a very top strategic level like for the [names DHB] kind of…a lot of what I do is advocacy. (P2, senior)

Health promoters proffered a range of responses when asked about the use of pilot programmes. A number were opposed to pilots on the basis they could impinge negatively on community who were research weary, or vulnerable to support being withdrawn at the conclusion of a pilot. Other health promoters considered pilots useful for endorsing a programme to secure further funding or as a test-pad to assess the validity of a programme before progressing it further:

Slightly dubious about pilots in that you, I get the whole thing around you discover what will work or what doesn’t, but you, that affects other people so you’ve set up an expectation, you’ve worked with people and then it disappears. So I think there’s the positive side of it in that you get to fine tune something, see whether it’s going to work in your region compared to somewhere else…perhaps for some there’s unintentional consequences or unintentional benefits but how do you do that in a way that doesn’t, I think communities are fed up with pilots. (P16, manager)

Collaboration and relationship building

Relationship building was viewed as central to the development of effective and sustainable collaborative partnerships. Examples of collaboration cited by health promoters ranged from relatively small-scale programmes involving one or two NGOs through to large scale, issues-based coalitions or alliances. A health promotion manager spoke of working with other agencies to advise and support them in funding proposals and joint-submissions “so the public health voice is strengthened” (P10, manager):

I mean a key role for a health promoter is managing relationships and facilitating those relationships rather than coming in as an expert telling people what to do in my opinion. (P13, manager)
I guess we intentionally look at where the synergies are in our contracts and where they come together is an opportunity to work in a stronger collaborative partnership. (P10, manager)

Health promoters spoke of being in partnership with a variety of stakeholders including: NGOs, Healthy Families, PHOs, university researchers, whānau ora collectives, territorial authorities, Māori NGOs, LMCs, schools, kura kaupapa, kohanga reo, hospital services, workplaces, and iwi.

A perceived benefit of working collaboratively was that it permitted greater sharing and dissemination of skills, resources, and information amongst partners in working towards a common goal and in doing so, better informed needs assessment and planning. One of the strengths of intersectoral action was reported to be its potential to wield greater influence through collective impact and wide engagement across a range of sectors. Working collectively or intersectorally could lend more gravity to a programme, generate more attention from social and political influencers and attract other organisations to become involved:

*We had a contractor [name of person]. She’s a policy analyst. She had a good political eye. We had [name of person], strong in PR and communications so quite different areas of expertise that sort of brought policy and health together quite nicely.* (P14, senior)

*There’s certainly strength in numbers and you’re more nimble and able to do things that a DHB can’t in the area of advocacy in particular.* (P12, senior)

*We get further working in partnership with people in organisations.* (P2, senior)

It was acknowledged that under a constrained funding environment, combining forces had become more than merely a means of pooling skills and asserting collective impact, it was also one of economic necessity. Without a budget allocated to evaluation specifically, health promoters were grateful to intersectoral partners and social development agencies who could co-finance evaluations or with whom health promoters could seek external funding opportunities. Health promoters from two regional PHUs deemed working in partnership vital to the sustainability of a programme because of the perceived limitations of being part of a small team:

*The reason we were able to do that was because ACC had some funding and we were able to fund the evaluation so we were able to do that.* (P10, manager)
I mean let's face it, I mean being a health promoter is hard and that we've got no resources and we want organisations to do health projects and health initiatives when we actually don't have much to help them with, so we have to rely on collaboration, partnerships, good working, um now strategic sort of head space, all those other skills come in. (P2, senior)

Some health promoters spoke of having to take the lead in coordinating the functions of the group, planning, writing reports, conducting evaluation and ensuring programmes were shaped by health promotion principles:

I think working with, working with those other departments and organisations, government agencies and you know more particularly that's your core business to try and influence and advise them around the public health approaches. (P3, manager)

PHU has more of a coordination role in this...so we're coordinating, organising, setting stuff up, you know, doing reports, planning, that sort of helping, probably doing a lot of the stuff that a lot of organisations don't want to do. (P17, senior)

Several health promoters commented on the complexity of accommodating different agencies and organisations in partnership, with each bringing their own agenda, priorities, organisational practices, and reporting and funding structures to the table. Some spoke of seeking stakeholder champions to spearhead efforts however it was not always easy to sustain these relationships because of changing organisational priorities, funding issues and staff turnover. Health promoters recognised the need to work with a degree of fluidity and flexibility as well as trust, to accommodate the different needs and perspectives of partners. The role of planning was recognised as crucial to this process:

Planning was key...we really did need to collaborate, we couldn’t have done it individually as organisations and so we were very structured around planning around who was doing what, what we wanted to achieve and who our target audience was and then a lot more planning... so it was about aligning, because their priorities weren’t necessarily ours but through the planning process, we shared priorities...Yeah, you’ve got to find common ground. (P13, manager)

Community champions for example are very different in different communities and very hard to identify, like it took me probably three years to find a councillor champion for [name of city]. (P2, senior)

We really have to be fluid at the end of the day. That organisation has their way of doing it as well. (P14, senior)

Despite the complexities of working collaboratively a number of success stories were discussed including that of a health promoter who had enjoyed a close working
relationship with the manager of a large NGO for over eight years, which involved them planning all of their programmes in tandem. Another health promoter had found autonomy working with a Māori NGO, drawing on their “collective vision” (P8, senior) to bring health services to an ‘at risk’ community:

*We just get on really well and have developed a very good professional partnership and yeah, we’ve just carried on really, so partnerships form because you need to in health promotion, it’s better than sitting there trying to do it on your own but also we did get on really well, our organisations align themselves.* (P2, senior)

*They’ve [Māori NGO] got the connections at marae level while the PHU can offer analytical processes and public health approaches and what works and what doesn’t.* (P8, senior)

Both Māori and non-Māori health promoters reported positive relationships with iwi, Māori NGO, Whānau Ora collectives and other Māori organisations (see ‘Māori perspectives’). However, a number of non-Māori health promoters also indicated there was a lack of engagement with Māori around consultation, planning processes and the building of strategic partnerships. Some health promoters relied on partnering organisations and their pre-existing relationships with iwi, to broker connections or consultation with Māori on their behalf. One health promotion manager spoke of relying on the DHB Māori directorate to network with iwi and other Māori organisations. A Māori health promotion manager spoke positively of the Māori Public Health Leadership programme for the confidence it had given health promoters to identify and address equity issues:

Speaking about Māori Public Health Leadership programme:

*They’re more comfortable in delivering kind of kaupapa Māori approaches but in mainstream so it empowers them to say what they need to say in terms of improving Māori health...what I would like maybe is to see that core strengthened around some of the skills for you know, planning and project management.* (P15, manager)

*It’s certainly an area that we need to strengthen. I think at operational level we do quite well in terms of working with Māori providers and Māori communities. I think it’s more that strategic relationships with iwi that are more tenuous. So in terms of like we, we have conversations around well how do we take annual planning out to the various iwi in our region, how do we get some sort of consultation going there and at the moment, we haven’t got something that’s formal.* (P16, manager)
Collaborative partnerships were described as not without challenge. The more organisations involved in partnership and the wider cross-section of groups represented the more likelihood there might be for collaborative action to stray or deviate from its original vision, thus reinforcing the need to establish clear parameters acceptable to all participating parties early in the piece. To minimise the potential for dissonance one health promoter recommended taking a measured and integrated approach to planning that involved clearly mapping the strategic direction of the group and terms of engagement, as well as finding consensus on goals and the allocation of roles and responsibilities early in the process. Several health promoters stressed the need to keep things focused and relevant or intersectoral partnerships could run the risk of simply becoming a “talkfest” (P12, senior):

*Smokefree coalition...what’s our vision for this strategy, what are our objectives? What are our key values or principles for the strategy? And to start working on some ideas for action and I think that was key in getting the buy in. From day one we never had any flack, we never had any negative comment coming back to us, as the drafts were prepared, because everyone had already brought into it because they’d all helped develop those underlying kind of statements about what we were trying to achieve.* (P12, senior)

Some health promoters talked about the difficulty of maintaining and sustaining intersectoral partnerships without a dedicated administrator or coordinator. Some reported that it fell on the PHU to coordinate the strategic direction and functions of the group, a role often assumed by health promoters because of their perceived expertise, experience and training. This added another layer of complexity and responsibility to their role:

*There isn’t a dedicated FTE associated with it [coalition] so we have leads within it but obviously to get a piece of work done is quite challenging if nobody has the time to commit to driving it.* (P15, manager)

A number of health promoters referred to local government as an important coalition partner because of their capacity to initiate policy change at regional level. However, some health promoters noted it was challenging to accommodate the multiple councils under their jurisdiction. One health promoter talked about the slow processes involved in obtaining council buy-in. Another health promoter spoke with frustration at what they described as a “risk adverse” council. They had learned to work incrementally with council to implement policy change in the area of smokefree spaces, initiating more
‘palatable’ programmes that once accepted, could be adapted to other more relevant settings or population groups:

Talking to councillors is a skill and it's not like telling them what they want to hear but strategically you need to be very switched on...so um so that messaging the way that we approach councils is almost like a project in itself, you know you have to be pretty, but then again we've got [cites number of] councils and they all work very different so I have to sort of develop a working relationship and a working pattern within, you know, between all five of them and then a blimmin’ policy person leaves and you've got to start all over again, that happened a lot over the year...it can get quite complex. (P2, senior)

Local councils because of which we have [cites number] so for us, it’s quite a significant kind of impact just because of the volume of them (laughs)...and trying to get them to have some sort of consistency across them. (P1, manager)

Several health promoters acknowledged that working intersectorally was by no means a ‘fix all’ approach. For example, the coordinator of a large and well resourced coalition that included many of the region’s ‘big’ influencers conceded that they were still limited in scope to agitate for policy change at national and industry level. The antidote to this was establishing where they could have most influence, and to focus their planning at this level. Several health promoters implied that addressing the social determinants of health sat largely outside their remit even when given the opportunity to work across sectors:

In saying that it’s very much at the [lists health issues] and not looking at things like, you know, living wage or housing or you know the other factors that influence those decision that are sort of broader than what we’re actually going to look at for this particular programme. (P14, senior)

Despite this, there were examples of intersectoral action that health promoters touched on that addressed the wider determinants of health including the MSD social-sector projects. An example of an initiative that addressed the wider determinants of health through intersectoral action was the Healthy Homes initiative, which was cited by a number of health promoters. Intersectoral partners in this programme included various groups: council, landlords, community groups, iwi organisations, housing development organisations and primary health services. Another example of a determinants approach targeted the protection of mahinga kai sites and involved local iwi, runanga, regional council and the PHU collectively. A further example involved an ongoing relationship between a PHU and a local Māori asthma trust to investigate healthy homes,
insulation, and housing assessments. In this instance, the PHU was able to offer funding for the programme and some evaluation assistance.

Health promoters gave varying accounts of the support they had received from national health promotion bodies like the HPF and Health Promotion Agency (HPA). Some were positive about the support they had received while others reported having very little to do with either one or more of these organisations:

*They (HPF) run those short courses around health promotion so we have had staff attend that, particularly our staff who don’t have a university qualification so you know, it introduces that whole concept of planning, implementing and evaluating into their thinking so it’s not unfamiliar when we start to improve their skills.* (P15, manager)

*We haven’t had a lot to do with them (HPA).* (P15, manager)

*I mean Health Promotional Forum have been useful, they’ve kind of gone a bit quiet lately I think.* (P13, manager)

*They (HPF) have a DHB and PHU health promotion leaders’ network that is not well attended by some of the DHBs. Some of the work they’re trying to do to connect us is quite important I think.* (P10, manager)

*Health Promotion Agency have kind of stepped into that area and are setting up this network for health promoters, alcohol health promoters which is great. I know they’ve set a network up for people working in healthy workplaces in terms of health promotion. They’ve got a little network going from representative PHUs around the country that aims to share information amongst the whole set of PHUs which I think is fantastic.* (P12, senior)

A small number of health promoters spoke of the sensitivities involved in working with the commercial or big corporate sector, where price-point tends to drive decision making. Here a health promoter working to reduce food obesogenic environments speaks realistically about the degree of influence they can have on the food industry:

*The immediate thing we found was a tremendous pushback from industry and nobody’s funded to fight industry.* (P9, senior)
Best practice programme planning examples

Participants were asked to cite an example of ‘good’ or ‘innovative' planning. Two such examples are presented here, both with relationship building at their core. It should be noted that I was not in a position to evaluate the effectiveness of either of these programmes because they were fairly new inceptions and neither had undergone outcome or impact evaluation at the time of interview, moreover it was outside my research brief. Nonetheless, the following examples demonstrate qualities of best practice; the first in its community development approach and responsiveness to Māori and the second, for its intersectoral partnerships.

A marae-based, community development approach to needs analysis

A Māori health promotion manager offers us a best practice example of a marae based community led needs assessment that had iwi aspirations and priorities at its core. Working from the ideology of voluntarism and the underlying principle of empowerment, the public health team were invited by iwi:

\begin{quote}
We’ve had iwi come to us and ask if we can help support them with a needs assessment for their area.

They wanted to go to every corner of the iwi, you know the, every corner of their iwi boundary to make sure that they were speaking to community.
\end{quote}

The PHU assumed a support role alongside iwi and offered them resources and skills without dictating the terms of engagement. The PHU provided a well-resourced, skilled team to support the needs assessment highlighting the value they placed on the process:

\begin{quote}
And so what we’ve done is a team of three...a researcher, an evaluator with the health promoter, three health promoters have gone out to the iwi and discussed, you know, exactly what did they want within their plans and you know the scope of the programme.
\end{quote}

Community champions were identified to conduct and drive the evidence gathering. This in itself might be viewed as an exercise in capacity building:

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9 I have not assigned identifier number codes to the quotes in these best practice examples in a bid to preserve participants’ anonymity
Trained up ten community people in the iwi who have had no experience and they thoroughly enjoyed it. Hopefully from that they can, we might have some iwi researchers in the future.

The iwi interviewers received a koha as an expression of āta or reciprocity; the building and nurturing of respectful relationships:

And was able to train them up with, you know, the same sort of lots of questions and was able to pay them well as well. You know like gave them a good koha for their time so ten iwi selected iwi members, went out and interviewed ten iwi members.

The findings of the needs assessment were reported back in a marae setting where iwi were able to communicate their own goals, needs and aspirations:

It was marae based and were able to do a joint presentation, the health promoter and the iwi you know coordinator around the findings. It was all around their iwi findings. Nothing to do with the District Health Board here. Even any media.

The needs analysis revealed issues that were important or relevant to iwi that arguably might not have been identified if the PHU had taken the lead on needs analysis. The PHU are currently working alongside iwi and an iwi affiliated health and social services organisation in a relationship the health promotion manager described as “a wonderful working relationship,” to support and develop initiatives to help iwi achieve their goals:

So it’s a work in progress, you know, it’s still happening and we are just a silent partner. We are there to tautoko, not to take over. We’re there to help in any way we can and so healthy homes, drivers licensing were issues that were big issues that came up.

A coalition working at systems change and policy level

A coalition, though still fairly early in its inception is worthy of mention for its sheer scale, commitment to a long-term plan, thorough attention to planning and incorporating the needs of coalition partners, and its level of engagement with a broad range of ‘big’ influencers in the region. The coalition is comprised of multiple organisations, spanning local government, iwi, health agencies, NGO and university partners. It should be noted that some of the planning commented on here is at a strategic level, but an exception was made because of the precedent this coalition sets for health promoters considering intersectoral action and because the strategic planning forms the backbone to programme planning across the multiple organisations.
The coalition formed with the aim of influencing regional systems change and public policy around healthy environments:

Sort of regional impact across the sector, saying you know what can we do, how can we work together... and the core purpose of everyone in the group was that it had to work at an environmental system level so look at the larger levers, the political input, the system changes, the environment.

The coalition was well resourced with a dedicated FTE programme lead position as well as a project coordinator. Leading this coalition was the health promoter’s sole responsibility within the PHU, illustrating the level of effort and commitment they were able to dedicate to the role, a luxury not afforded to other health promoters working intersectorally:

[name of PHU] is the backbone for the coalition so we do a lot of the stakeholder engagement and we organise inter-agency groups and we do all the reporting functions for the group.

With long-term goals in mind, the coalition dedicated the best part of its first year to building relationships and finding common ground, setting the terms of reference for the group, establishing goals and planning programmes:

2014 to 2015 was all just planning and yeah I think the, we, anything we do pretty much requires two weeks for partners to comment, the opportunity for them to opt out if they'd like to. We have agreed to a like no surprises approach so anything that people want to do needs to go through the whole group. And so I don’t think you can rush that if you want people to properly buy in to what comes out of it you know? You’re just trying to build relationships.

Working intersectorally permitted opportunities for sharing and dissemination of resources, data and information between the partnership organisations, to inform needs analysis and planning:

And I think the other reasons it's good is that we're sharing data like all of our agencies are sharing data with each other and like, and I know in all like other health promotion jobs I've done there's so much data collected and you just don’t see any of it. And so it's sort of like you end up doing these little like surveys or questionnaires or you know things that aren’t really meaningful because you need to evaluate what you’re doing but in fact someone could have data on that whole community or you know and you could just synthesise it to what you need for your data.

