A SNAPSHOT OF COMMUNITY HEALTH DEVELOPMENT EVALUATION IN AOTEAROA NEW ZEALAND

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), no material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or any other institution of higher learning.

Signed……………………………………………

Date………………………………………………

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ABSTRACT

In community health development (CHD) settings there is increased demand for more robust evaluation by funders of health and wellbeing initiatives who want to ensure that money is wisely invested and meets community needs. Evaluation of these initiatives is not always contracted to external professional evaluators, and increasingly more robust evaluation is expected of agencies and providers of the CHD initiatives. Therefore, within this setting there is a range of ways of doing evaluation and various perceptions about what kinds of evaluation are most appropriate.

This research aimed to explore how evaluation is practised by those evaluating community based CHD in New Zealand. The perspectives of those who do evaluation, including external evaluators, programme providers, and funders were explored. Of interest were answers to the questions: 'what kind of evaluation is being practised?'; and 'what are the elements of successful CHD evaluation?'. This small study offers a contribution to previous research by not only considering the values and valuing experiences of professional evaluators who come from their own theoretical background, but also including the perspectives of CHD workers, providers and funders who evaluate their own programmes in CHD settings in New Zealand.

Appreciative inquiry was used as a framework for conducting individual interviews with a small sample of evaluators, programme providers and a funder. Findings show differences in the three groups in that providers, because of their project management roles and accountabilities to external funders, were more focussed on project evaluation that would provide evidence of project outcomes and improved service delivery. As external agents evaluators in this study encouraged and supported providers to build their evaluative skills and capacity to carry out evaluation. The funder while concerned with accountability was still aiming to build providers capacities. It was found that although evaluation was always required, the evaluation skills in provider organisations and the funding for evaluation were often inadequate. These factors impacted on what evaluation was possible.

Given that some of the concepts and values important to both CHD and evaluation are connected and overlap, and the increased demand for funders, providers and community groups to evaluate their own initiatives, it is hoped that these results will provide insights into some of the considerations for building evaluative capacity within this context, in order to advance empowerment, social justice and equity in New Zealand.

ABBREVIATIONS

Abbreviation	Meaning
ANZEA	Aotearoa New Zealand Evaluation Association
AUTEC	Auckland University of Technology Ethics Committee
CHD	Community health development
E	Evaluator
F	Funder
MPDS	Māori Provider Development Scheme
NZ	New Zealand
PP	Programme Provider
RCT	Randomised Controlled Trials
SCAF	Stronger Communities Action Fund
WHO	The World Health Organisation

GLOSSARY

Expression	Meaning
Aotearoa	A Māori name for New Zealand meaning 'land of the long white cloud' (Te Whanake, 2012)
Fonofale	A pan-Pacific & Samoan Health model (Pulotu-Endemann, 2009) which locates health within the context of family and culture integrated with spiritual, mental physical and other components
Fonua	Tongan Health Model which refers to the land and its people and their on-going relationship, a concept that is present in many other Pacific cultures (Tu'itahi, 2009)
Hapu	"kinship group, clan, tribe, subtribe - section of a large kinship group" (Te Whanake, 2012, p. 1).
Iwi	"a large group of people descended from a common ancestor" (Te Whanake, 2012, p. 1).
Kaupapa Māori	Māori cultural aspirations, preferences and practices (Mahuika, 2008, p. 6)
Lotu Moui	'Lotu' means "church" or "prayer" in most Pacific languages, while "Moui" is a Tongan and Niuean term that generally means good health that encompasses mind, body and soul. The 'mind, body, spirit' approach to health is holistic and inclusive. Importantly, it is consistent with Pacific people's concepts of health and wellbeing (Counties Manukau District Health Board, 2012)
Marae	An open area in front of a Maori sacred traditional building. It often also includes the complex of buildings surrounding this area (Te Whanake, 2012).
Pakeha	A Māori term for a person who is not of Māori descent; especially refers to a white person of European descent (Te Whanake, 2012).
Tangata whenua	local people, hosts, Indigenous people of the land (Te Whanake, 2012) (Māori in New Zealand)