The health promoter was able to draw on a wide range of complementary skills and expertise from coalition partners to tackle issues; skills ranging from public relations
and communications through to needs analysis, planning, policy and project management experience. In return, the health promoter was able to bring their knowledge and experience around planning, equity and evaluation to the table:

Quite different areas of expertise that sort of brought policy and health together quite nicely...so we're quite well resourced as it turns. So we've got some people who have got a wealth of knowledge.

The health promoter identified one of the strengths of the coalition was its commitment to a long term plan:

The other thing I think that makes it really good is having that plan, the five year plan, because when we go for meetings with stakeholders or when we go to local boards we have something really concrete.

The coalition was able to reduce the potential for disparities in ideology and priorities amongst its coalition partners through its attentiveness to planning and relationship building, and the setting of clear goals and parameters for operation. Needs analysis involved a literature review to highlight best coalition practices and quarterly interagency meetings had brought together a speaker on equity and introduced other areas of interest to the coalition. A university researcher specialising in the issue was able to provide expert advice, and advise on goals and objectives, to make sure they were relevant and measurable:

Yeah and its difficult you know because everyone's got their own reporting structures and funding lines and ways of working and we're at the very, very early days....

When we're looking at new projects being added or you know if the partner agency would like to join everything goes back to well what's our vision, what's our purpose, what are our principle ways of working and looking as to whether they align with those.

Summary
Health promoters reported needs analysis and prioritisation of health issues as largely driven by DHB contractual obligations and MoH priorities. While some health promoters affirmed the importance of starting with a community's needs and priorities it was acknowledged that amalgamating the articulated needs of community with government priorities was not always an easy fit. Health promoters from some units described needs analysis as following fairly “informal” or “ad-hoc” processes. Many participants valued the access to in-house analysts to assist in the collection,
preparation and analysis of data for needs analysis and planning, though access to this resource was not equal across all units.

Health promoters utilised a range of different approaches and models in their planning ranging from: community development, intersectoral action, settings based, systems change, and issues-based portfolios or as was the case for a number of units, a conflation of some of these approaches. Relationship building was viewed as integral to collaboration, which in turn was recognised as an important feature of sustainable health promotion practice. Collaboration permitted greater sharing and dissemination of skills, resources and information for planning however these relationships were viewed as not without challenge in having to accommodate differing agendas, priorities and practices. Subsequently, health promoters stressed the important role of planning in developing collective relationships, coupled with the need to be flexible, fluid and opportunistic in their planning with stakeholders and the community.

While equity was unanimously cited as a keystone principle guiding practice and health promoters reported applying an equity lens to programme planning, there was less evidence that as a programme progressed that health promoters were formally or actively reviewing or evaluating equity or reach within a programme and making subsequent modifications. The Treaty was also referenced as a guiding principle though several health promoters remarked on programmes that continued to miss the “mark for Māori health.” Others alluded to programmes in which strategies or approaches either did not align with proposed goals, the target population or outcomes. Finally, some health promoters commented on the ideological differences in values between PHUs and DHBs, which could pose a challenge to planning.

**Evaluation**

**Introduction**

It became apparent relatively early into the interviewing process that evaluation was not spoken of with the same confidence as planning, consequently interviews tended to be more weighted towards programme planning. It may have been I inadvertently allowed less time to elicit full clarification of answers in this section because it was the back-end of the interview and I was mindful participants had already been overly generous with their time. While this may have been the case it remains, a large number of health promoters articulated a general lack of confidence in conducting evaluation.
and at times some health promoters appeared unsure how best to explain their evaluation practice:

*Okay so through the project planning, we can do formal evaluations which will be like a qualitative study or quantitative, can do that as well...yeah that's not very much detail is it. Sorry.* (P13, manager)

*I couldn’t give you a specific name of a tool or a model.* (P5, senior)

*That’s a bit vague isn’t it?* (P3, manager)

It should be noted that while I chose to situate ‘needs analysis’ as a frontispiece to planning, it could equally sit here as an illustration of formative evaluation. In this section evaluation is discussed under the following headings: overview; methods, approaches and tools; equity considerations; linkages with stakeholders and community; support for evaluation; challenges to evaluation; and RBA.

**Overview**

There was a general consensus amongst health promoters that evaluation practices could be improved, as illustrated here in the comments of three health promotion managers:

*I don’t think we do evaluation particularly well, I’ll say that straight up.* (P15, manager)

*I really do think our evaluation processes can be a lot sharper than what it is.* (P3, manager)

*I’ve recognised that we think we’re good but we’re not really (laughs).* (P13, manager)

While a number of health promoters stressed the importance of evaluation two managers expressed a degree of ambivalence, with the view there was too much emphasis placed on evaluation and that it featured too often. One of the two managers had reconciled that if planning followed sound programme logic and prioritisation of the target population was achieved, then short-term gains could arguably be linked to improved population health without the need for extensive evaluation.

*I suppose it is very definitely seen as a priority.* (P9, senior)
We over evaluate and we expect communities want to be involved. (P11, manager)

Some health promoters conveyed the sense that planning was prioritised over evaluation. Some for example spoke of the lack of dedicated funding for evaluation, another mentioned the responsibility they felt to the funder to deliver on programmes, some described health promoters as more ‘action’ or ‘doing’ focused by nature than evaluation oriented, and finally evaluation was not always viewed as a priority for partnering organisations making it a more challenging prospect for PHU health promoters:

We’re very planning driven. You know, its, it’s very heavy at one end but I guess that’s one reason is because you know you’ve got a funder, you’ve got dollars coming in from the Ministry and they want to know what you’re going to do with it so we, we spend all this energy into planning what we’re going to do… You get to the end of it and think oh we better have an evaluation…even though you see in our planning you know we talk about we’ve got to incorporate an evaluation and have this evaluated but it tends to get pushed you know, slip off the radar. (P3, manager)

Health promoters gave the impression evaluation sometimes occurred in a more informal, ‘basic or ‘ad-hoc’ manner. It was suggested under these terms it might be considered more a ‘review’ or ‘feedback’ than an evaluation:

Yeah, so I mean people aren’t shy about coming forward if something’s not working. (P15, manager)

You know [name of town] is so socially connected that somebody could put something out on one of these pre-loaded facebook sites and you could get quite a lot of comments but it might not be seen as a formal evaluation but it could be something that we use…so the formal evaluation kind of before a project might not, well it might not be formal but I guess the health promoters are using their networks and relationships to think you know, how can this change for that particular outcome. (P15, manager)

If we’re doing it in house yeah its usually just looking at some data if we’ve got any or providing some anecdotal comments from stakeholders. You know it’s pretty ad hoc. (P12, senior)

Oh feedback…you know if you get positive feedback…it’s just helpful. (P17, senior)

Things are sort of done based on sort of like perceptions and gut and how people think it goes. (P14, senior)
Methods, approaches and tools

A large number of health promoters reported using self-reported sources of information foremost, particularly surveys, followed by pre-existing quantitative data. An example where quantitative data was used involved a unit drawing on longitudinal ACC data to capture regional trends, even then they were still unable to establish a causal link between their long-running programme and the data despite promising indications:

So we have to just do the best we can and that is by doing our own evaluation, you know, by way of surveys mainly. (P4, senior)

Always do a baseline survey to gather the needs and wants of that particular workplace...and then once the challenge had finished they would evaluate the attitude behaviour change and the number of policies that had changed as a result of that programme. (P15, manager)

Things around surveys, indicators, sort of like qualitative feedback. There’s probably a bit of like feedback debrief that’s sort of you know like anecdotal. What did we see? How do we feel? Those are probably the core...at the programme level it’s probably more just like those smaller like yeah like evaluative surveys or looking at yeah what happened as a result of what you did. (P14, senior)

One health promotion manager paid caution to their staff’s over-reliance on Survey Monkey as a tool and their mistaken assumption that in using the tool itself, the information gathered would be inherently valid:

I worry because these people have hooked onto Survey Monkey thinking it’s the, you know, the messiah and they fly out surveys all over the place and I’m thinking actually your survey design is rubbish...and people don’t realise that actually there’s a whole science to how this stuff is done...I don’t think you understand actually, you can’t quote that data because actually that data’s not valid. (P1, manager)

Several health promoters found focus groups an inefficient means of garnering information because of the logistics of finding a common time to suit all participants coupled with the costs and resources involved:

We have used focus groups before...they’re time consuming and you need a bit of money to get people along and you need someone to run them and so I haven’t done them for a few years, they’re a bit of a pain, I just don’t really have the time or resources to do them so I do surveys most of the time. (P2, senior)

Health promoters perceived that limited resources and capacity, a lack of locally relevant indicator data, the complex nature of health issues and a focus on short-term
approaches all impacted on the type of evaluation they were able to conduct within the unit. For example, some health promoters indicated process evaluation or ground level reporting was more feasible than higher-level outcomes or impact evaluation. Health promoters from two units ventured that the undertaking of comprehensive evaluation was outside the skill set of health promoters in their units and would necessitate further training and mentoring in evaluation:

So often what we will tend to do is do quite a lot of process evaluation and do that kind of planning rather than have formal evaluations. (P10, manager)

Most often it’s just process evaluation. A little bit of formative evaluation but mostly focussed on process and maybe some outcome evaluation but very, very short term outcomes. (P12, senior)

[DHB] want to see results now. (P11, manager)

Some of our evaluations are how did a particular workshop go so we would be, you know, we would have some kind of survey or questionnaire and we’ll analyse that. (P16, manager)

One health promotion manager opined some of the “best data” (P1, manager) they had collected had come from taking a “clipboard and a piece of paper” (P1, manager) out to the community. On one occasion, they had been able to utilise the results of a community-based survey to successfully challenge alcohol-licensing policy in the area.

Process evaluation allowed health promoters the opportunity to assess the strengths and weaknesses of a programme, adapt or modify strategies and strengthen relationships. For example, an evaluation of a marae-based programme revealed that the project had reached saturation in the number of families involved after the initial uptake, raising the issue of how to increase participation beyond the founding families. One health promoter had used process evaluation to develop and progress co-design projects in an “evolutionary process” (P1, manager).

In the following example an evaluation of an incentives-based smoking cessation support programme for pregnant Māori women drew on self-reported data from consumers to reveal the need for the programme to be more inclusive of whānau. As a result the incentivised scheme was extended to other whānau living in the home:

Tighten up the programme, like make it better, you know work out what some of the flaws and things were in it but also to prove that we’d had success with the programme and so we got a really cool independent survey and she went
out and talked to every man and their dog that was engaged with the programme, got lots and lots of really good quality feedback from smokers and others and pulled it all together and basically what we found at the end of the day was that just working with the women is never going to cut the mustard, it has to be smoke free whānau and extended our programme out. (P1, manager)

Many health promoters continue to use programme logic, introduced to PHUs in 2006, to guide their evaluation:

Yeah but eight times out of ten we’ll be developing a programme logic with relevant stakeholders not just in isolation and identifying, you know, what’s the long term goal here. What are our short term, medium term objectives and then pinning any evaluation work back on that. (P12, senior)

**Equity considerations**

A number of health promoters were unsure how to answer the question, ‘how do you evaluate if a programme is equitable or accessible?’ and sought clarification from the interviewer. The vast majority spoke fairly confidently about using HEAT to guide them during initial programme planning however beyond this many appeared incognisant of how to assess the delivery of programmes and their current or prospective impact on health equity. The general consensus was that while consideration of equity issues readily occurred during the early stages of programme planning through the employment of HEAT or another similar equity tool, there was less evidence that as an intervention progressed that health promoters were formally or actively reviewing, refining and evaluating equity within a programme. A couple of health promoters used the interview question as a prompt to reflect on their previous practice and questioned whether their planning had gone far enough in evaluating the reach and impact of a programme in reducing health inequalities. Several health promoters suggested that if a programme targeted a priority area or population group, this in itself could be expressed as a measure of equity:

Yes, that’s a good question (awkward chuckle)...I don’t think we have been evaluating that in particular, I think it has come more in that our programmes are aimed at vulnerable communities in large part, yeah I don’t think we’re doing that. (P16, manager)

Well that’s something for me to think about more because I do hope that we, you know it’s the unintended consequence thing isn’t it? I do hope that we, because we need to think about what we’re doing and we plan what we’re doing that we wouldn’t do that but I need to think about that more. Yeah, I think being aware of unintended consequences is something we talk about and I would hope that we are cognisant of that. I’m not sure what processes we
have in place at the end to check that we haven’t done that but I know that we think about it at the beginning. (P13, manager)

Some health promotion managers appeared to rely on Māori health promoters within the unit to assess whether or not a programme was equitable and accessible for Māori. While Māori health promoters may be well placed to make such assessments, a more formalised and directed approach might be warranted, alongside recognition of the additional responsibility this entails for Māori health promoters (see ‘Māori perspectives):

Generally we don’t formally [evaluate] but we would always have the HEAT tool in the back of your mind particularly with our health promotions being, workforce being mainly Māori so they’ll be speaking up if you know, for example if they think that the health literacy is really not there, that the consumer group or the target population won’t understand what you’re talking about and you know, there’s barriers of access to service for example, you know, yeah…it’s just business as usual. (P15, manager)

Evaluation of a programme could reveal whether it was compounding or not going far enough in addressing inequalities and in doing so allow health promoters the chance to modify, abandon or add further supports to the programme. A lack of resources and expertise as well as budgetary constraints were all perceived as contributing to a unit’s inability to assess whether a programme was accessible or equitable:

So equity in terms of access or acceptability…to be honest it’s probably once over lightly because of budget issues. Unless a programme is specifically targeted at a community and you want to know then whether or not that community accesses it then equity is probably not considered. (P12, senior)

One health promoter reminded us of the need to consider culturally competent approaches to community engagement in evaluation processes to ensure participation and ownership:

They’re not going to fill out this survey…have to get creative. (P8, senior)

We had to use other ways to engage participants who are not comfortable with paper…literacy is an issue. Korero and listening became our process. (P8, senior)

Several health promoters cited programmes that while borne from best intention missed the mark in terms of reaching Māori. In these instances, evaluation and robust
assessment using an equity tool might have revealed earlier that the programme was not reaching Māori:

Well meaning programmes, don’t get me wrong, but they’re not hitting the mark for Māori health. It’s increasing inequality if anything and, or promote Māori breast feeding rates at [name of major festival event]. Now not a lot of Māori can afford to go to [name of major festival event]. Those tickets are three hundred dollars so I voice my concern. It does my head in a little. Got to go home and lie down on the couch. (P7, manager)

Linkages with stakeholders and community

Community involvement in evaluation appeared to vary from unit to unit, and project-to-project. As previously discussed in the ‘needs analysis’ section health promoters who played a coordination role in programmes were sometimes one step removed from community and therefore relied on stakeholders and partnering organisations to assess the reach and acceptability of programmes. Potentially complicating this disconnect, partnering organisations were not always thought to possess the necessary evaluation skills nor understand the value of evaluation or health promotion concepts that would enable them to confidently build evaluation into their service delivery. This meant health promoters sometimes had to assume the role of imparting their evaluation knowledge:

So, but you know unless you’ve got somebody that is working alongside you that understands that whole, that evaluation sometimes you get complacent and I’ll be honest and I have got complacent but I do when we’ve got community projects and we’ve got stakeholders on board and have key stakeholder groups I do push that whole, you know, the formative process and outcomes evaluation. Whether its applied or not but yeah. Yes, whether they get to understand it or whether they want to engage with that evaluation process, that model, I don’t know... (P4, senior)

Community involved at outset so integral to evaluation process. (P8, senior)

Most of it is done by the stakeholders. Yeah, the community is representative of the stakeholders that form the project, absolutely so no we wouldn’t. In most cases, yeah it’s not all occasions it’s usually just the stakeholders that have the community interest and voice. (P4, senior)

Here a health promoter laments that they did not engage community formatively to gauge their responsiveness to a community alcohol policy process to reduce alcohol outlets. Community consultation may have revealed the barriers to participation in the policy process much earlier:
I came across certain barriers that I wasn’t expecting to meet and I, whenever I tried to adapt them I couldn’t really...I kept coming across, up against barriers. (P9, senior)

Yeah well it was that whole aspect of other priorities and we don’t see this as a priority and you’re coming out and you’re telling us that it would be good to participate but it’s not our priority. (P9, senior)

Several health promoters spoke about not putting the burden of evaluation back on community suggesting community were both weary and wary of being involved in evaluation. One health promotion manager was critical of the way in which they had communicated the results of evaluation back to the community:

We’re conscious of not taking up too much of their time, they’re very busy people. (P9, senior)

I find that really worrying that we don’t report back to people particularly well. (P1, manager)

Three health promoters commented on the benefits of forming linkages with primary and tertiary health care services, particularly as a means of accessing data and identifying potential gaps in programmes. These linkages included PHO, Accident and Emergency services, Obstetrics, Injury Prevention and dentistry:

The team here like Injury Prevention we work very closely with the paediatrician here in the children’s ward, very close with the data that comes across on the hospital. To give us good evidence around whether we’re...improving child injury prevention. So our paediatrician is linked up and you know with our health promoter. (P7, manager)

One health promotion manager attributed the success of an evaluation they had conducted to the respectful relationship they had developed with the organisation whose programme they were evaluating. Relationship building had allowed the two organisations to make clear programme recommendations conjointly, while the presentation of findings, both verbally and written had made the community feel valued:

One of the good outcomes was really the relationship that developed over that time between our staff and the services that came up with quite clear recommendations and quite practical recommendations. (P16, manager)

Some of them said wow this just makes us feel good, you know people felt valued, it was a very professional result. (P16, manager)
One health promoter operating at a broad systems and policy level said the interview had triggered them to question their evaluation processes and the level of engagement they had with community. They wondered how in the future they might be able to be more inclusive of community in evaluation and consultative processes:

I think especially after talking to you like the things around like the process and you know and not just looking at like what you’re trying to achieve but like how did you achieve it like. You know, did everyone feel like you did it in a way that was you know like beneficial to them, you know, like it’s not just about the end goal. It’s about how you got there and I don’t know if we’re necessary, yeah, understand yet fully with like the way that we’re working how you measure that. (P14, senior)

Support for evaluation

Two health promoters suggested that more formal frameworks or “some kind of national evaluation programme” (P6, manager) were needed to guide evaluation processes:

We need better frameworks or ways of deciding what we do and don’t do. Like you don’t sort of finish something and go, or you don’t have checkpoints it would be like oh is this going to escalate to being an issue…things are sort of done based on sort of like perceptions and gut and how people think it goes. (P14, senior)

Health promoters reported receiving support for evaluation from various quarters including students on placement, contractors specialising in evaluation, Social and Health Outcomes Research and Evaluation (SHORE) Whariki, HPF and the HPA. SHORE Whariki was unanimously commended for its support and training in logic modelling and evaluation:

Yeah and the other bonus with it is they [SHORE Whariki] provide evaluation support for two to three years following your training that’s free. So I’ve sent them project plans and evaluation plans and evaluation reports. (P12, senior)

Health promoters identified various areas of support they considered would enable them to conduct evaluation more effectively, such as additional funding for professional development, greater access to external evaluation expertise, and overall recognition from management of the value of health promotion itself and the practicalities and challenges involved in conducting evaluation:

I think at an organisational level just getting more of that external evaluation factored into a lot of what we do would be really useful... and getting enough
time for people to even evaluate to see if it’s working or if it’s the best way to do things. Instead of bringing like one system in after another and changing focus so very often. (P5, senior)

I think some coaching around incorporating the evaluation into our work. I think, like I say we understand the value of it, that it is valuable but I don’t think we apply it as well as we could so if someone was walking alongside us and saying hey that there, you know, make sure you grab that or make sure you have something in place around that because that’s going to be really valuable later on...when you come to evaluate the outcomes or evaluate your work. (P3, manager)

A recognition that health promotion is not easy to evaluate, it does not mean it’s not working...and that to achieve long term change takes long term investment and resourcing otherwise we’re just going to be doing superficial things that won’t achieve anything. (P13, manager)

As was the case with needs analysis and planning, many health promoters felt well supported by their DHB public health analysts, researchers, and evaluators and were appreciative of the expertise they could offer in the areas of evidence gathering, advising on evaluation methods, research/ and drafting reports though again some units reported feeling less supported:

We also have analysts in a team that are really useful in terms of evidence gathering and advising on evaluation methods if we want something quite structured. (P13, manager)

With [name of evaluator] here you know a qualified evaluator it’s just lovely to have her involved here... and she’s valuable as research evaluator. (P7, manager).

For instance, two DHB analyst teams were undergoing restructure and did not have the capacity to support health promoters while other units reported that not having on site access to analysts or evaluators impacted on the level of support they received.

Challenges to evaluation

A key but perhaps not surprising finding given the constricted funding environment, was that all health promoters felt hampered in their ability to conduct evaluation. In terms of resource, evaluation usually equated to the time in-house personnel could give to the job on a small budget:

Evaluation...we try to do it on the cheap. (P17, senior)
We don’t have a formal budget for any evaluation that sits past the person who’s completing the work. So everything’s expected to have an evaluation component in it but in terms of budgeting for that I mean I guess you could say from the outset this project needs x amount for evaluation but the culture would be that that resource is a person. (P14, senior)

The cost effectiveness of doing evaluations all the time stops being valid for us. (P1, manager)

A number of health promoters reported that financial constraints meant they were seldom able to employ the expertise of an external evaluator, which again impacted on the level of evaluation they were able to achieve:

I mean mostly because it’s, you know, it’s really expensive and...I’d like to do more summative evaluation, more, you know full on evaluation...but it’s really expensive to get people to come in and get baselines and things along those lines and then you know, get to the end and do another lot. (P1, manager)

The vast majority of participants responded with a resounding “no” when asked “are you able to evaluate the impact of a programme on health issues that are complex in nature or entail long-term change?” Some health promoters attributed their inability to establish a causal link between the actions and outcomes of a programme with population level outcomes, to the multiple factors that influence health. A lack of funding, resources, capacity, time, access to local data and the short-term nature of programmes were also perceived as barriers to conducting outcome evaluation. In the absence of being able to evaluate the long-term impact of a programme or its contribution to the collective whole of efforts both regionally and nationally, some health promoters extrapolated the potential outcomes of a project through logic-modelling, best-case evidence and projects with a proven track record. For example, while a health promoter conceded they were unable to directly associate the success of a programme aimed at reducing the number of alcohol retailers in the area to a wider national goal of a reduction in alcohol related harm, they could draw on existing evidence to make inferences based on “logic and theory” (manager, P6):

“We are making progress? Is it reducing the number of smokers? Is it reducing the burden of disease? And how much do we need to invest in it versus just trying to sell the programme logic? That’s probably where we’ve settled. (P6, manager)

(Laughs) No, there is no real way that we could do that I think. Not with the resources we have. (P10, manager)
I think in terms of the complex causal change, I think it’s theoretical. You can say logically we’re doing this and logically it will have an impact. (P16, manager)

To be able to collect all the data and analyse it and to actually report it in a way that’s going to be valid would just be so expensive that I couldn’t justify it. I’m much better off just going actually evidence says this is going to work so we’re just going to trust it. (P1, manager)

Look it’s very, very difficult and we get asked that question all the time, do implementing these policies reduce the levels of smoking in the community? The very quick answer is that we don’t know and that is because there are so many other strategies going out there, that like we are part of a bigger picture, you can’t say you’ve implemented a policy, it’s had that effect but what we do know is that it increases the chance of people to quit smoking, to reduce the visibility to young people seeing smoking and increases the ability for people who have quit to remain quit with those visual cues being removed. (P2, senior)

One health promotion manager reflecting on their fifteen plus years in the profession was critical of what they perceived was a lack of advancement and commitment to outcome evaluation under the long-held belief it was too difficult to determine a causal relationship between programmes and outcomes:

You’ve got to commit to something for a little while... I was a health promoter too long ago now... and I remember then all of the kind of debates and the fear from health promotion as a sector about the difficulty of causational inference and the complexities of it and they’re always like oh it’s too hard, there’s too many compounds, it’ll take too long to demonstrate so we never started, we never really started evaluating some of the big concept stuff we’re talking about. (P6, manager)

Another health promoter raised concerns about their lack of ability to evaluate the collective whole of their coalition’s efforts because the group lacked expertise and the published evidence base was lacking. Funding was considered an additional obstacle to undertaking such a large scale and complex evaluation yet paradoxically the securement of future funding was dependent on such an evaluation occurring. The coalition in question had over 60 projects running concurrently between the multiple coalition partners illustrating the enormity of such an undertaking. On a similar vein, a health promotion manager struggled to reconcile how health promotion could prove itself when there was a tendency to “evaluate it piecemeal” (P9, senior), project by project, instead of evaluating the collective whole or a range of strategies:

I think we are. I think it needs more help because you know there’s very few people who understand systems thinking and how to evaluate it and also
collective impact but I think that, that’s probably the rising challenge for us is how do we get some good models out there of how we can understand our piece of the puzzle and where it fits more broadly into what other people are doing...We’re not quite sure that we’re going in the right direction. (P14, senior)

Discussion was generated around the potential for internal evaluation to become marred by subjectivity and bias when the health promoter evaluating the programme is also its primary author. Three health promoters viewed an external evaluator as someone who could offer objectivity and neutrality to the process:

*I guess external evaluation would be really good because internally like if you’re the one setting the questions and looking at the different things that are of interest to you, you may not be as open minded about what you are collecting. Or you may not be as objective because you are sort of immersed in the delivery, in the planning and everything else. But external evaluation comes with that independent eye from someone who’s probably an expert in the area or the field and who will be able to look at your programme more comprehensively and more objectively.* (P5, senior)

Lack of time was regarded an impediment to sound evaluation especially when trying to balance the need to evaluate alongside the other demands of the role. Some health promoters suggested the MoH’s six-month planning and reporting cycles, which often overlapped and according to one health promotion manager, occurred too frequently, compounded the issue:

*What people say is that by the time you’ve done the evaluation people also like over read it and then there’s all this time till the next cycle. Like you’re doing the next cycle as you’re evaluating the old one.* (P14, senior)

A small number of health promoters commented on the lack of access to, or gaps in local population indicators or baseline data on which to base evaluation. They also commented on the fact it was not always easy or possible to extrapolate local data from national data:

*Like I said it’s a bit of a missing, like we’ve put, we’ve got indicators where we can’t measure them because there’s just no data sets in [name of city] on them.* (P14, senior)

**Results Based Accountability**

The MoH describes Results Based Accountability (RBA) as a “simple, practical way for organisations to evaluate the results of their programmes” (Health, 2018b). At the time
of interviewing PHUs were in the throes of transitioning to RBA for their annual planning and reporting (Ministry of Health, 2016a).

Health promoters were at varying stages of implementing RBA into their planning and reported a mixed response to its usability. Responses ranged from very supportive to indifferent and apprehensive while, a few health promoters saw both positive and negative aspects to its usability:

_I like it._ (P15, manager)

_We’ve moved a little way forward but not perhaps as far as we would like._ (P10, manager)

_RBA is quite complex... and you do have to understand performance measures, you know? And you do actually have to have some good maths literacy, you’ve got to know the difference between numbers and percentages and things along those kind of lines._ (P1, manager)

_We do what we have to do. I don’t think we’ve got a hundred-percent handle on it just yet. I think it works really, really well for regulatory work, I think that makes perfect sense, I don’t always think it works as easily for health promotion work._ (P13, manager)

Some proponents of RBA liked it because it allowed them to set achievable and incremental, realistic targets, while others liked it for its succinct reporting functions and comprehensive approach. A couple of health promoters regarded RBA and its emphasis on performance measures as an antidote to their previous struggle to justify and evidence how the outcomes of individual programmes had contributed to long term outcomes and wider government-set population targets:

_I like it because you know it’s not about reaching that, that goal but actually turning the curve. So you know change, as long as we’re seeing change for the better. We get challenged on being able to evidence the effect of our interventions and you know, sometimes that change can be many years in the making but if you’re putting in place some small targets, you know that can track your progress towards the end outcomes._ (P4, senior)

_I think what it does is it completes the story very succinctly.... so all of our strategies or our programmes within our strategies are RBA based...it make you address all the things, everything, like your evidence base. It makes you simply ask the question, is anyone better off, why are doing it, why, what is the thing that you’re doing and who’s accountable, when is it going to happen? You know it’s got the whole story there._ (P17, senior)
A couple of health promoters reported feeling not adequately supported by the MoH in terms of implementing RBA into their practice, citing lack of communication and training gaps as key issues. Some desired greater transparency, consistency and clarification around RBA requirements. Others had felt well supported in their RBA training and acknowledged the MoH for making allowances for its adoption by granting a transition period prior to making it a mandatory reporting requirement:

_We did all our training with [name of external contractor] because [they were] deemed to be the shizz, like [they're] the expert in New Zealand and then when we get Ministry of Health people coming in, they have a different interpretation to it._ (P1, manager)

_We would still like further clarity from the Ministry of Health about what they see in regard to our reporting requirements in RBA. We work together across the [name of island] and we have a workforce development group and we asked on several occasions if we could do this and we have had one training, which was fairly helpful but it doesn’t really fully explain how we do it. That’s now being picked up by the clinical leaders’ group there about how we might be able to get further clarity around that because it does make it challenging._ (P10, manager)

A number of health promoters had resorted to seeking their own RBA training through organisations like MSD and Injury Prevention, or had contracted independent external facilitators:

_That was something we sourced independently because we knew about community development health promoters that had been involved in some of those MSD RBA workshops and I went to one and said that would be great. So we sourced that independently as did the other [name of] Island PHUs._ (P10, manager)

One health promoter questioned why the Ministry had not signalled the transition from a logic model to RBA by offering a training and support programme to the extent they had with SHORE Whariki when logic modelling was introduced into PHUs:

_The Ministry of Health used to fund SHORE Whariki to run Programme Logic for public health units and they would kind of do training in the individual regions in towns and cities but it’s on programme logic and since then, the Ministry of Health has shifted its focus to RBA and it hasn’t made that similar shift in the contract so yeah that would probably be my only suggestion._ (P15, Manager)

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10 Government funded contract supporting health promoters in programme logic
Several health promoters commenting on a system that favours the assignment of numbers and percentages as indicators of outcome and performance questioned the validity and relevance of some of this data to higher-level outcomes and long-term health gains:

*Perhaps to come back to the types of modelling in the RBA if we talk about numbers and percentages. And while they can be measured sometimes you wonder whether it’s the most valuable measure. You can measure the number of people who attended a workshop session or training and you can go from the evaluation and the percentage of them who say they have learned something that they will put into practice but then there’s the next step. Do we know that happened and what difference did it make... but it may not be very clear as to what difference it is making even in the shorter term. So that is challenging.*

(P10, manager)

*Health promotion, I think, is not always easy to measure and I don’t want us to get down to measuring widgets and numbers of meetings.* (P13, manager)

One health promotion manager spoke of their Medical Officer of Health’s unease about the introduction of RBA and its application to public health while another health promoter opined RBA was better suited to regulatory work. Others perceived there was a disconnect between the performance measures they were expected to report on and wider population measures or outcomes. Another health promotion manager expressed concern that RBA might lead health promoters to take a more prescriptive or pedestrian approach to tackling issues:

*How do you evaluate the collective whole, and not just discrete parts?* (P15, manager)

*Sometimes the stuff we’re trying to measure is so complex that actually you don’t have reliable measures and then you’re forced to put an outcome, you know a measure in there that’s kind of ludicrous and I guess the best example of that nationally is our, you know our obesity, childhood obesity measure I was like oh my God (laughs), how do we even know that a check by a GP or practice nurse is going to result in reduction in child weight.* (P1, manager)

*It forces measurement around things that may not be the actual outcomes. I understand the need for measurement and showing, I get that...I think it can sometimes stifle and I think it, I mean it takes me back to what used to happen a while ago, we went to ten meetings, we did this, we did that and it’s always this catalogue of activities in some ways and I think lifting the gaze is more productive.* (P13, manager)
Some health promoters did not perceive RBA an easy fit with their established systems, strategies or models with one health promotion manager describing RBA as an “awkward fit” or “more of a headache” (P6, manager):

*RBA’s all very outcome kind of based and it doesn’t necessarily allow you to kind of define what the influences were...you know how in your logic model, you’ve got, you know these are my early outcomes that I’m expecting, this is what I’m doing, you know these are all the things I’m doing, this is the short term, midterm, long term outcomes and this is what my goal is at the end of it, so when you’re doing your evaluation, what you’re looking for are those linkages.* (P6, manager)

A few health promoters expressed concern that neither the Ministry’s annual reporting regime nor the introduction of RBA encouraged anecdotal evidence, the “narrative” or community voice to be included11:

*I think that without case studies or being able to tell the narrative, most of the stuff that will capture hearts and minds is missing.* (P16, manager)

**Summary**

It became apparent relatively early in the interviewing process that health promoters did not demonstrate the same confidence in evaluation as planning. The general consensus amongst health promoters was that evaluation could be improved, with perceived barriers identified as: funding and resourcing constraints; lack of time and access to expertise, workforce capacity issues; and gaps in access to locally relevant indicator data. Several health promoters described evaluation as sometimes following informal or “ad-hoc” processes and under these terms, it was more likely to be considered a “review” or “feedback.” Health promoters reported that the complex nature of health issues combined with an organisational focus on short-termism and the aforementioned barriers all impacted on the type of evaluation they were able to conduct. Health promoters reported a mixed response to RBA; a number liked it for its succinct reporting functions and because it allowed them to set achievable targets and realistic goals. Some health promoters conveyed dissatisfaction at the level of support the Ministry had offered in the transition to RBA while a number grappled with the indicators used to measure performance, and how they might contribute to larger population outcomes.

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11 PHU specifications for health promoters (Tier 2) does in fact invite health promoters to include the narrative in their reporting
Māori perspectives

This section explores some of the complexities experienced by Māori health promoters and the direct and indirect implications for planning and evaluation. Three Māori health promoters were recruited; two health promotion managers and one senior health promoter.

Māori and non-Māori health promoters alluded to the additional responsibility or accountability that came with being a Māori health promoter within a government organisation, responsibilities that often lay beyond the bounds of their contractual obligations:

“We have an evaluator and a researcher and even though that person is not Māori we place a Māori health promoter next to her so then she’s supported...She knows she doesn’t come from a Māori worldview but that’s why we place a Māori health promoter beside her to keep her safe.” (P7, manager)

There appeared to be a tacit expectation that the role of the Māori health promoter extended to: developing relationships and networks with local iwi, hapū and other Māori organisations on behalf of the unit; moderating the acceptability and equity of programmes for Māori, as well as mentoring and arbitrating culturally competent and safe practice. A number of non-Māori health promoters affirmed their reliance on Māori health promoters and their networks to “ascertain whānau priorities” (P3, manager) and access Māori settings:

“Our staff, even though they have set positions...if they’re Māori work across all our programmes...so the consultation will go through them.” (P11, manager)

“We rely on our Māori health promoters a lot for working in that space and rightly or wrongly, I just can’t go out to certain communities and just work with them, you know...We rely on our Māori health workers and our Māori relationships manager a lot in that space.” (P2, senior)

“Having a culture and a way of working with Māori staff is a whole other challenge. There’s that double whammy of they’re expected to do their job but also to provide all this advice and to be the key link...I think that sometimes we, certainly Māori staff talk a lot about you know we’re expected to do this and how do we recognise as an organisation the cultural skills that they bring and often they’re not recognised.” (P16, manager)

“Because we have staff here with connections, it’s you know, there’s always that discussion.” (P17, senior)
The Māori health promoter who works where they ‘live and play’ or has whakapapa links to the local area might experience increased responsibility and accountability to whānau and community as well as to the organisation. Non-Māori and Māori health promoters both referred to these relationship pathways as important to their engagement with Māori when it came to planning and implementing programmes:

*We've got team members that whakapapa strongly to our local iwi and so having that connection is that, is that you know it enables us to then work with that iwi.* (P4, senior)

*I have a number of Maori health promoters, they have very really amazing networks within their own community, it’s about tapping into those networks I think and those cultural structures that exist.* (P13, manager)

Despite DHBs having a mandate to grow and develop the Māori health promotion workforce in accordance with He Korowai Oranga Māori, Māori health promoters in my study unanimously reported there was “room for improvement” (P4, senior) in organisational support for Māori workforce development:

*So we've had quite a focus on increasing the number of Māori staff on our health promotion team. That’s a focus for the DHB but I think it’s still, still way behind the mark in terms of you know the actual numbers of Māori staff in New Zealand and within the DHB here.* (P3, manager)

One Māori health promoter had been in negotiation at organisational and union level to attain pay parity with their non-Māori colleagues in recognition of the cultural expertise and skills they brought to the role as per their collective employment agreement. While lack of pay equity might have potentially undermined the meaning and value this Māori health promoter ascribed to their work, they still spoke of their work with a sense of passion and commitment.

Participants spoke from a Māori worldview with Māori aspirations and empowerment as their foci when asked about their aspirations for planning and evaluation. Priorities lay in growing and supporting a Māori health promotion workforce and the desire for greater flexibility in planning and evaluation which would allow them to use more kaupapa Māori approaches:

*That, that iwi Māori have their own home grown people that, that can deliver sound evaluating, sound, you know, research projects, that we empower them, we grow our own to deliver, to, you know, to be the very best they can.* (P7, manager)
Māori health promoters espoused the kaupapa Māori notion of āta or taking time to develop relationships, show respect and reciprocity. Here a non-Māori health promotion manager acknowledges the challenge for Māori working in a goal-oriented and resource-stretched environment:

*Some of the things that staff can talk about is how do you view that whakawhanaungatanga if you like around the relationship building and you know, you can have team leaders saying look you haven’t got time to go and have cups of tea everywhere so there’s kind of that judgement around yes we want an outcome from it, of course we do but we’re going to allow the time and the, you know it’s quite different isn’t it? You know what does something effective come out of, is it simply evidence based practice or is it through relationships and I think it would be pretty hard to um...to weight each of those against one another because if you’ve got no entry point and no credibility, no relationship, well you can have the best programme in the world but you might not, you just might not get anywhere with it.* (P16, manager)

*It’s a time factor, it’s a resource factor, it’s a you know, a priority factor...other planning demands or work demands, other factors get in the road.* (P3, manager)

*What we’ve learned is it’s relational...it is, it takes a long time.* (P13, manager)

*What I say is what’s good for Māori is good for all and you know the whanaungatanga, the getting to know one another, the kai, the hospitality, the face to face, the no rush, no agenda. I mean sometimes Ministry of Health and DHB do have an agenda and it’s like get this done by this date.* (P7, manager)

For Māori health promoters, working collaboratively with other Māori organisations and groups appeared to allow them the opportunity to work ‘outside’ the boundaries of PHU and DHB organisational structures, and plan in more kaupapa Māori ways:

*We were there wanting to make sure that the iwi had, it, you know they had hold of it and they were driving it and we were just there to help with their aspirations.* (P7, manager)

Māori health promoters valued the relationships and partnerships they had formed with hauora Māori organisations and other Māori development agencies, and iwi. These relationships were described in reciprocal terms; in return for their health promotion expertise and organisational capabilities Māori health promoters gained access to community and experienced greater autonomy to work in a Māori sphere with Māori aspirations and collectivism at the centre.
When asked about the planning of programmes and how to determine appropriate strategies to use in a programme both Māori health promotion managers identified planning should foremost focus on Māori needs and aspirations:

*My staff are always telling me you know, we know what works, it’s got to work for Māori. If it’s not working for Māori then don’t bother trying it so that’s a constant, constant consideration.*  (P3, manager)

A Māori health promotion manager expressed frustration that a smokefree programme continued to operate despite a lack of community supports for Māori or whānau ora connections. The manager levelled responsibility at the funding and planning team for not proposing equitable approaches in the first instance:

*There’s no whānau ora connection...no one’s spoken to the kohanga reo...just a whole lot of things that funding and planning needed to consider.*  (P7, manager)

*I don’t believe, I’ve already had a couple of rows with them [Funding and Planning] and I don’t argue. I don’t argue at all but man did I argue. I would argue the point to the hilt if I had to.*  (P7, manager)

Several Māori health promoters articulated a desire for the reorientation of health services and systems to better reflect the aspirations and needs of Māori. Suggestions included placing a cultural and equity lens over all hospital services, implementing a whole-of-organisation approach to cultural safety, and developing more community/iwi/marae based culturally appropriate services and initiatives:

*We need to be looking at taking health into the community and how do we do that?...If you have community that are advocating or saying look you know why don’t you bring your dental services to us in our community or why can’t we have a physio based here or why can’t we have a psychiatrist based here.*  (P4, senior)

One Māori health promotion manager credited their cultural identity as the driver or primary motivator for their work. This particular manager had actively instilled kaupapa Māori practice and te ao Māori values into the culture of their PHU in the form of te reo, waiata, powhiri and marae visits. There was the sense that Māori health promoters did not separate or differentiate their Māoritanga or the work they performed in their own community with that of the workplace:

*When we talk about kaupapa Māori I think when I came into this mahi I brought my Māoriness with me.*  (P7, manager)
I’ve had to rely on the strengths that I bring to the team and that is my ability and you know around Māori public health. That is my strength and I do portray that in my day-to-day work and I think people see that. (P4, senior)

That’s Māori Public Health at its best when we go and sit in there [marae]. (P7, manager)

The level of support Māori health promoters perceived they received at organisational level varied. One health promotion manager initially spoke highly of management and their support for kaupapa Māori initiatives but after further discussion revealed their frustration at well-intentioned programmes that fell short of meeting the needs of Māori:

And you know just, just what fight do you fight you know? So with my concerns with you know my managers here and my mental health has just absolutely been strained around some of that. (P7, manager)

Historically there have been times when the DHB has done the leading and yes they have led but the, the lack of engagement per se or the, not inappropriate but I just think that there have been some providers that have felt left out (P4, senior).

**Summary**

Interviews revealed the tacit expectation that Māori health promoters act as cultural competency advisors, facilitate connections and networks in the community, ascertain whānau and community aspirations, as well as assess the acceptability and reach of programmes for Māori, signalling the level of responsibility placed on Māori health promoters in PHUs. Māori health promoters espoused the kaupapa Māori notion of taking time to develop relationships, show respect and reciprocity, opining planning should focus foremost on Māori needs and aspirations for the good of all. Māori workforce development was viewed as a priority.

**The PHU setting**

The relative size of a PHU and its site situation, community health needs, geographic location, population coverage and connection with other PHUs were among factors health promoters perceived impacted on their ability to plan and evaluate programmes, acting as both barrier and facilitator to the development of effective programmes.

A number of health promoters stressed the uniqueness of their region culturally, geographically and demographically, subsequently raising the need to plan and adapt programmes to fit the special qualities and health needs of their local population:
I’d like the Ministry to allow us to have the regional variation…to not dictate too much how these things need to happen…to allow local variation…the best evidence is known but you can choose what fits you. (P13, manager)

You know we’re a very small team and you know, it’s a geographically diverse spread out kind of population so any of the interventions we put in place have to have some sustainability process put in place so that requires partnership. (P1, manager)

I mean for us here our primary focus is Māori and you know Māori population and so for me and the things I talk to my team about is, is you know a programme that reconnects Māori with their world to me is an effective health promotion programme and so that’s all components of their world, you know taha iwi. (P3, manager)

A number of health promoters commented on the added complexity of serving more than one DHB and/or iwi along with multiple territorial authorities and other social development organisations. The more entities involved the more health promoters have to accommodate different strategic positions, agendas and organisational structures, potentially placing additional stress on health promoters coordinating the functions of the group. One health promoter spoke of the challenge of communicating or disseminating information across the wider organisation:

I think that’s quite a dilemma…you’re working, I think it’s about [cites number] councils and [cites number] iwi and more, you know [cites number] major PHO networks…and you’re just kind of thinking well it’s a lot of different partners. (P16, manager)

Some regional PHUs felt ‘out on a limb’ both literally and figuratively because of their geographic location, distance from the country’s main centres and relative size to other PHUs. Here a health promotion manager articulates their frustration at the lack of engagement from the HPA, since resolved through a proactive appeal made by the manager:

We have a lot to do with the Health Promotion Agency but yep I had a little tanty and said you know seriously, you cannot just test us in Auckland and Wellington…you know this is not good enough, look I’m not saying it has to be us but you know, please do some regional testing or get some regional engagement around the things that you’re doing because otherwise we just don’t know whether they’re going to work in smaller communities. (P1, manager)

However, it was not only regional PHUs that commented on how distance could become a barrier to seeking external support. Here a manager of a PHU located in a main centre
explains how distance and location impacted on the support they received, largely attributable to logistics and cost:

*I haven’t used them [HPF] a lot for that (planning and evaluation), I think partly you, we would have to bring them down here really. I mean they do run courses but at the moment unless things are in [name of city], be pretty rare for us to send people. (P16, manager)*

Health promoters in several of the smaller regionally based units repeatedly referred to the impact, size and location had on their ability to plan and evaluate programmes effectively. Health promoters at one of these units talked about having to be “inventive” and resourceful in their planning which equated to borrowing practice models and programmes from other units which they would then adapt to fit their own region’s needs:

*I guess we don’t pilot interventions so much here because we’re only a small workforce, there’s a limited capacity to plan and implement and evaluate a pilot so we would often look to elsewhere in the country to see what’s working well and then look at how we can adapt that to [name of region]. (P15, manager)*

A health promoter who had initially worked for a large PHU and had since shifted to a smaller regional unit offered an interesting perspective on the differences they perceived existed between the two units and how these had impacted on their ability to plan and evaluate programmes. They were of the opinion that the larger PHU, by size and resources alone, showed a more informed approach to health promotion programme planning and evaluation. They discussed the divide between the two units in terms of resourcing and staffing capacity, operations and health promotion approaches:

*So two different public health units in the way they deliver their services and you probably can appreciate one, obviously one is a lot bigger…so for me it was a, a kind of like a oh OK things don’t kind of rock here like they used to in [name of PHU] so basically you just have to manage with what resources you have. (P4, senior)*

A health promotion manager of a smaller regional unit was acutely aware of the need to foster and sustain relationships with other organisations and stakeholders in order to gain better traction on programmes that with their limited staff capacity they were unlikely to realise on their own:
I think some of that’s capacity in terms of size. You know my team’s [cites number] people and that’s miniscule. You know (laughs), you know without working with others, we’re just not going to get anywhere so unfortunately we can’t really dictate terms. (P1, manager)

Can’t afford to work in isolation. (P4, senior)

There were perceived to be some positives to working in a smaller unit; in regional areas health promoters often live in the community in which they work or already have a presence in their community, enabling them greater community linkages and access to community voice to aid their planning and evaluation. In return, the community and other stakeholders might be more likely to show greater acceptability of a programme that is initiated by someone with a personal investment in their community:

It’s sort of like the stories first I would say. In a small community like we are it’s very tangible. It’s not like a big city. (P17, senior)

I think the beauty of our district is that we aren’t a large population so there are a lot of whānau links with health promotion with health promoters into the communities, you know with the sporting activities, with the social activities, with the working environment so yeah. (P15, manager)

And one regional unit acknowledged they felt well supported by their DHB in terms of being able to seek financial support for training opportunities outside the region:

We’re actually quite lucky in terms of our professional development budget in that you know, the DHB recognises we are a reasonable distance from peer support so yeah they are quite generous. (P15, manager)

Health promoters from some of the smaller regionally based PHUs lamented the fact distance combined with lack of workforce capacity prevented them from engaging with tertiary institutions, researchers, health practitioners and students who might have otherwise supported their practice:

I guess that’s the other thing about being regional...we don’t have an academic institution that has a population public health kind of focus you know whereas, and I always argue that when I’m talking about funding and to the Ministry...we don’t have any of those opportunities. (P1, manager)

Interestingly while one of the health promoters held the view that “all of us [regional units] are in that same kind of position whereas everybody else has got access to that kind of stuff” (P1, manager), this was not always the case. For instance one health promotion manager who was based in a large university city spoke of having limited
engagement with researchers, “no, not on a regular basis” (P10, manager), suggesting that neither distance nor size were the sole determinants of engagement. This said, several health promoters located in larger centres commented on the positive relationships they had developed with local universities, students and researchers. Engagement varied from those who had recruited students on placement, to assist with evaluations of projects to another who had actively sought the expertise of a population health researcher as a member of a large coalition tackling the region’s obesogenic environments:

Various people have got different relationships there, we take interns in here, we have public health registrars come through here, we also engage with the geography people, they’re really useful actually and where else have we engaged with, the social marketing areas of the University. (P13, manager)

It was not just the geographical location of a unit that had a bearing on health promoters’ ability to plan and evaluate programmes effectively but also the physical location of health promoters themselves within PHU premises. One health promotion manager discussed the positive impact co-location within their unit had had on their day-to-day operations. The unit had made “a deliberate shift to try and co-locate and get people to work together” (P11, manager) in a health hub in which the PHU sat beside Allied Health, various NGOs and a PHO among other public health providers. The manager who had facilitated the co-location model praised it for allowing greater cross-pollination and communication between and across different health services and permitting shared strategic planning. The co-location model also allowed the PHU to develop an ongoing relationship with a local PHO. This contrasts to a number of other health promoters who said no such relationship existed with their local PHO, which could be seen as a lost opportunity to integrate health services for improved and equitable access:

Have access to us. They come, and because we’re in the hub it’s much easier. It’s a big open building...so we have, yeah we do have a lot of contact with our NGOs. (P11, manager)

It’s trying to be all inclusive. Like it’s relevant to the planning side of your programme, absolutely it makes it so much easier. (P17, manager)

In another region, a health promoter discussed the experience of relocating from a satellite building to a central building and the impact it had on their relationships within
the PHU. This relocation had perhaps most importantly opened up a fruitful and productive relationship with the evaluation team among others:

Now we’re all in one building, it’s actually been really good because I’ve got really good relationships with the evaluation team, before which I never really had before so I rely on them a lot for my own evaluation. (P2, senior)

Conversely, here a health promoter laments the lack of access to data generated by partnering DHB analysts who are housed across several different sites. This of course had the potential to impact on both needs assessment and evaluation:

This is I suppose in some ways where we struggle a little bit. We’re, because we very rarely, we don’t actually have access to the, direct access to the DHB analysts and that type of thing. That’s because they are all separate. They are all in their [cites number] DHBs and they work for these three DHBs. So we have a very small unit here with a small number of staff. (P9, senior)

PHUs are encouraged to learn from successful initiatives in other DHB areas (New Zealand Ministry of Health, 2016) and with this in mind health promoters were asked about their relationship with other PHUs and the sharing or borrowing of ideas and programmes. Sharing often appeared to occur extemporaneously; at conferences or through word of mouth, or as the result of an internet search. While a number of health promoters spoke positively of programmes they had borrowed from other PHUs, and several described the good relationships they had developed with other PHUs, many also indicated a desire for greater sharing across units. Some spoke of the potential for sharing to occur amongst existing inter-regional networks\(^{12}\), however two health promoters commented on the fact that these networks often involved “conversations at management level” or “at a high level” or were more aimed at regulatory work rather than at programme planning level. Lack of time, financial constraints and the absence of a structured or regular forum for sharing were all perceived as barriers to networking:

I don't think we share between our DHBs as effectively as we could. (P3, manager)

It’s a very personal thing. There’s no structure to actually be able to do that with ease. It’s simply becoming aware of who are the people are working in other DHB’s that you can talk to. (P9, senior)

\(^{12}\) DHBs are organised into four regions; Northern, Midland, Central and South Island and each is required to present plans to show how they will operate regionally, in addition to their individual plans.
Occasionally if you very rarely get to go to a conference you might get to meet other people or you might or occasionally, you know, you will get things like central region networks or people working in smaller, smaller clusters. (P9, senior)

When we’re doing the, developing the tool...we had to kind of use the internet quite a bit and look up stuff on other DHB’s websites. But it was not information that we would have otherwise known when taking on this project. So it was like we’re really digging up for information and trying to make connections with DHBs that we thought could inform our programme. So there’s nothing proactive that’s been done to make sure that all that practice and all that information and knowledge is shared on a regular basis. You actually have to find it out when you want to use it or when you need it. (P5, senior)

Of those health promoters who had shared programme planning ideas it was usually with neighbouring PHU or with units regarded as progressive or possessing expertise in a particular area like tobacco control:

Progressive in this and they’re talking about needs assessments and I’m talking about, talking to other people, “I just had conversations with the health promotion manager person up there...because they’re quite progressive in tobacco free areas and he knows what he’s doing so I had a long chat with him the other week about how you did it, for example so, which is very helpful. (P2, senior).