Expression	Meaning
Te Pae Mahutonga	(Southern Cross Star Constellation) a model for Māori health promotion that brings together elements of modern health promotion (Ministry of Health, 2012)
Te Whare Tapa Whā	The four cornerstones (sides) of Māori health -Te Whare Tapa Whā, bring together the physical, mental, social and spiritual dimensions of health and healing in one health model(Ministry of Health, 2012)
Te Wheke	Translated refers to 'octopus'. Family health is related to the eight tentacles each representing an important aspect (such as family, spirituality, the mind, physical) that collectively contribute to total wellbeing (Ministry of Health, 2012)
Te Puni Kokiri	Ministry of Māori Development
Tikanga	The way things are done or practices within Māori culture "correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention" (Te Whanake, 2012, p. 1).
Whānau	Extended family, or "family group, a familiar term of address to a number of people - in the modern context the term is sometimes used to include friends who may not have any kinship ties to other members" (Te Whanake, 2012, p. 1).

CHAPTER 1: INTRODUCTION

Evaluation involves an "experimenting global community, one characterized by commitment to reality testing, respect for different perspectives, and open dialogue about evidence – a world in which on-going learning is valued and practised, and knowledge is generated and used" (Patton, 2008, p. xviii).

When I was involved with faith based programmes in Papua New Guinea recently, I became very aware that there were any number of 'aid' programmes targeting communities and yet these didn't seem to match what I saw to be the realities of everyday life for the communities where I was living. On closer inspection, these programmes seemed to be top down, externally driven, and when the programmes finished, they finished! That is, there didn't seem to be any continuation or sustaining of project ideas into new strategies, or community ownership once projects had been completed. To use Friere's terms, little 'empowerment' of the community was occurring (Freire, 2006). Empowerment refers to conscientization, raising peoples' awareness of their situation and what they can do about their own situation (Freire, 2006).

In addition, I came to see the role that funding played in these programmes. For example, while the promise of project funding often provided hope for communities that they could improve their own circumstances, project goals and purposes were often determined by the external funder without community involvement in these discussions. In addition, evaluations were based on set goals without the consideration of other benefits which may have accrued. In many cases, whilst valuable, these projects did not always meet the needs or fit the local realties of peoples' lives. It also seemed that sometimes communities adopted these plans as a means of receiving financial help even though project goals at times distracted them from their main concerns. I had also noticed the same dynamic in my community work in New Zealand.

Recognising that evaluation is part of a project cycle process, I became extremely interested in how funded projects were decided on, designed, agreed to, and

evaluated. Hence, the focus of my study about 'evaluation'. When I started reading and studying evaluation I saw that evaluation is approached with a range of possible actions, ranging from compliance 'tick the box' evaluations to what I considered to be empowering forms of evaluation which involve the community in the decision made at every stage of the project cycle – in the identification of the need for a project, and its design, implications and evaluation. I saw that too often the community were seen as users or recipients of the project only, rather than active stakeholders.

My background in the health field sparked my curiosity about the evaluation of community health development programmes in New Zealand, particularly in South Auckland where I live.

South Auckland is the target of many community health development programmes given the poor health statistics in this area. Of those who live in South Auckland, a high proportion are Māori and Pacific people (17%); 12% of all New Zealand's Māori population (22%) live there along with 39% of all New Zealand's Pacific population. Māori lag 11 years behind the national mean life expectancy and Pasifika life expectancy is six years lower than average (Counties Manukau District Health Board, 2008; Statistics New Zealand, 2006). Clearly people in South Auckland are disadvantaged on a range of health counts.

My view was that evaluation of funded community health development initiatives in New Zealand could and should be an alive, on-going, cyclical process of action, reflection and consultation, where stakeholders are included at major decision points of the whole cycle. The evaluative processes used would be flexible and adaptive. This would ensure that community health development programme decisions are informed by systematic learning identified by the community itself, as opposed to it being a predetermined finite closed activity controlled by external people.

For my study, I decided to focus on the evaluation of community health development programmes in South Auckland; an area which in my view could benefit from empowering and capacity building evaluation processes.

I considered it valuable to document/research the voices of three key actors: evaluators, programme providers and funders, involved in evaluation of CHD because each play important yet different roles. Hence, clarifying the roles each play, and the interactions between them, can help us to better understand how evaluation is important for CHD.

The following sections provide a background to evaluation; and introduce CHD and the New Zealand context.