Apart from [neighbouring city], we don’t tend to have a lot of conversations with a lot of other PHUs to be perfectly honest. (P17, senior)

Summary
The PHU setting was perceived to facilitate as well as act as a barrier to health promoters’ ability to plan and evaluate. For instance, some smaller regional PHUs felt ‘out on a limb’ in terms of staff capacity, access to resources, support and training opportunities. However, while these gaps may have been felt acutely in some of the smaller regional units, neither size nor location were found to be the sole determinants of engagement or support, with gaps in provision and capacity universally felt across units. Facilitators included a co-location model and onsite access to analysts and researchers.

Success and aspirations
Common responses to the question ‘what makes a health promotion programme successful?’ were having a clear purpose and the end goal in sight, relationship building, collaboration, and meeting community need. Other features of a successful programme were perceived to be the reduction of inequalities, doing no harm, getting buy in from
DHBs, ensuring a programme was sustainable, and working with health promoters who were adaptable and inventive:

_A health promoter who is gentle, warm, listens, special sort of mahi._ (P7, manager)

_The right people at the right time, good relationships across society and at all levels._ (P8, senior)

_Working with community, consulting with them right from the beginning._ (P5, senior)

Health promoters were asked to reflect on what they would like to see happen in planning and evaluation and were invited to respond on either a personal, organisational level or other. Their responses are captured below; some were suggestions made by individuals, others were reiterated by two or more participants:

- A desire for further training particularly in the area of evaluation
- Greater recognition of the role of health promotion in general and in a show of further support, increased financial investment in programme evaluation and expertise like in-house analysts and external evaluators
- Improved access to collective data to guide planning and provide data for evaluation purposes
- Find some resolution to bridging the gap between Ministry priorities and the needs and aspirations of community
- More national strategic direction in planning and evaluation
- Resolve the challenge of employing lots of part-time FTE while maintaining consistency and effectiveness across programme planning and implementation
- Retain Māori FTE
- More intersectoral planning
- Longer planning cycles to enable long-term planning in recognition of the time that is needed to embed change
- Resolve competitive contracting in the spirit of greater collaboration and more efficient use of resources
- Greater value placed on evaluation and reflection
• Increased financial support, resources and time to share, plan and evaluate across PHUs

• The use of more comprehensive, multi-strategy approaches

• Support from government for regional variation in planning and delivery of programmes

• The development of a national strategy on Smokefree 2025

• The development of an evaluation framework or more streamlined evaluation processes

• MoH to encourage more risk taking and innovation in programme design

Overall, interviews revealed health promoters sought more support, training, time, funding, resources and general recognition to assist them with their planning and evaluation.
Chapter Six: Discussion

Without exception, all 17 participants showed big heart and openness in sharing their experiences of planning and evaluation, equally all demonstrated commitment to the role.

In this section the results of interviews with health promoters are discussed in relation to the literature with a focus on four key areas: planning, evaluation, Māori perspectives and the PHU setting. Discussion in this section is weighted more towards evaluation than planning because this is where health promoters demonstrated less confidence and subsequently, more need. Following a critique of the study findings, the chapter reflects on the strengths and limitations of the study, makes recommendations for improvements to NZ health promotion programme planning and evaluation in PHUs, before concluding with a final summary. This section addresses objectives two and three of my study (Chapter 2, p. 10).

Planning

Health promoters in my study reported a variety of approaches to planning ranging from settings based, community development, systems based approaches, intersectoral action to issues-based portfolios. Health promoters cited examples of programmes leveraged at upstream action like policy and regulation work, as well as programmes targeted at lifestyle-related health risk factors and individual behaviour change. Some health promoters voiced concern about programmes that continued to place responsibility on the individual. Researchers have suggested that strategies aimed at individual behavior change should be part of a broader set of strategies to be effective (Jackson et al., 2006). While an upstream determinants approach to planning is generally considered the most likely to effect change (Baum & Fisher, 2014; Commission of Social Determinants of Health, 2008; Gore & Kothari, 2013; Green & Tones, 2010) comprehensive action and funding have failed to correspondingly meet the demands of addressing the social determinants of health (Smith, 2014). Research shows short-term funding and policies are not conducive to structural changes or behaviour change (VicHealth, 2015), congruently a number health promoters in my study found funding constraints, a lack of resources, short-term contracts and six monthly reporting cycles limited the scope of their planning and evaluation. The ‘Healthy Homes’ programme was the most concrete and often cited example of a programme that targeted the social
determinants of health. Beyond this initiative, several health promoters reported the challenges of working in this upstream sphere; citing organisational barriers and the intricacies involved in coordinating multiple intersectoral partners.

Several health promoters in my study raised the issue of reconciling planning with the realities of practice, often referred to as the “theory-practice gap” (Green & Tones, 2010, p. 504), specifically in relation to the reduction of health inequalities. For instance, one non-Māori health promoter grappled with their inability to reach and facilitate equitable outcomes for Māori despite consideration of equity issues during the planning process. Other health promoters similarly alluded to programmes that despite their planning did not align with proposed goals, the target population or outcomes, like the smoking intervention described as having “no whānau ora connection” (P7, manager) or the pharmacy-based smoking intervention aimed at pregnant women which proved to be the wrong setting to engage the target population. These gaps in delivery and outcome serve to accentuate the importance of undertaking critical reflection and thorough needs assessment, and illustrate the need for cultural responsiveness, participatory approaches and evaluation throughout the life-course of a programme. Perhaps more tellingly, these gaps reveal the complexities of health itself and reinforce the need for multi-strategy approaches at individual, community and policy level to tackle the wider determinants of health if real health gains are to be made (Baum, 2015; Green & Kreuter, 1999; World Health Organisation, 1986a, 2005).

Health promoters in my study alluded to the tensions that exist in trying to marry government targets and expectations with community need when conducting needs assessment. Other researchers have similarly spoken of the need to find “common ground” (Green & Kreuter, 1999, p. 58) between the perceived needs of community, their assessed needs, and government targets and priorities (Baum, 2015; Green & Kreuter, 1999). A community is more likely to become invested in a programme if they are included from the outset in identifying the issue and a solution and the resulting programme is reflective of their articulated needs (Green & Tones, 2010; Nutbeam & Bauman, 2006), and health promoters in my study certainly found this to be true. However, some health promoters in my study also noted they were sometimes one-step removed from community and were thus reliant on other organisations and agencies to assess the needs of community and clients. With this reliance on stakeholders comes the risk of ‘gate keeping,’ a programme becoming simply “community placed” rather
than “community based” (Minkler & Wallerstein, 2008, p. 3), needs becoming misrepresented or the needs of those on the margins not being registered. Further if partnering organisations do not have a clear understanding of health promotion concepts like equity, participation and empowerment, as health promoters in my study reported was sometimes the case, needs analysis and planning run the risk of becoming compromised if the fundamental principles of health promotion are not observed. Notwithstanding, community and agencies are often best placed to determine who is representative of a community and can impart invaluable local knowledge. Some health promoters in my study spoke enthusiastically about fruitful programme partnerships they had formed with other organisations and community groups. A number of health promoters were conscious of the need to find a balance in working with communities that might feel both weary and wary after repeatedly finding themselves the ‘subject’ of health promotion pilots or programmes.

The potential of intersectoral collaboration to influence change is well documented in the literature (Marmot et al., 2008) and certainly some health promoters in my study spoke positively about the opportunities collective action afforded in terms of sharing resources, skills and presenting a united front. Planning was viewed by some as central to the effective functioning and management of these partnerships. In the case of one coalition, the best part of a year was spent planning; to establish precise terms of reference, find common ground in setting goals and objectives, designing individual programmes and collectively devising a five-year plan. Another health promoter had conducted their entire annual programme planning in tandem with a local NGO over more than eight years. The literature identifies the factors perceived to contribute to the effectiveness of collaborations as sharing a common vision, good planning, strong leadership, access to resources, ability to compromise, trust, effective organisational support and capacity, communication, time, flexibility and clearly delineated roles and rules of operation (Florin, Mitchell, Stevenson, & Klein, 2000; Green & Tones, 2010; Joffres et al., 2004). Attentiveness to planning early on is more likely to lead to more informed decision making, consensus on goals and objectives, promote more sustainable relationships, and minimise the potential for irreconcilable differences in ideology or priorities to arise. In my study these multi-organisational relationships were described as not without their challenge; in accommodating different agendas and priorities, reaching consensus, trying to move beyond becoming just another “talkfest” (p. 12) and in finding the time, resources and means to coordinate planning and evaluation.
collectively. Researchers have previously recounted the various challenges and barriers to successful intersectoral partnerships (Green & Tones, 2010; Joffres et al., 2004). Florin et al. (2000) in a longitudinal study, found the strengths of coalition plans came from the number of hours worked by paid coordinators and attendance at meetings. Incidentally, health promoters in my study reported not having the comparable luxury of time or resourcing to plan as comprehensively as the former example. Interestingly the coordinator of this coalition, made up of some of the region's big social development influencers, conceded there were still limits to what they could achieve in terms of impacting change at a social, economic and political level. Other studies have similarly highlighted the challenge of working in complex, multi-relational, politically charged and sometimes oppositional environments like those of the tobacco, alcohol and food industries (Alvaro et al., 2011; Baum & Fisher, 2014; Jenkin, Signal, & Thomson, 2011; Signal & Ratima, 2015).

A whole-of-government approach that targets regulatory action, a social determinants approach and a universal commitment to intersectoral action are required to make the necessary improvements in health equity and health outcomes. To do so will involve tremendous political willpower, resources, innovation, and a vision for the long-term.

**Evaluation**

_Evaluation can be a bit of mystery sometimes for our staff (P3, manager)._  

Health promoters in my study appeared less confident discussing evaluation practice compared to planning; some openly disclosed their lack of confidence, while a small number demonstrated uncertainty when searching for the appropriate terminology or words to articulate their practice. Some health promoters described evaluation as occurring in a more informal, ‘organic,’ or ‘ad-hoc’ manner and under these terms it was considered more a ‘review’ or ‘feedback’ than evaluation. Respectively, the literature has described health promoters’ evaluation skills and practice as “variable” (Dunne et al., 2012, p. 109; Round, 2005, p. 1), “ad hoc” (Dunne et al., 2012, p. 109; South & Tilford, 2000, p. 733) and lacking in confidence (Green & Kreuter, 1999). Despite the absence of a question in the interview schedule specifically asking health promoters to identify challenges to either planning or evaluation, health promoters nonetheless signalled various barriers they perceived hampered their ability to conduct evaluation effectively, particularly higher-level outcomes. Interestingly, health promoters did not critique
planning in the same manner, perhaps emphasising the various challenges that continue to define evaluation as ubiquitously referenced in the literature (Brandstetter et al., 2012; Francis & Smith, 2015; Huckel et al., 2016; Jolley, 2014; Lobo et al., 2014; Napp et al., 2002; Smith, 2011; South & Tilford, 2000).

Health promoters in my study were cognisant of the value of evaluation, though a number acknowledged their evaluation practice could be improved, as could operational and organisational support for evaluation, sentiments shared by health promoters in other studies (Brug et al., 2011; Francis & Smith, 2015; Huckel et al., 2016; Jolley et al., 2007; Napp et al., 2002; O’Connor-Fleming et al., 2006; South & Tilford, 2000). The various impediments to evaluation cited by health promoters correlated closely with many of those identified in previous studies as they related to: lack of time, funding and resources; gaps in the data; unwieldy evaluation processes; short term planning and reporting cycles; a lack of training opportunities, research skills and staff capacity; unequal access to internal expertise and finally; professional and geographic isolation (Brug et al., 2011; Francis & Smith, 2015; Huckel et al., 2016; Jolley et al., 2007; Joss & Keleher, 2007; Lobo et al., 2014; Napp et al., 2002; South & Tilford, 2000).

Researchers maintain that support for evaluation needs to occur at an individual, organisational and policy level (Francis & Smith, 2015; Lobo et al., 2014; Smith, 2011). Huckel et al. (2016) contend that the level of value a government organisation places on evaluation can be regarded as crucial to evaluation practice and that a “culture of evaluation” (p.211) is one that integrates evaluation into all areas of decision-making, including programme design, implementation, and funding. Accounts by health promoters in my study of under-resourcing, time constraints, short planning and reporting cycles, as well as disparities in research and evaluation support, would suggest that an organisational “culture of evaluation” (Huckel et al., 2016, p. 211) was largely felt to be lacking in PHUs. Some health promoters conveyed the sense that planning was prioritised over evaluation, best illustrated by the health promotion manager who commented that evaluation tended to “slip off the radar” because “we’re very planning driven” (P3, manager) and the health promoter who said that health promoters per se were more programme or “doing focused” than evaluation oriented. Previously the literature has found that health promoters tend to regard planning and the implementation of programmes as their primary responsibility, particularly so when there is pressure from expectant funders to deliver concrete programmes (Brug et al.,
The perceived lack of support for evaluation articulated in my study was further reflected in the fact that a large number of health promoters typically equated evaluation with the time alone they could give to the task. Health promoters reported there was generally not a dedicated budget for evaluation and as was the case in a number of units, external evaluators were seldom employed because of budgetary constraints. Other studies have cited evaluations that are “constrained by the usual” 5-15%\textsuperscript{13} budget allocation (Brug et al., 2011; Swinburn et al., 2007, p. 306). The lack of dedicated funding indicated by health promoters might be construed as reinforcing the perception that evaluation is considered secondary to programme planning and delivery. Several health promoters indicated they were grateful for the occasions when they could share the cost of evaluation with other stakeholders. Researchers have previously claimed that staff commitment to evaluation, knowledge, training and skills alone are not sufficient if an organisation lacks the capacity to provide the resources or foster support for a research culture where evaluation is valued for its contribution to programme modification, policy development, health improvements and the upholding of health promotion principles like equity and participation (Joss & Keleher, 2007; Keleher et al., 2005; Lloyd et al., 2009; Lobo et al., 2014; Pettman et al., 2013).