1.1 Evaluation

Evaluation is defined as a distinctive process that makes use of multiple methodologies and methods drawn from a diverse range of social sciences, to make sense of human phenomena (Mark, Greene, & Shaw, 2006). It is also is defined as a process that uses a range of evidence to make judgments about the value, merit, worth, significance or importance of something (Patton, 2008; Scriven, 1991). Evaluation has "many faces … and given its dynamic nature it is not surprising that no single definition has taken hold among all evaluators" (Mark et al., 2006, p. 7).

Evaluation may influence one or many stakeholders. Each stakeholder involved in an evaluation may have their own definition of the *value, quality* or *merit* of a programme. Hence what constitutes *value*, *quality* and *merit* warrants further exploration. How these definitions are acknowledged, integrated or compromised in various contexts is challenging and was explored in this study.

Mark, Greene and Shaw (2006) suggest that there is not one single history of evaluation, but multiple histories. These histories are dependent "upon one's discipline and domain of evaluation work" (p. 9). Mark, Green and Shaw (2006) give an American example of how theorists in the 1960s and 1970s such as Ralph Tyler were considered to play a pivotal historical role in influencing practices of evaluation within education, yet these influences have often been ignored in non-educational social evaluation fields. Rather, these social evaluation fields in America

instead emphasize the impact of the 'Johnson administrations' 'Great Society''[1] as a major influence on the historical development of evaluation (Mark et al., 2006).

Political influences and geographical location also influence the historical development of evaluation. For example, the American histories of the development of evaluation philosophies and practices are subject to different historical and social influences than found in other countries. For this study, New Zealand's social, cultural and political influences on evaluation practice are a central focus.

Understandings of the role, purpose and process of evaluation have changed since the mid-1970s, from an 'external' 'top down' directed activity, to one which may include programme participants in the whole programme cycle. Generally speaking, prior to the 1970s evaluations were largely carried out by independent external evaluators. These evaluators were contracted to large organisations in order to conduct evaluations which monitored processes and generated evidence for accountability purposes. These evaluations were also intended to demonstrate that compliance to a set of externally defined set of project goals had occurred. Hence they informed on-going decision-making and they were meant to foster further organisational learning (Adams & Dickinson, 2010; McKegg, 2011; Stevenson, Florin, Mills, & Andrade, 2002). This type of evaluation located the decision making, information and the control of processes with external experts who were often outside the project. Therefore there was little stakeholder engagement in the evaluation decision making; rather the community was used for information gathering purposes. The intentions of these evaluations were to improve programmes for the benefit of the recipients (those for whom the programmes were targeted). However in many cases little interest was paid to building capacities, or developing the knowledge and skills of members of the community.

Empowering forms of evaluation are more noticeable in the last decade, practised by socially minded evaluators who "anchor their work in an intentional commitment to democratic social justice, equality or empowerment" (Greene, 2006, p. 118).

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[1]Great society – in the 1960s in United States of America President Johnson formulated social reforms for the elimination of poverty and racial injustice by promoting a set of domestic programmes that addressed medical care, education, urban problems and transportation (Mark et al., 2006).

Examples of some of these forms of evaluation approaches include: *empowerment, transformational, deliberative democratic,* and *developmental evaluation* (Abma, 2005, p. 3; Chelimsky, 1998; Coryn, Noakes, Westine, & Schröter, 2010; Cousins, 2001; Cousins & Whitmore, 1998; Fetterman, 2007; Gariba, 2008; Greene, Johnson, Jimenez, Ahn, & Boyce, 2010; House & Howe, 2000; Mertens, 1999; Miller & Campbell, 2006; Patton, 1994; Wallerstein & Duran, 2006; Weiss, 2003).

These empowering evaluation approaches have in common participatory methods which can have the aim of ensuring stakeholder values, needs and desires are considered within the evaluation practice processes. An example is Mertens' (1999) transformative evaluation which is practiced with "marginalised groups such as women, ethnic/racial minorities, people with disabilities, and those who are poor" (p.4). One example is the work Mertens carried out with a deaf community in America (Mertens, 1999). These types of approaches to evaluation provide a platform for action for social betterment, which is further described in Chapter Two.

Since the 1970s indigenous evaluators have also begun presenting approaches which fit well within ethnic contexts. In New Zealand, one such approach is *Kaupapa Māori evaluation* (Barnes, 2003). This approach is discussed in Section 1.3.

With my background in health and community work I was particularly interested in how evaluation was practiced in funded programmes aimed at community health development in South Auckland.

1.2 Community Health Development

The term 'community health development' refers to a broad range of strategies for, and approaches to, improving population health (Felix, Burdine, Wendel, & Alaniz, 2010). The orientation of this study falls in line with The World Health Organisation's (1986) definition of health that as well as recognizing spiritual wellbeing, includes physical, mental and social well-being. The goal of CHD is to make a positive difference for the health and wellbeing of the community and individuals within the community (Keleher, MacDougall, & Murphy, 2008; Raeburn & Corbett, 2001). Community health development is more than a strategy; it is a

way of looking at the world centred around values which honour the unique contribution each individual can make for the betterment of the communities in which they live (Labonte, 1992; Laverack & Labonte, 2000).

Community health development is the integration of three important frameworks: community development, health promotion and primary health care. An example of these three frameworks is represented in Figure 1.1 following (Huang & Wang, 2005).
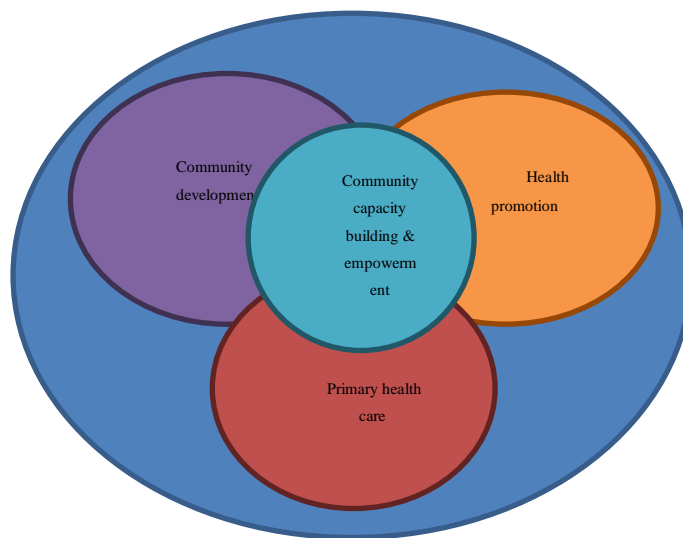
Figure 1.1 Framework of Community Health Development modified from Huang and Wang (2005, p. 15).

These three frameworks (Figure 1.1) each contribute to building community capacity and empowerment, thereby the potential for creating change (Baum, 2008; Felix et al., 2010; Huang & Wang, 2005). Community capacity building is closely related to empowerment and it refers to providing the resources, skills and support to accompaniment to communities so they can take actions to improve their own lives. Empowerment in CHD in my study refers to ownership and control by people over their own destinies (Nutbeam, 1998). Community capacity building and empowerment are, therefore, the two pivotal elements of the entire CHD approach and provide the foundational elements for evaluation in this setting.

Community empowerment aims to influence equity in health by including participants in decision making about their own health. Over the last three decades

the three associated areas of CHD, that is, primary health care, health promotion and community development have changed in their approaches to health development in two ways. The first has involved a shift to ecological, sector wide and collaborative processes as opposed to the previous foci on individuals, disease prevention and, expert controlled development (Raeburn & Beaglehole, 1989). Influences such as the work of Paulo Friere[2] (in the 1960s and 1970s), the Declaration of Alma Ata[3] (1978), and the Ottawa Charter of Health Promotion[4] (1986) and many other social change fields such as community psychology and research in social justice, have cumulatively helped develop the idea of divesting knowledge, power and control to local communities (Rappaport, 1977; Ball, 1997). These processes enable communities to build their own capacity and thus become empowered.

The second shift that has occurred is in how communities are perceived: whereas communities were once traditionally seen to be deficient and lacking, the emphasis has shifted towards emphasizing community assets and strengths (in the early 1990s) (Kretzmann & McKnight, 1993). These paradigm shifts have inspired people working and researching in the area of CHD to focus on building capacity and empowering target populations, especially indigenous and vulnerable communities, to take charge of their own health using development approaches. As statistical evidence demonstrates these groups are not thriving within Western models (Durie, 1998; Walker, 2006). This study located in the unique social, cultural and political context of New Zealand.