Health outcomes and programmes themselves need to be measured according to equity, (Commission of Social Determinants of Health, 2008; Petticrew, Whitehead, Macintyre, Graham, & Egan, 2004; Potvin et al., 2007) or inequalities can remain unchecked and persist. Policy makers and researchers have called for improved evidence of the effects of programmes on health inequalities (Commission of Social Determinants of Health, 2008; Potvin et al., 2007) yet gaps in reporting and challenges to the evaluation of equity prevail (Davies & Sherriff, 2011; Jolley et al., 2007; Kelly, Morgan, Bonnefoy, Butt, & Bergman, 2007; Petticrew et al., 2004). Health promoters in my study cited a lack of resources, and expertise combined with financial constraints as key barriers to assessing whether a programme was accessible or equitable; impediments similar to those identified in other studies as impositions on evaluation in general (Brug et al., 2010; Francis & Smith, 2015; Jolley et al., 2007; Lobo et al., 2014). Some health promoters in my study reported using what might be described as arbitrary or ad-hoc

\textsuperscript{13} The percentage cited for the ‘% of total programme costs allocated for evaluation’ varied between studies but they all sat somewhere between 5-15%
means to determine whether a programme was inclusive or acceptable to the target population. For example, some non-Māori health promoters reported relying on Māori health promoters within the unit to informally determine whether a programme was acceptable to the target population, moreover others appeared to equate programmes that targeted the disadvantaged or marginalised as an indicator of a programme’s reach or a measure of equity itself, which while indicative does not take into consideration those who might not be captured by an intervention or unintended effects. Jolley et al. (2007) study found that health promotion principles like equity and participation were not specifically appraised in evaluations so equity was considered met if the programme was targeted at a marginalised group and participation was measured by attendance, forsaking the actual quality and representativeness of participation. Evaluation needs to be systematic and sensitive to those missing from a setting or initiative, identify unintended effects or harm, and assess whether resulting programme outcomes are equitable (Glasgow et al., 1999; Sanson-Fisher et al., 2014). Evaluation also provides a platform to assess whether programme modifications might improve discrepancies in health outcomes and participation (Green & Tones, 2010; Green & Kreuter, 1999; Lobo et al., 2014) and certainly, in my study health promoters gave examples of evaluation that had led to programme modification in order to extend the reach and acceptability of a programme.

Health promoters in PHUs are encouraged to use equity tools and are expected to demonstrate in their annual planning how they intend to improve outcomes for vulnerable communities as well as detail the measures they will use to assess a programme’s contribution to improving equity (Ministry of Health, 2016a, 2016b). While health promoters in my study reported using HEAT or another equity tool during the early stages of programme planning, there was less evidence that as a programme progressed its potential to contribute to the reduction of health inequalities was reviewed in the form of programme refinement or evaluation. This was perhaps reflected in programmes that were viewed as “not hitting the mark” (p. 7, manager) or the health promoters who used the interview question, ‘How do you evaluate if a programme is equitable or accessible?’ as a prompt to reflect on the fact they had not previously considered how their planning and evaluation might engage or not engage community or be inclusive. This raises the question, whether in addition to applying an equity tool early in the planning phase, where it appeared to have been considered most often in my study, it is advisable to reapply a tool during implementation and
retrospectively at the end of a programme to mitigate the potential for unintended effects or increased inequalities? It also highlights the important role needs assessment and participatory approaches play in the pursuit of equitable approaches and outcomes. While the authors of HEAT (Signal et al., 2008) designed it with flexibility of use intended; offering the option of a quick review of potential gaps and issues in a programme or alternatively, a more in depth response, it may be more advantageous to consider equity throughout the life course of a programme rather than a once-only approach at the beginning of the planning process. A report on the application of health equity tools in Australia, NZ, the UK and Canada (Public Health Ontario, 2014) found enablers to their use included support from policy makers, buy-in from management, the availability of support and technical expertise, as well as access to and the ability to analyse appropriate data and conduct literature reviews. It would be useful to examine the application of equity tools in NZ health promotion practice more closely to ascertain how and at what points these tools are being applied and to what purpose.

My study paralleled other studies (Chambers et al., 2015; Francis & Smith, 2015) in that surveys appeared to be one of the most popular methods of data collection for evaluation, followed by other self-reporting sources of information. Waa (1998; 2015) offers a balanced view of cross-sectional surveys as a viable, comparatively cost-efficient and practical alternative to experimental evaluation, while still retaining the ability to shed illuminating and informative data. Conversely, other researchers have raised questions about poor survey design, and the use and validity of self-reported sources of data as a means of measuring behaviour, social change, or attitude, particularly given the complexity of public health issues (Baum, 2015; Lobo et al., 2014). Baum (2015) for example, argues that self-reported data is best used to collect descriptive information, such as basic factual behavioural data and should be used with full disclosure of research processes including any discrepancies, or the data risks becoming weakened. Questions raised around the use of self-reported sources of data include knowing how to determine whether the group surveyed or interviewed is representative of the general population? What is the potential for bias of recall or social desirability? Is the survey creator trained in survey design? How do you determine who may have been excluded and the factors that excluded them? How do you explicate the values that underlie people’s answers (Baum, 2015; Kelly et al., 2006)? One health promotion manager in my study expressed concern about their staff’s over reliance on Survey Monkey and questioned the validity of the data because of what they described as poor survey
design, while another health promoter from the same unit reported that colleagues used Survey Monkey confidently but needed to look beyond that to “bigger picture evaluation” (P4). Lobo et al. (2014) assert that in some organisations there is a limited understanding of what constitutes an evaluation beyond a survey or the collection of operational data, furthermore the data collected is not always appropriate to the evaluation questions or simply not collected well. Chambers et al. (2015) review of evaluation reports revealed that almost half of respondents used only one form of data collection, and this was usually survey. Similarly, one third of health promoters in a study by Jolley et al. (2007) reported using one method only and this was usually a participant follow-up survey. Health promoters in my study reported using different methods to collect data and this is where a review of evaluation reports would have been a useful adjunct to my study; to determine more accurately the different types and most used data gathering methods, the mix of qualitative and quantitative sources and their applicability as measures of objectives and outcome. “Methodological pluralism” offers the best step forward for health promoters wishing to evaluate complex, multi-strategic initiatives (Baum, 2015, p. 155).

Several health promoters in my study emphasised the importance of interviews as a means of collecting data because they contain the stories of a community. Labonté (2011) shares a similar appreciation for the role of people’s stories in evaluation when he says, “stories become actionable knowledge when they are understandable, defensible, sincere and organised for a shared purpose” (p. 162), a view contrary to a bio-medical view of evidence. Some health promoters in my project held that the requirements of RBA with its emphasis on numbers and percentages to relay performance did not invite the story to be told. Arguably the format of the PHU annual planning template as it is framed by RBA does not invite the ‘story’ to be told though health promoters are advised in the health promotion service specification that “having RBA quantifiable measures does not preclude you from using narrative in your reporting” (Ministry of Health, 2016a, p. 13). Storytelling is central to many indigenous cultures, making qualitative research techniques all the more pertinent and relevant to cultural settings compared with the constraints of “rigid data collecting frameworks that may have limited ability to capture cultural or emotional paradigms that influence self care behaviours, or belief systems unique to non-Western societies” (Jamieson, Parker, & Richards, 2008, p. 53).
In the interview, participants were asked if it was possible to evaluate the impact of a programme on health issues complex in nature or entailing change over a long period. The vast majority of participants responded with a resounding “no” and some accordingly relayed the difficulty of trying to attribute a causal link between an intervention and population outcomes due to the many forces that act on health and the time lag. Beyond this, lack of funding, time, staff capacity and capability, access to local indicator data and short-term planning and reporting cycles were all cited as barriers to higher-level, long-term evaluation with the implication that ground level evaluation was more feasible. The challenge and feasibility of conducting complex evaluation is well documented in the literature, (Baum & Fisher, 2014; Brug et al., 2010; Jolley, 2014; Kelly et al., 2010; Nutbeam, 1998a; Pettman et al., 2012; Waa, 1998) alongside the knowledge that behavior change and time-specific health promotion programmes are simpler to evaluate than complex, long-term initiatives (Baum & Fisher, 2014). Further complexity occurs in trying to evaluate the collective whole of collaborations and multi-strategy initiatives, which is compounded by a lack of validated tools and methods (Stolp et al., 2017). A health promoter in my study commented on the challenge of evaluating the whole of their coalition’s collective actions because of the lack of tools and an evidence base for systems change evaluation, not to mention the challenge of coordinating and resourcing such a large undertaking.

The use of logic modeling to explicate potential outcomes, programmes based on those with a proven record of success, the collection of data at strategic points of a programme’s life, “methodological plurality” (Baum, 2015, p. 155), and a commitment to long term programme cycles together provide the necessary tools and means to evaluate complex, long-term initiatives. This broader approach to evaluation finds support from (Kelly et al., 2010) who claims, “Evidence alone is not a sufficient basis for making recommendations. Evidence does not speak for itself. It requires interpretation, and theory and modeling are part of that interpretation” (p. 1061).

Health promoters and researchers have previously proposed that a regulated or standardised approach to evaluation might alleviate practitioners’ insecurities and promote a culture of evaluation (Dunne et al., 2012; Huckel et al., 2016), a view mooted by two health promoters in my study. However, prescriptive approaches do not necessarily account for the complexity and diversity attached to individual programmes and the population they serve, making standardisation a complicated proposition. For
instance, in a review of 34 evaluation frameworks no single framework was found appropriate to evaluate whether interventions aimed at children and families reduced the health gradient (Davies & Sherriff, 2011). Nevertheless, minimum standards of practice and broad evaluation frameworks (Allegrante et al., 2009; Davies & Sherriff, 2014; Department of Health & Human Services, 2010; Health Promotion Forum of New Zealand, 2012) might at the very least contract some of the gaps in the current evidence base and improve evaluation practice. For example, the Aotearoa New Zealand Evaluation Association Superu and Aotearoa New Zealand Evaluation Association (2015) have developed a broad set of evaluator competencies to encourage practitioners to integrate context, cultural competence, Treaty obligations, appropriate methods, professionalism and meaningful engagement with stakeholders and community into their evaluation practice. The Health Promotion Competencies for Aotearoa New Zealand (2012) similarly offer a set of competencies that identify the knowledge and skills required to evaluate effectively. A number of health promoters spoke favourably of the introduction of RBA while others questioned its use and potential to contribute to population outcomes based on service delivery performance measures. Several health promoters in my study grappled with a system that favoured the assignment of numbers and percentages as indicators of performance and questioned the validity and relevance of some of this indicator data to long-term health gains and larger population outcomes. Berry cautions, “Political bureaucracies and patronage systems, as well as other ostensibly benign trends, such as results-based management, can all undermine genuine attempts to create sustainable changes in vulnerable communities.” (Berry et al., 2014, p. 42).

The degree to which community and stakeholders were involved in evaluation appeared to vary from unit to unit, and project-to-project. Partnering organisations were sometimes thought to not possess the necessary evaluation skills nor understand the value of evaluation or health promotion concepts like equity that would enable them to confidently build evaluation into their service delivery, which resulted in health promoters having to often take the lead. One health promoter spoke of the risk of becoming complacent about evaluation when there was no drive from partnering organisations to conduct evaluation. Health promoters in Brug et al. (2011) study found that the gaps in capacity of partnering organisations could be a challenge to evaluation. A health promotion manager in my study was critical of the way in which results of evaluation had been communicated back to the community, while another health
promoter whose project failed to appeal to its target community regretted not seeking community consultation from the outset to gauge their priorities. Others commented on the value of disclosure, consultation and involvement with community in familial settings. Waa (1998) endorses an approach to evaluation that empowers the underserved, respects their differences in perspectives and experiences and involves consultation from the group being evaluated. He extends this approach to the engagement of Māori stakeholders throughout the evaluation process insofar as observing cultural competency, creating trusting relationships, understanding Māori beliefs and perspectives and ensuring evaluation is relevant to Māori needs (Waa, 2015). In my study, a Māori health promoter working in collaboration with a Māori NGO was mindful of the need to consider health literacy and alternative methods of data collection as part of a culturally responsive evaluation in which community participation and ownership were considered paramount.

**Māori perspectives**

Throughout the course of interviewing, both Māori and non-Māori health promoters alluded to the heightened sense of responsibility placed on Māori health promoters to mentor and arbitrate culturally safe practices and assess the acceptability and reach of programmes for Māori, on behalf of the unit. This was in addition to fulfilling their day-to-day contractual obligations. There was also a tacit expectation that Māori health promoters, particularly those who had whakapapa or mana whenua connections to the local area would foster iwi and Māori relationships and ascertain community priorities, on behalf of the unit, thus potentially magnifying the level of responsibility they might feel to both community and unit. In a qualitative study of the Māori public health workforce “dual accountability” to organisation and community was found to impact on the retention of Māori staff in mainstream public health (Tunks, 2004).

Māori researchers refer to Māori health workers and researchers as possessing two “bodies of knowledge” (Durie, 2004, p. 1141) or the ability to understand and work with both te ao Māori (the Māori world) and tikanga values and Western perspectives (Tipene, 2017). In a study of Māori public health workers, participants described their

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14 Tikanga: “the set of beliefs associated with practices and procedures to be followed in conducting the affairs of a group or an individual. These procedures are established by precedents through time, are held to be ritually correct, are validated by usually more than one generation and are always subject to what a group or an individual is able to do” (Mead, 2003, p. 12)
role as weaving whānau ora approaches throughout their work, to build iwi, hapu and whānau relations, and provide cultural support and mentoring to colleagues, much like participants in my study viewed their role (Moeke-Maxwell, 2007). The acquisition of cultural skills hinges on the “lived experience of what it is to be Māori” and is not something that can be learned through education or training programmes alone, (Signal & Ratima, 2015, p. 51) signalling the level of responsibility and accountability that ultimately rests with Māori health promoters working in PHUs to ensure the needs of Māori are observed throughout the course of planning, implementation and evaluation.

Māori health promoters in my study expressed a desire for DHBs to value, grow and develop the Māori health promotion workforce. This was illustrated by the health promoter who was in the midst of undergoing mediation for remuneration in a bid to have their tikanga Māori expertise recognised, under their collective employment contract. The Public Health Advisory Committee (2006) calls for recognition of tikanga Māori as a key competency while respondents in Moeke-Maxwell (2007) study highlight the importance of pay parity and remuneration to support staff capability. DHBs have a mandate to develop the Māori health workforce in accordance with He Korowai Oranga and Te Uru Kahikatea (Ministry of Health, 2007a; New Zealand Ministry of Health, 2014) and public health infrastructure funding is available for workforce development pathways, like the government-led Māori leadership programme which was spoken highly of by a Māori health promotion manager in my study though they also noted, “I think it’s [Māori workforce development] still way behind the mark in terms of you know the actual numbers of Māori staff in New Zealand and within the DHB here” (p. 3, manager). Revealingly, a survey of Māori working in public health reported those in PHUs were “significantly more likely than the total Maori workforce to be somewhat dissatisfied with their current health roles” (Phoenix Research, 2004). It may be this survey is outdated, however in light of this finding and the comments made by Māori health promoters in my study, it would seem timely to revisit in greater depth the experience of Māori health promoters working in PHUs; to establish their current levels of satisfaction and support, investigate the mechanisms for awarding remuneration and promotions, and explore the potential for Māori staff to use whānau ora approaches in their work. The MoH service specification for health promotion states that “for health promotion to be effective in improving Māori health it is essential that Māori critically assess and contribute to planning, delivery, and evaluation of initiatives and are included in provider organisation governance and strategic planning” (Ministry of
Such a weighted responsibility calls for greater government commitment to Māori workforce development and formal recognition of the critical role Māori health promoters play in working towards improved outcomes for Māori in a PHU setting.

Māori health promoters in my project opined programme planning should focus foremost on Māori needs and aspirations based on the principles of equity, cultural integrity and “what’s good for Māori is good for all” (P7, manager). Māori health promoters also valued the notion of whanaungatanga and manaakitanga in their work, which meant taking the time to develop and nurture relationships, show respect, generosity and reciprocity (Mead, 2003). Māori health promoters were cognisant of the “time, energy and understanding” (Durie, 2012, p. 27) required to design and implement programmes that were reflective of Māori needs and tikanga; conditions contradictory to the realities of the short-term planning cycles, and “value-for-money,” “performance-based” programmes set by the MoH (Ministry of Health, 2016a). Durie states, “The question of time is hugely important because a Māori approach is that you allocate time for what needs to be done, rather than being preoccupied about being on time” (Durie, 2012, p. 26). Signal and Ratima (2015) suggest that where an organisation’s structures are incompatible with Māori needs, a shift in culture and processes is necessary to make these more inclusive of Māori. The authors use as an example of this shift, the development of policies to clearly define how programmes should be planned and developed in accordance with the Treaty. The service specification for health promoters working in PHUs (Ministry of Health, 2016b) outlines support for the use of “kaupapa” Māori approaches, and acknowledges the essentiality of Māori in contributing to the planning, delivery and evaluation of programmes (links with pathway 2 in Korowai Oranga). Yet, the reality of practice described by Māori health promoters in my study would suggest that organisational and contractual obligations prevented them from integrating tikanga Māori or whānau ora fully into their work. Respondents in Moewaka-Barnes’ (2007) qualitative study similarly viewed contractual obligations, financial and resource constraints and a general lack of support for incorporating whānau ora into practice as barriers to its integration.

In light of Māori continuing to experience greater inequities in health than non-Māori (Blakely et al., 2006; Blakely & New Zealand Ministry of Health, 2007) it could be argued that unless planning encompasses a culturally competent model with Māori needs and
aspirations at the forefront, programmes may by default exacerbate inequalities, rather than reduce them (Signal & Ratima, 2015). Equity, framed by the Treaty of Waitangi, should therefore lie at the heart of any planning for improved outcomes for Māori. Signal and Ratima (2015) posit the “relevance is about ensuring that Māori health promotion interventions are aligned to Māori realities so that they are accessible and meet the needs of Māori communities” (p. 50). However, a number of non-Māori health promoters in my study reported a lack of engagement with iwi, hapū and whānau, and both non-Māori and Māori health promoters spoke of well-intentioned programmes that did not meet Māori aspirations and improved health outcomes for Māori. Two Māori health promoters spoke of juxtaposing values between Māori perspectives and DHB or clinical values, which was perceived to impact on their ability to plan and implement programmes. Researchers have previously identified the underlying tension of working in a government department, and the dual responsibility of serving both government and Māori, and navigating between Māori and Pākehā perspectives (Tipene, 2017; Tunks, 2004), potentially signalling the challenge for Māori health promoters working in a PHU setting.

Māori health promoters in my study inherently valued the networks and positive relationships they had established with Māori NGOs, whānau ora collectives and other iwi organisations and stakeholders. They spoke enthusiastically and appreciatively of these working partnerships, conveying the sense that these relationships not only allowed them access to Māori at ‘marae level’ but also the ability to work with greater collective autonomy and cultural integrity. One health promotion manager had initiated their own cross-regional network of Māori health promoters, to share and soundboard workforce issues and ideas around planning and reporting after finding regional meetings largely lacking Māori perspectives and a health promotion focus. Surveys of the Māori public health workforce have previously identified networking with other Māori as important to professional development and the retention of the Māori health workforce (Ratima, Ministry of, T., & Health Research Council of New, 2007)

While Māori health promoters in my study spoke of organisational challenges and tensions they embraced programmes noted for their collective approaches; such as the iwi-based needs assessment which identified community research champions, placed the PHU in a supportive role, and had Māori aspirations and needs at its core. This initiative was attentive to Māori aspirations, cognisant of the value and time needed to
build meaningful relationships, placed health promoters in a supportive role alongside Māori and demonstrated a desire to empower whānau to take ownership of their own health.

**PHU setting - facilitators and barriers to planning and evaluation**

This section discusses some of the organisational, social and physical factors that health promoters perceived impeded and facilitated their ability to plan and evaluate effectively as these related to resourcing, ideological values, funding, access to expertise and training, and the geographical location of PHUs. It also examines the extent to which sharing occurred across PHUs, as a means of informing planning and evaluation. As I have already established, health promoters in my study echoed previous research in expressing a desire for greater support in the form of training and workforce development, funding, time, access to data, expertise and recognition in general (Francis & Smith, 2015; Keleher et al., 2005; McQueen, 2007; Pettman et al., 2012; Reupert et al., 2012). This section sits alongside Hawe, Noort, King, and Jordens’ (1997) conception of health promotion capacity building as the development of individual skills, organisational structures and resources in the pursuit of improved health outcomes. This view of capacity building (International Union for Health Promotion and Education (IUHPE), 2000) finds wide support in the literature (7th Global Conference on Health Promotion, 2009; Heward, Hutchins, & Keleher, 2007; New South Wales Health Department, 2001).

Health promoters in my study suggested that geographical location, corresponding population coverage, and the relative size of a unit could all influence the level of internal and external support they received to assist with planning and evaluation. Health promoters in Australia who are geographically isolated or work in small teams have reported finding it difficult to access the necessary skills, training and resources to effectively conduct evaluation (O’Connor-Fleming et al., 2006; Swerissen & Tilgner, 2000). In my study health promoters at two regionally based PHUs perceived the support they received was unequal to their larger city counterparts, and correspondingly cited reduced staffing capacity, access to fewer training opportunities, less prospects to access expertise and develop meaningful networks with researchers and specialists, both internally and externally. One health promoter drew these comparisons from their experience of working in both a larger unit as well as a smaller regional unit. While this may have been the case, a health promoter located in a large
city spoke of their lack of connection with the local university in terms of support for research, planning and evaluation and another health promoter situated in a large centre reported being without the expertise of an in house evaluator or analyst because of DHB restructuring issues and financial austerity measures. These and other examples suggest that the location and relative size of a unit alone were not predictors of the level of support health promoters received in planning and evaluation. In reality, while gaps in accessing resources and expertise may have been felt more acutely in some of the smaller, regionally based units, the perceived lack of support, funding and resourcing was universally felt and appeared to extend across the country’s PHUs, invariably impacting on health promoters ability to plan and evaluate and source support. Despite these perceived barriers, smaller regional units also conceived positive facets to their size and location, particularly when it came to forming relationships with community and stakeholders.

PHUs are encouraged to learn from successful initiatives in other DHB areas and share ideas and evidence to consolidate efforts (New Zealand Ministry of Health, 2016). The WorkWell programme is an example of such an initiative, cited by health promoters in my study. Beyond this example, some health promoters demonstrated resourcefulness and initiative in ‘borrowing’ programmes and ideas from other PHUs, and others reported positive relationships with neighbouring and other PHUs. However, a number of health promoters also reported there were few formal opportunities for sharing programme planning and evaluation across units and indicated a desire to work more closely with other PHUs to share ideas and resources, rather than the ‘ad-hoc’ practice of sharing that a number of participants reported occurred presently. Conferences provided a forum for sharing but this appeared to occur more on an incidental basis through networks and connections rather than an organised programme of events. Participants in Francis and Smith’s (2015) qualitative study similarly proposed greater inter-organisational and cross-regional collaboration between practitioners to increase access to a wider range of evaluation skills and resources.

The development of a competent workforce has been identified as an essential component of capacity building for the future of health promotion (Barry et al., 2012).

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15 WorkWell has been developed by Toi Te Ora – Public Health Service (Toi Te Ora) who have been recognised by the Ministry of Health as leaders in workplace wellbeing. Toi Te Ora offers training and ongoing mentoring to other public health units to enable them to deliver WorkWell in their region.
Health promoters in my study reported receiving varying levels of internal and external support for planning and evaluation from researchers, specialists, analysts and national health promotion organisations. Health promoters were appreciative of the opportunities to access internal and external expertise and training and many spoke positively of the support they had received from DHB analysts, external evaluators, specialists, university researchers and national health promotion organisations like HPA and HPF. SHORE Whariki, for instance, was unanimously commended for its support and training of health promoters in evaluation using a logic model. However, access to some of this support was clearly felt to be unequal and in the case of some national health promotion organisations and agencies, was not always viewed as accessible, or in touch with the professional development needs of health promoters. The development of collaborations between researchers, agencies, evaluation specialists and health promoters has been mooted as beneficial to health promoters wishing to develop skills in planning and evaluation, draw on expertise, build confidence and access academic literature to guide practice (Brug et al., 2011; Francis & Smith, 2015; Jackson, 2003; Lobo et al., 2014; Napp et al., 2002; South & Tilford, 2000). In addition these relationships have also been viewed as central to the development and transference of research into practice, and the management and wide dissemination of quality evaluations (South & Tilford, 2000). Tertiary institutions in NZ offer qualifications in public health while experiential training has traditionally been viewed as the domain of the workplace (Public Health Advisory Committee, 2006) though some institutions do offer a practical component to courses. Increased collaborative approaches between the tertiary and public health sectors might better meet workforce development needs for those entering the profession (Public Health Advisory Committee, 2006). The Collaboration for Evidence, Research, and Impact in Public Health, Australia provides a model example of a tertiary-based, multi-disciplinary capacity building initiative between practitioners and researchers (Curtin University, 2016). Another practitioner-researcher partnership can be found in the strategic relationship between the Cancer Society and the University of Otago’s Cancer Society Social and Behavioural Research Unit.

Not long into the interviewing process it became evident that health promoters were required to draw on a broad set of skills in the role of planner, analyst, data collector, budgeter, coordinator, networker, evaluator and researcher (Health Promotion Forum of New Zealand, 2012; Ministry of Health, 2016b). Researchers and policy makers
expand on this list of expectations and skills to include; work “in a socially just way,” “develop and apply good communication, facilitation and project management skills” (Waa in Signal & Ratima, 2015, p. 117), show knowledge of mixed-methods research, operationalise the principles of health promotion and demonstrate the skills necessary to develop effective intersectoral partnerships (Waa in Ministry of Health, 2016a, 2016b; Signal & Ratima, 2015). Smith (2014) recognises that health promoters may lack confidence in some of these areas given the breadth of the job description and subsequently recommends that health promoters be supported in these roles. As health promoters increasingly shift towards more complex ways of operating at intersectoral and policy level, it might be timely to investigate alternative models of working that allow for the clustering of expertise and skills, and innovative ways of sharing resources beyond the confines of individual units. Care is needed to ensure that such a shift is not primarily motivated by budgetary constraints.

While the results of my study are not generalisable in a quantitative sense, the age demographics of participants raises concerns about a potentially aging workforce\(^\text{16}\) and the attendant issues of employment sustainability, institutional knowledge loss and the significant costs and time involved in training new staff (Lovell et al., 2015). Lovell et al. (2015) in a nationwide survey of health promoters identified a possible crisis in the retention of health promoters, this despite a government commitment to training and other workforce initiatives. The findings of a cross-sectional study (Morgaine and Egan, ‘New Zealand health promoters: a national cross-sectional survey’) soon to be published will shed further light on the current state of the health promotion workforce. This potential crisis also represents an opportunity for the profession to explore innovative ways of attracting and retaining their workforce. Beyond providing appropriate remuneration, training and increased funding one possible solution might be to employ individuals to work in specialist areas according to experience and expertise, instead of working in a more ‘generic’ role. Thus someone with project management and highly-tuned organisational and management level skills might specialise in the area of intersectoral action and policy, while someone with skills in community development might accordingly work solely in this area. Such an approach could be viewed as a further step towards the ‘professionalisation’ of health promotion.

\(^{16}\) Just over 70% of participants were in the 50+ years age group
Finally, a number of health promoters in my study suggested that their on-site proximity to the rest of the PHU team, and the wider DHB team of researchers, evaluators and analysts not only facilitated greater collaboration in planning and evaluation but also strengthened relationships and communication. For example, the co-location model recently introduced in one unit was reported to have given the PHU wider access to other primary health services and NGOs, in addition to strengthening internal relationships. Of particular note was the close linkage the PHU had formed with their local PHO as a result of the co-location arrangement; a relationship several other health promoters reported was regrettably lacking in their units. The ease of accessibility to on-site internal expertise, particularly analysts and evaluators, experienced by some health promoters compared to others was also perceived to facilitate support for planning and evaluation. These two areas are worthy of further exploration in terms of their potential for improved planning and evaluation and in the case of the co-location model, the formation of stronger linkages with other health services within the sector.

Partnerships, workforce development, a supportive organisational culture and the provision of resources have all been identified as key areas for capacity building (New South Wales Health Department, 2001), areas finding corroboration in my study as impacting on health promoters’ ability to plan and evaluate.

**Strengths and limitations**

A key strength of the project was the willingness shown by participants; their enthusiasm and candidness as well as the time they generously gave to the interview. The sample of PHUs was representative of provincial and urban, small and large sized workforces, and showed diversity in population coverage and geographic spread, spanning the length and width of the country. Of the 18 potential candidates I initiated contact with, only two declined; one on the basis of work commitments, and the other responded to my first email seeking more information about the study and interview process but did not respond to my follow up email and phone message. Another strength was the inclusion of three Māori health promoters, who carried mātauranga Māori (Māori knowledge) and perspectives of planning and evaluation. Overall, the study could have been strengthened if in addition to the interviews, participants had been asked to supply planning and evaluation reports for auditing, as was done in two earlier Australian studies investigating evaluation (Francis & Smith, 2015; Jolley et al., 2007). An audit might have affirmed and/or revealed discrepancies in the interview
findings and provided useful descriptive information such as: what types of planning and evaluation were used most often, the level of rigour and scope shown in planning and evaluation, the application of equity tools and finally, strengths and gaps in reporting and research. Similarly, eliciting the perspective of key collaborators and stakeholders might have strengthened the study. Unfortunately, the scale and scope of the project did not allow for either of these adjuncts to happen.

One of the primary limitations of the study was that interviews tended to be weighted more towards planning than evaluation even though the interview schedule showed a fairly even balance of question across the two domains. While this imbalance likely reflects health promoters’ lack of confidence in evaluation compared to planning, it may also be that because the evaluation questions came at the back-end of the interview and I was conscious of not wanting to take up too much of health promoters’ time, that clarification was not sought to the same degree as it was for planning. In addition, participants’ responses may have been influenced by social desirability bias, in that they may have wanted to appear progressive or aspirational in their planning or evaluation practice in front of the interviewer. Equally, health promoters’ answers may have been influenced by the need to appear supportive of MoH policies and directives for fear of repercussions from their employer. A further limitation arises around the selection of senior health promoters, who were nominated by health promotion managers as per my request. It is not known how the views of selected participants may have differed from the views of those participants who were not selected. While the study findings may not be generalisable to all health promotion settings given that infrastructure, expectations and values are likely to be different, the diversity of the sample and strong themes across these mean there are likely to be relevant aspects for many. Finally, as is the case with all qualitative research, the beliefs and values of the researcher will inevitably influence the shape of a project, from its conceptualisation right through to data analysis (Kuper, Lingard, et al., 2008). Mindful of this I have attempted to be transparent and thorough throughout, adhering to trustworthy research processes.
Chapter Seven: Recommendations and issues warranting closer investigation

This study presents a snapshot of NZ health promoters’ experiences and views of planning and evaluation. To follow is a set of recommendations for the development of planning and evaluation practice in NZ PHUs\(^\text{17}\) based on the literature review and findings.

Support and training

• Health promoters were unanimously grateful to DHB analysts and evaluators for the research skills and expertise they brought to planning and evaluation. However, access to this expertise was reported to be unequal across units, placing additional demands on some health promoters. It is recommended that the issue of access to internal DHB expertise and research support is further investigated, to ensure internal services and resource allocation are equitably accessible across the country’s PHU.

• Suggestions for further training and professional development in planning and evaluation, as identified by health promoters and based on my observations include: equity approaches and the use of equity tools, research and data collection methods for needs analysis and evaluation, RBA, analytical skills, establishing measurable indicators, cultural competency approaches, intersectoral action, social determinants of health approaches (Commission of Social Determinants of Health, 2008), participatory approaches and the use of multileveled strategies.

• Some health promoters spoke highly of the support they had received from national agencies like HPF and HPA while others reported little engagement. It is recommended these organisations consider how they could improve engagement or better serve health promoters, particularly those based in more remote regions. There is potential for HPF and HPA to play an instrumental role in the ‘professionalisation’ of health promotion in NZ, an area that has already seen some momentum in the form of training, support and resources.

\(^{17}\) Some of these recommendations may be applicable to other health promotion organisations
• Some health promoters indicated they would have appreciated more support, and health promotion-specific training and direction from the MoH when it came to implementing RBA. Any future shifts in strategic direction or changes to MoH reporting requirements should include appropriate support and on-the-ground training for health promoters.

• Health promoters commended the government funded SHORE Whariki evaluation programme for its accessibility, no cost support, practical applicability, and ongoing evaluation support. Developers of any future government-initiated training programmes should be mindful of this exemplar of ‘good practice,’ and invest in programmes that are similarly accessible, well organised and well resourced, offering consistency across the country.

• Investigate the viability of creating a central platform or forum for the publication and dissemination of planning and evaluation exemplars. Provision would need to be made to allow health promoters the necessary time, support and access to specialist research assistance to prepare and write up reports for dissemination.

**Relationships**

• Health promoters expressed a desire for greater sharing of planning and evaluation across PHUs. Accordingly, forums for sharing could be investigated, including opportunities to present or workshop best practice examples of planning and evaluation. Such a move would require adequate funding and resourcing, with particular consideration of how regional units are included.

• The literature affirms that relationships with researchers and specialists can be beneficial to the development of evaluation skills and some health promoters in my study spoke positively of the support they had received from researchers, and external specialists. Linkages with researchers could be strengthened and developed to support research in practice, with thought to how smaller regional units might also be included or supported. Thought might also be given to how tertiary providers can better integrate planning and evaluation into their teaching, to extend learning beyond the theoretical to the experiential and expand the skill base of future health promoters. This might involve hands-on
practicums or placements in health promotion organisations. It is acknowledged that some tertiary-based health promotion courses do already offer some practical components.

- Explore the potential and practicalities of introducing core competencies as baseline or graduating standards for health promoters as a means of ‘professionalising’ the profession. Look to international models and examples where standardisation and accreditation have been developed for practice settings.

**Support for Māori**

- Create opportunities, resources and time for Māori health promoters to develop networks with other Māori health promoters regionally and nationally. Extend this networking to include Māori NGO, iwi, Whānau Ora collectives and other Māori organisations.

- It is timely to revisit in greater depth the experience of Māori health promoters working in PHU to establish their current levels of satisfaction and support, as well as investigate the mechanisms for awarding remuneration and promotions, and explore the potential for Māori staff to use whānau ora approaches in their work.

- Māori and non-Māori health promoters in my study acknowledged the important role Māori health promoters play in making community connections, instilling tikanga values and cultural competency in the unit. These additional responsibilities might be more formally recognised by way of; the creation of specialist roles to accommodate the breadth of skills Māori health promoters bring to the role, greater autonomy to work in kaupapa Māori ways and finally, appropriate remuneration to support Māori workforce capacity and leadership opportunities.