The next section highlights the cultural, historical, social and political contexts in Aoteaora New Zealand which are likely to influence evaluation practice in CHD settings.

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[2] Paulo Friere, the Brazilian theorist who argued for radical means of political conscientiatization sought to bring about community driven development (Freire, 2006).

[3] The Declaration of Alma Ata was adopted at the International Conference on Primary Health Care, 1978. It requested the world community, all governments, and development workers to protect and promote the health of all people. It was the first international declaration outlining the importance of primary health care.

[4] The Ottawa Charter of Health promotion was signed at the World Health Organisation-organised First International Conference on Health Promotion, in1986. The Charter states: -"Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being" (World Health Organisation, 1986, p. 1).

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1.3 New Zealand

In line with global trends, New Zealand's community health development practice is more often linked with ideas that vision the community as an asset base; and the promotion of social justice, equity, empowerment and community inclusion in the solving of their own challenges (Baum, 2008; Chile, 2004; Felix et al., 2010; Kahssay & Oakely, 1999; Raeburn, Akerman, Chuengsatiansup, Mejia, & Oladepo, 2007; Wallerstein, 1993). Community health development practice developments influence thinking about what type of evaluation is expected from CHD workers and external evaluators. One example in practice is Raeburn and Rootmans' (1998) PEOPLE[5] system (Raeburn & Rootman, 1998). The PEOPLE system places control of community development processes with the people themselves.

A unique distinction in New Zealand is the formal Crown relationship with and obligations to the Tangata Whenua (indigenous people of New Zealand, Māori), formalised in the Treaty of Waitangi[6]. The Treaty of Waitangi (1840) provides "the overarching point of difference between research and evaluation in Aotearoa and research and evaluation in other contexts" (Barnes, 2009, p. 3). At the same time, New Zealand also has a diversity of cultures and ethnic groups, which provides a further perspective for the exploration of evaluation in culturally diverse settings. Pacific people have also proposed guidelines for research and evaluation practice in New Zealand such as the guidelines for Pacific research set by the Health Research Council (Health Research Council of New Zealand, 2005) and Newport's (2003) account of her experience as a Pacific evaluator in the book *Evaluating Policy and Practice: A New Zealand reader*. Further discussion about New Zealand and Pasifika perspectives is included in Chapter 2.

In New Zealand, the health and wellbeing status of Māori (indigenous peoples of New Zealand), Pacific peoples, and other ethnic minorities is demonstrably well below the standards of other people living in New Zealand - as identified by state

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[5]PEOPLE system - the letters of which represent People-centredness, Empowerment, Organisational and community development, Participation, Life quality and Evaluation (Raeburn & Rootman, 1998).

[6]Treaty of Waitangi-An agreement entered into in 1840 by representatives of the Crown and Māori (indigenous peoples of New Zealand) iwi (tribes) and hapu (subtribes) (New Zealand History online, 2012).

census statistics and the New Zealand Deprivation Index[7] - (Ministry of Social Development, 2012; Statistics New Zealand, 2006).

Currently, *The New Zealand Health Strategy* (2000) provides the basis for Government health action. The *Strategy* identifies priority areas aimed at improving the health of all, and focuses on tackling health inequalities and ensuring that services are appropriate for people from lower socio-economic groups and for Māori, Pacific and other ethnic minorities (Ministry of Health, 2000). In particular, government health and state policies and organisational strategies are now beginning to address inequalities of health through local partnership arrangements and community health development strategies involving local ethnic communities (Counties Manukau District Health Board, 2012; Ministry of Health, 2002b; Ministry of Social Development, 2009; Waitemata District Health Board, 2011).

An example of this is the New Zealand Department of Internal Affairs in the late 1990s funding of seven CHD projects throughout New Zealand through an initiative called Stronger Communities Action Fund (SCAF). The aim of these projects was to help strengthen communities by enabling them to identify and make decisions about the funding of some local social services to meet their needs (Dialogue Consultants, 2003).

Indigenous peoples around the world and in New Zealand are increasingly documenting their reality, their experiences and what is important to them through models of health and wellbeing as opposed to having their reality defined by Western medical models. These include for example *Te Whare Tapa Whā*[8] and *Te Pae Mahutonga* are Māori health models (Durie, 1999) and *Fonofale* and *Fonua* are Pacific health models (Tuʻitahi, 2009). The values and ways of viewing the world which are important to indigenous groups and ethnic minorities are now being considered by CHD workers, evaluators and policy developers working in these

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[7]New Zealand Deprivation Index-This measure reflects aspects of social and material deprivation. The index combines nine variables from the Census of Population and Dwellings, including income threshold and income source, employment, qualification, and family type (Ministry of Social Development, 2012).

[8]*Te Whare Tapa Whā* and *Te Pae Mahutonga* (Māori models) and *Fonofale* and *Fonua* (Pasifika models) bring together the physical, mental, social and spiritual dimensions of health and healing in culturally recognised ways in the various different models (Durie, 1999).

contexts (Bishop, 2005; Durie, 2001; Wehipeihana, Davidson, McKegg, & Shanker, 2010).

Cultural approaches to evaluation are also evident in New Zealand as mentioned in Section 1, such as Kaupapa Māori evaluation (Barnes, 2009; Bishop, 2005; Oliver, Spee, & Wolfgramm, 2003; Wehipeihana et al., 2010). Kaupapa Māori evaluation can be defined as an approach which involves Māori control and ownership to meet indigenous/Māori needs and aspirations; and is carried out within an indigenous/Māori worldview, which is likely to question the dominant culture and norms and aims to make a positive difference and be transformative (Barnes, 2009).

The western idea of health and wellbeing often considered to be the 'mainstream' or 'normal' is challenged by discourse and publications about the neocolonial domination of research experienced by Maori in New Zealand (Bishop, 2005; Smith, 1999; Durie 1986). Pasifika academics also question how applicable a Western framework is when defining their health.

A Kaupapa Māori approach to research and evaluation positions researchers within the cultural aspirations, understandings and practices of Māori people both literally and figuratively, to implement and organise the evaluation activity (Bishop, 2005). Cram and Kennedy's (2010) research provides an example of Kaupapa Māori research. Their research aimed to find methods for researching whānau (extended family) which are compatible with Māori aspirations.

1.4 Research Focus

Globally, little has been studied about the experience and practice of CHD providers and funders who evaluate their own programmes (Shaw & Faulkner, 2006; Whitehall, Hill, & Koehler, 2012). Likewise no studies were located in academic data bases which explored the way evaluation is practised in New Zealand by different evaluation actors, such as funders, providers and external evaluators[9].

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[9] Lunt, Davidson & McKegg's (2003) book does provide accounts of practice in New Zealand from various perspectives (Māori, Pacific, evaluators working with providers).

The aim of this study is to provide some understanding of how funders, evaluators and CHD providers evaluate funded CHD programmes within the dichotomy of 'top down' approaches to disease prevention and lifestyle change and the 'bottom up' empowerment discourse and models of current CHD and evaluation.

When planning this study, I envisioned that the evaluation of community health development initiatives in New Zealand needed to include the community voice in evaluative processes which are responsive, flexible, adaptive and empowering within the complex realities of CHD. Evaluation would then be informed by systematic learning identified by the community itself as opposed to a predetermined finite closed activity controlled by external agencies. This empowering and responsive type of evaluation then has the potential to become part of the mechanism for recalibrating the relationships between the funder, provider, evaluator and community representatives in ways that are more empowering than is often currently occurring. One of the differences in approaching evaluation in this way is the philosophical starting point underlying the evaluation approach.

For this study an Appreciative Inquiry framework was chosen, aimed at advancing a strength-based, empowering and capacity building focus looking at CHD evaluation models. In order to apply an Appreciative Inquiry framework, this study examines the perspectives and relationships of three key actors in the evaluation process: that is, funders, programme providers and external evaluators. As noted (page 10) no studies were found which included the perspectives of these three relevant actors who play various roles within the evaluation of CHD programmes. The study is therefore unique as it exposes some of the associated challenges and successes faced by those evaluating in CHD – the extent to which what they espouse aligns with what they practise. My thesis' stance is that understanding successes in practice can provide a starting point to inform future evaluation training, financial and resource decision making for CHD workers.