**Structural**

- Increasingly health promoters are expected to work intersectorally to address the social determinants of health and health equity issues. Such an approach requires health promoters to develop a specialised set of skills to work with multiple partners across the broad social, economic and political sphere. A
consolidated national approach is needed to provide the necessary support, skills and resources for health promoters to work at this level.

- Health promoters reported relationships across the health sector were mixed. Several health promoters for instance spoke about the lack of collaboration with local PHOs. Facilitating a more integrated relationship and improved communication channels across the health sector will help improve services for more equitable outcomes.

- A longer-term approach to planning and evaluation is recommended in recognition of the complexities of health and associated behavior change. In consideration of this proposal, the appointed six monthly reporting cycle and tendency towards short term project planning and short-term contracts warrant review in favour of more sustainable long-term approaches.

- In light of equity issues being raised by health promoters it might be timely to examine the application of equity tools in NZ health promotion practice, to ascertain how and at what points these tools are being applied and to what purpose and effect.

- Health promoters suggested that their on-site proximity to the rest of the PHU team, and the wider DHB team of researchers, evaluators and analysts facilitated greater collaboration and support for planning and evaluation. On-site access to DHB expertise and the co-location model are arrangements warranting further examination, to ascertain their practicality and value to planning, evaluation and the strengthening of relationships and communication.

- Investigate and develop the infrastructure needed to create a ‘culture of evaluation’ in PHUs. A review of current evaluation reports could be a useful starting point; to determine the different types of evaluation and most used methods, the mix of qualitative and quantitative methods and their applicability to measures of outcome. Other areas to review could include funding, resources, skills, training and support. Explore whether a centralised centre for evaluation excellence, support and dissemination could form part of this proposed infrastructure.
• Develop the relationship between DHBs and PHUs and instil a whole-of-organisation approach to preventive health, health promotion and equity. Public health expertise should be represented in DHBs at management level to ensure strategic direction and clinical models are balanced by health promotion perspectives and population-based approaches.

• Initiate a ‘think tank hui’ of health promotion specialists from across the country to robustly debate the role of health promotion in the twenty first century and explore the potential for a health promotion national strategy to be developed. The aim of the ‘think tank’ could be to investigate innovative, diverse approaches as well as the means to distill health promotion action down to the essentials necessary to achieve equity and health improvement.

• Conduct a nationwide review of current PHU health promotion programme planning, to determine the mix of downstream and upstream initiatives, identify best practice programme examples and ascertain responsiveness of programmes to topical issues and equity.

Big picture

• Training and education on the social determinants of health to become mandatory in schools, and extended to public health practitioners, policy makers and stakeholders across the social, economic and political sphere (Commission of Social Determinants of Health, 2008) In doing so a determinants view of health might become embedded at societal level, encouraging understanding not divisiveness. For example, a petition was recently lodged at parliament calling for the Māori land wars to be included in the school curriculum as a way of acknowledging our history of colonisation and its ongoing effects.
Final summary

This thesis explored the overarching question, ‘How do health promoters in PHUs in NZ plan and evaluate their programmes?’ Interviews with 17 health promoters revealed the complexity of negotiating top down and bottom up priorities, multiple needs and a demanding environment that is not always conducive to health promotion values, time frames or approaches. In this context, some health promoters spoke of ideological differences in values between PHUs and DHBs posing a challenge to planning. Moreover, a culture of evaluation appeared largely lacking at organisational level; illustrated in the lack of resources and funding, a tendency towards short-termism, variable access to expertise and support and the lack of time available to conduct higher-level evaluation.

Needs analysis, the first step in planning, was largely driven by MoH and DHB priorities, though a small number affirmed the importance of starting with the needs of community first, before seeking alignment with government priorities. The majority of health promoters reported an integrated approach to needs analysis, one that coalesced community need with MoH directive, though some acknowledged that it was not always easy to balance the two sets of priorities. In-house analysts and researchers were widely valued for their role in collecting, preparing and analysing data for needs analysis, planning and evaluation though access to this expertise appeared to vary.

Health promoters reported using a diverse range of planning approaches and strategies from those leveraged at upstream action like policy change through to community-based programmes, and those targeted at individual behaviour change. Such diversity lies within the scope of the broad range of activities outlined in the Health Promotion Service Specification (Ministry of Health, 2016b) and best practice planning identified earlier in the literature review. Health promoters commented on the shift in health promotion ideology from a health education and individual behaviour focused model to a more strategic approach to planning in which health promoters were working alongside other organisations, services and the community in a coordination role, to plan and deliver integrated programmes. In this context, participants regarded intersectoral action, collaborative partnerships, and community engagement as important components of planning, with many reporting promising and effective examples of these in practice. However, health promoters also acknowledged that the
practicality of incorporating these principles into practice was not without challenge. Subsequently, some health promoters voiced concern about programmes that continued to place responsibility on the individual. It should be noted that within the confines of this study I was unable to determine whether the programmes referred to were part of a broader, multi-strategy programme. This is where an audit of annual planning and evaluation reports would have been useful (see ‘strengths and limitations’). Others alluded to programmes that either did not align with the target population, or intended goals and outcomes. Overall, health promoters were grateful for the external and internal support they received but they also sought greater organisational and operational support for planning in the form of training, funding, time, more opportunities for sharing planning across PHUs, access to internal and external expertise, and general recognition of their role from DHB management.

While equity was unanimously cited as a keystone principle guiding practice and health promoters applied an equity lens to programme planning, there was less evidence that as a programme progressed that health promoters were formally or actively reviewing or evaluating equity or the reach of a programme to guide programme modification. During the interviews, some health promoters questioned how best they might reach the most vulnerable in a community. The Treaty was also referenced as a guiding principle though several health promoters reported gaps in provision for Māori. Some described programmes that continued to miss “the mark for Māori health,” not only signifying the challenge of reconciling planning with the realities of practice in striving to achieve equitable outcomes but also emphasising the persistent nature of wicked problems and the need for multi-strategy approaches to combat them.

In terms of evaluation, my study identified a number of methodological and organisational issues canvassed in the literature. To begin with, participants appeared less confident about evaluation than they were planning, and the general consensus was that evaluation processes could be improved. Health promoters cited various barriers to conducting evaluation as these included: funding and resourcing constraints, short-term planning and reporting cycles, lack of time, variable access to expertise and training, gaps in ready access to locally relevant data and variously the challenges entailed in evaluating complex, long-term programmes. Accordingly, many health promoters expressed a desire for operational and organisational support to strengthen evaluation capacity. Health promoters registered a mixed response to the introduction
of RBA; while many appreciated its practical application others expressed concern about the use of numbers and percentages as indicators of population change.

Interviews revealed the tacit expectation that Māori health promoters act as cultural competency advisors, facilitate connections and networks in the community, and ascertain whānau and community aspirations, as well as assess the acceptability and reach of programmes for Māori, signalling the level of responsibility and accountability that rested with Māori health promoters in PHUs. The Ministry recognises the essentiality of Māori in assessing and contributing to the planning, delivery and evaluation of initiatives (Ministry of Health, 2016b). Such a weighted responsibility calls for greater commitment to Māori workforce development, more autonomy to work in kaupapa Māori ways, and formal recognition of the crucial role Māori health promoters play in working towards improved health outcomes. Māori health promoters opined planning should focus foremost on Māori needs and aspirations for the universal good.

The PHU setting was perceived to facilitate as well as act as a barrier to health promoters’ ability to plan and evaluate. For instance, some smaller regional PHUs felt ‘out on a limb’ in terms of staff capacity, access to resources, support and training opportunities. However, while these gaps may have been felt acutely in some of the smaller regional units, neither size nor location were found to be the sole determinants of engagement or support, with gaps in provision and capacity universally felt across units. In terms of the PHU setting as a facilitator, one participant spoke highly of a co-location model they had adopted that had opened up the possibilities for planning inter and cross-sectorally, while in another example, health promoters spoke of the benefits of having access to an onsite team of analysts and researchers.

As with any project, the findings of this thesis should be read with an awareness of its limitations. To build on and strengthen the findings of the current study, future research might seek the perspectives of key collaborators and stakeholders, in addition to an audit of health promoters’ planning and evaluation reports, to permit a broader, more independent appraisal of planning and evaluation practice in PHUs.

Finally, the current government, a Labour-led coalition, while new to the role appears to be explicitly addressing the omnipresent issue of rising inequities in NZ. Much will depend on whether they are granted a second term and can demonstrate boldness and audacity in tackling the social determinants of health. Health promotion has an
important role to play in contributing to the reduction of inequities in health care and health status, and relieving the burden of chronic disease. This will require government impetus and infrastructure to strengthen the position of health promotion and facilitate best practice planning and evaluation. In the meantime it is hoped that the recommendations presented here are given due consideration in deference to the commitment, enthusiasm and professionalism health promoters in my study demonstrated, despite the many challenges, in their planning and evaluation practice.
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Appendix A – Ethics Approval

D16/015

5 February 2016

Dr R Egan
Department of Preventive and Social Medicine
Dunedin School of Medicine
University of Otago Medical School

Dear Dr Egan,

I am writing to confirm for you the status of your proposal entitled “New Zealand health promotion planning and evaluation: a qualitative study”, which was originally received on December 22, 2015. The Human Ethics Committee’s reference number for this proposal is D16/015.

The above application was Category B and had therefore been considered within the Department or School. The outcome was subsequently reviewed by the University of Otago Human Ethics Committee. The outcome of that consideration was that the proposal was approved.

Approval is for up to three years from the date of HOD approval. If this project has not been completed within three years of this date, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz
Appendix B – Information Sheet

NEW ZEALAND HEALTH PROMOTION PLANNING AND EVALUATION: A QUALITATIVE STUDY

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

This study aims to understand how health promoters in New Zealand (NZ) Public Health Units (PHUs) plan and evaluate their programmes. It will involve a review of the existing health promotion literature and interviews with health promoters working in NZ. The study objectives are to:

a) Understand best practice health promotion programme planning and evaluation

b) Identify current health promotion programme planning and evaluation practices in NZ PHUs

c) Recommend improvements for NZ health promotion programme planning and evaluation practices

Health promoters in New Zealand often operate in an environment that prioritises evidence-based practice, explicit targets and fiscal restraint. Such demands on performance and productivity, coupled with an ageing population, rising rates of chronic disease and enduring inequalities compound the challenges health promoters face and emphasises the importance of effective planning and evaluation of programmes. It is hoped this study will help to highlight current planning and evaluation practice in New Zealand, reveal the perceived benefits of effective planning and evaluation, illustrate examples of good practice and in doing so, inform workforce development and training needs. This project is being undertaken as part of the requirements for a Master of Public Health.
What Types of Participants are being sought?

The project seeks to recruit 20 participants, including a health promotion manager and a senior health promoter from ten of the country’s PHUs. The first step in recruitment will be to contact Managers/CEOs of each of the PHUs to inform them of the research project. Subject to confirmation from management, the health promotion manager of each unit will be contacted via this emailed information sheet and a follow-up phone call. At this time the manager will also be asked to recommend a senior health promoter who might also be appropriate to interview. If participants consent to the study a time will be made for a face-to-face or telephone interview.

The inclusion criteria is; one, health promotion manager (or equivalent as understood by the CEO/senior manager); and two, a senior health promoter (as recommended by the health promotion manager).

What will Participants be asked to do?

Should you agree to take part in this project, you will be asked to take part in a structured face-to-face (in a mutually agreed place) or telephone interview that will take approximately 30-40 minutes. The interview will be audio recorded.

The questions will cover the following areas as they relate to planning and evaluation:

- Models, health targets and tools used to plan and evaluate programmes
- Perceived benefits of planning and evaluation
- Operationalising the Treaty of Waitangi
- Professional development and capacity building opportunities
- Evidence gathering, needs analysis, preparing new programmes, reporting processes
- Developing intersectoral relationships
- Examples of good planning and evaluation in your own practice
- Improvements for future planning and evaluation in the sector

Participants will be invited to make further comments at the conclusion of the interview if they wish. Please be aware that you may decide not to take part in the project without any disadvantage to yourself.

What Data or Information will be collected and what use will be made of it?

The interviews will be audio recorded and then transcribed. Only basic demographic information will be recorded, specifically gender, ethnicity, length of time worked in the field of
health promotion and age. As far as possible the identities of the PHUs will remain confidential, as will the identities of individuals. The interviews will be assigned pseudonyms as will each unit/geographic region. The data collected will be securely stored in a way that only Sarah Wood (researcher), Richard Egan (supervisor) and Rose Richards (supervisor) will have access to the transcriptions. Any personal identifying information such as contact details and the audiotapes will be destroyed at the conclusion of the project but any data on which the results of the project depend will be retained for 10 years in secure storage.

The results of the project may be published in a peer-reviewed journal and will be available in the University of Otago Library (Dunedin, New Zealand). Oral and written findings will also be shared with PHUs health promoters at an appropriate health promotion forum.

Can Participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:

**Sarah Wood**
Department of Social and Preventive Medicine
University Telephone Number: 021 259 9516
Email: woosa237@student.otago.ac.nz

**Richard Egan**
Department of Social and Preventive Medicine
University Telephone Number: 03 479 7206
Email: richard.egan@otago.ac.nz

This study has been approved by the Department stated above. However, if you have any concerns about the ethical conduct of the research you may contact the University of Otago Human Ethics Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix C - Consent Form

New Zealand Health Promotion planning and evaluation: a qualitative study

CONSENT FORM FOR PARTICIPANTS
I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information such as the interview audio will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least ten years;
4. While this project involves a predominately structured interview format more open questions may be asked towards the end of the interview. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.
5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.............................................................................. ........................................
(Signature of participant) (Date)

........................................................................................................
(Printed Name)
Appendix D – Interview Questions

How do health promoters in New Zealand plan and evaluate their programmes?

Interview Schedule

The researcher recognises that you may work within a particular organisational model and that accordingly, some questions may not be relevant to the realities of your everyday practice. Whatever approach you take, your views will form a valued contribution to a discourse on current health promotion planning and evaluation with a foot forward to how you would like future practice to look like.

Needs assessment

• How do you first identify the need for a health promotion programme?

• How do local and national priorities inform the way you conduct a needs analysis?

• Do you work with stakeholders and the community to assess their needs and gather information specific to them? Please explain.

• What other ways do you gather demographic and other relevant information?

• Can you describe an example of consultation or engagement with an individual, group or organisation that proved beneficial to needs analysis?

Planning

• How do you develop measurable and realistic goals and objectives for a programme?

• Can you describe an example of good or innovative planning you were involved in? What made it good or innovative?

• What health promotion models, tools, theories and frameworks do you use in your organisation?
• What do you like about using these tools/models and how practical/flexible are they in helping you with your planning?

• What principles and values do you draw on to guide your planning and how do these principles or values inform your planning?

• Do you conduct pilot studies/interventions as part of your planning and if so, how have these helped inform your planning previously?

• How do you go about identifying appropriate strategies to use in a programme?

• At what level is your planning targeted?

• Can you give an example of how your planning aimed to address the wider determinants of health?

Partnerships/relationships/collaboration

• The New Zealand Health Strategy encourages DHBs to learn from successful initiatives in other DHB areas. Do you have an example where you have worked with or modeled a programme on another PHU? Explain.

• What support and expertise do you receive internally and externally to help you with planning and evaluation?

• Give an example of a successful relationship with another agency or community group that was integral to your planning and/or evaluation.

Responding to the Treaty of Waitangi

• What support would you like to see for Māori in planning and evaluation within your organisation? How do you think this can this happen?

• To what extent and how is planning of a programme built around whānau and iwi priorities?

• What relationships do you have with your local Māori community, runanga or other Māori organisations?

• Do you have an example of a partnership with iwi, runanga or another Māori community or group that supported or strengthened your planning and/or evaluation?
Evaluation

• What are the fiscal conditions of evaluation within your organisation?
• What evaluation models and tools do you use?
• What types of evaluation do you do best and most often?
• How do you use evaluation as a means of project development? Example?
• Describe an example of good evaluation you’ve been involved in and explain what made it good.
• How do you include community in the evaluation process?
• How do you evaluate the impact of a programme on health issues that entail long-term change or complex causal chains?
• How do you evaluate if a programme is equitable or accessible?

Support and training

• What education and training have you received to help you with your planning and evaluation?
• How would you like to be further supported in your planning and evaluation? What professional development would you like to receive in the future to help with your planning and evaluation?

Reporting/administrative matters

• How are your programmes budgeted?
• What recording and reporting requirements are there in your organisation for planning and evaluating programmes?
• Who are you accountable to in your reporting?
Political influence

- How is your planning and evaluation practice affected by the political agenda of the day or shifts in government strategy or organisational policy?

How do we make things better for the future?

- What do you think ultimately makes a health promotion programme successful?

- Looking ahead, what three things would you like to see happen in planning and evaluation, either within your organisation and/or the wider sector?

- Is there anything else you would like to say about health promotion planning or evaluation before we conclude the interview?