The research questions were:

1. What kind of evaluation is practiced in CHD contexts in New Zealand? And

2. What are the elements of successful evaluation?

By exploring the approaches, types and methods of evaluation used, this research examines whether these practices are providing the 'space' for community groups to participate in knowledge generation, be empowered and build their capacity for self-determination. Also explored is whether there are similarities and differences across the three participant groups (i.e., funders, providers, external evaluators). Answers to these questions may also provide information about the social, cultural and political elements influencing evaluation practice in New Zealand.

1.5 Thesis Structure

This first chapter has provided a snapshot of community health development and evaluation practices that are distinctive to New Zealand's historical, political, social and cultural context. This chapter also included the aims of the study, the researcher's position and values, thesis structure and definition of terms used throughout this study.

The second chapter provides a literature review and discussion of current and relevant international and national literature on evaluation in CHD. It also discusses New Zealand's social and cultural setting specifically in regards to evaluation practice with the indigenous people, Pasifika communities and other cultural groups. This chapter presents some of the elements of success when doing evaluation within the context of CHD in New Zealand. The rationale for using a qualitative approach, Appreciative Inquiry and the study design, methodology and methods of data collection are explained in chapter three. The findings of the study are presented in chapter four including descriptions of the demographic characteristics of the participants and the findings in response to the main research questions. Chapter five summarizes the key findings and discusses the implications of this study in relation

to current theories and supporting improvements of evaluation in CHD for future practice and training.

1.6 Definitions of Key Terms

The key terms are defined here to ensure that working definitions derived from a review of relevant literature are clarified upfront to make less room for ambiguities. The terms such as *community health development, evaluation, empowerment, values,* and *health and wellbeing* as they are applied in this thesis are outlined below.

Community health development

In this thesis, the term CHD includes any community targeted health development activity which aims to empower and build the capacity of communities to take charge of their own health (Baum, 2008; Keleher et al., 2008). Key components of this definition include the *empowerment* of and the building of *capacity* within targeted communities. This definition encompasses social, cultural and economic health determinants (Wilkinson & Marmot, 2003) and these activities, in sum, are popularly referred to as health promotion, primary health care, public health, community health, and community development for health promotion (Adams et al., 2009).

Evaluation

Evaluation is defined in this thesis as a process that uses a range of evidence to make judgments about the value, merit, worth, significance or importance of something (Patton, 2008; Scriven, 1991). To prevent confusion, terms and concepts associated with evaluation are described: a) evaluation approaches (philosophical orientation underpinning practice; b) evaluation types (the purpose of the evaluation); c) evaluation methods (data collection methods) (Duignan, 2009).

Evaluators

Within this study, the research participants - the funder, the programme providers and the evaluators - were all asked to describe their experiences as 'evaluators' of community health development programmes. However, throughout this thesis the term *evaluator* is used when referring to external evaluators. The other two groups of participants are described as *programme providers* and the *funder.*

Empowerment

The term *empowerment* is used liberally throughout this thesis. While it is noted that this term may be conceived differently by those from other ethnicities, [10]within this thesis it refers to ownership and control by people over their own destinies (Laverack et al., 2007; World Health Organisation, 1986).

Values

The term *values* is problematic and could be the subject of a stand-alone thesis. However, my working definition proposes that values encompass peoples' personal, cohesive system of beliefs. These include peoples' philosophical beliefs and their personal world view. These beliefs frame peoples' conceptual frameworks, and shape our perceptions of the social reality and ways of thinking.

Health and wellbeing

There is no definition of health that can be applied universally to every context (Keleher et al., 2008). A broad definition of health and wellbeing is used in this thesis: one that refers to health as a resource for everyday life and is a positive concept. This definition also acknowledges other determinants of health which are often found outside the health sector, including spiritual, cultural, social and political determinants (Baum, 2008; Durie, 1998; Keleher, MacDougall, & Murphy, 2008; Nutbeam, 1998; Tu'itahi, 2009; World Health Organisation, 2008).

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[10] See the Laverack, 'Ofanoa, Nosa, Fa'alili, & Taufa (2007) study of four Pacific communities in New Zealand which suggests empowerment is understood differently by different ethnic groups. For example empowerment from a Western cultural perspective may value individualistic actions as opposed to the perspective of someone from other cultural perspectives which value collectivist action.

CHAPTER 2: LITERATURE REVIEW OF EVALUATION OF COMMUNITY HEALTH INITIATIVES IN NZ

My view is that successful evaluation must begin from a positive starting point (Fetterman, 2007; Jennifer C Greene, 2006; St Leger, 2008). This chapter introduces the three conceptual frameworks which form the basis for my study from which literature about evaluation in CHD is studied and analysed: a strengths-based approach, the location of power and action learning. Each of these is explained below. These concepts, especially when considered from a strengths-based perspective, are pivotal throughout this thesis. To locate the perspectives of these three frameworks, an accompanying account of the historical development of evaluation in New Zealand is provided.

The first of these three frameworks involves a strength based approach to evaluation, that is, positive empowering strategies for reviewing CHD practices. The second framework, the locus of power, presents ideas about where control is located in evaluation. Locus of power, as referred to here, involves 'top down, bottom up' and 'internal and external' processes (see Figure 2). The third framework is the concept of action learning which derives from Arygris and Schŏn's (Argyris & Schŏn, 1996) single and double loop learning model. In this thesis, action learning refers to a system wide approach even though social, cultural and political contextual factors impact upon systems. Considering each of these conceptual frameworks either in tandem or in isolation enables a better understanding of community health development programmes and their evaluation.

2.1. Three Conceptual Frameworks Informing this Critique

The conceptual ideas and philosophies underlying the three selected frameworks - a strengths-based approach, the location of power and action learning - provide the analytical lens which I will use to review the literature on evaluation, and evaluation in community health development.

2.2.1 Strengths-based approach

When referring to a strengths-based approach, this is describing a way of looking at the world from the point of view of what is right and working well rather than what is wrong and not working. For example, at one extreme intervention models may be based in dominant culture and belief systems that view 'others' (e.g. those in minority cultures, or those with high needs) as deficient, resulting in programme initiatives which perpetuate activity within the deficit model (Borrup, 2002; Kretzmann & McKnight, 1993; Larrison, 1999; Laverack & Labonte, 2000). From another extreme, the strengths or assets of a community can be identified as a starting point to build on (Borrup, 2002; Walker, 2006). The application of the strengths-based approach in practice, therefore, ensures the values of programme participants are recognised; and community participants become involved in the design and execution of evaluation and on-going programme planning, design and implementation (Bishop, 2005; Madison, 1992; SenGupta, Hopson, & Thompson-Robinson, 2004; Smith, 1999).

The discussion here about 'strengths-based' approaches evidences that peoples' view of the world, whether looking for problems or noticing strengths, influences the overall organisational approach to CHD interventions and their evaluation. These strengths-based approaches link with the discussion in the next section about the locus of power –whether it's 'top down' or 'bottom up'.

2.2.2 Locus of power –'top down' vs. 'bottom up'

Community health development approaches can be described in terms of where power is located: either within the health development agency operating in a 'top down' manner, or within the community working in a 'bottom up' fashion (Kahssay & Oakely, 1999; Kretzmann & McKnight, 1993; Morgan, 2001; Raeburn & Corbett, 2001; Raeburn & Rootman, 1998). While both approaches seek the same desired outcome, e.g. improved health and well-being, 'top down' programmes are typically pre-tailored, and initiated and controlled by agencies/individuals external to the funders or the community of interest.

As reported 'top down' programmes also often address disease prevention strategies through lifestyle programmes in which participants are given information/education to encourage them to adopt healthy behaviour (Baum, 2008; Laverack & Labonte, 2000; Raeburn et al., 2007; Raeburn & Beaglehole, 1989). Top down funded programmes do not always relate well to the empowering objectives of community health work (Batten & Holdaway, 2011; Kretzmann & McKnight, 1993; Laverack & Labonte, 2000; Raeburn et al., 2007). It is likely also that there will be tension between 'top down' devised projects which at the same time aim for a 'bottom up' community empowerment and development result.

On the other hand, 'bottom up' programmes involve health promotion or community development workers supporting and acting as facilitators for community partnership and development projects. The facilitators seek to identify issues of concern and assist communities to define their priorities, and preferred delivery style as well as identifying links with others to address these concerns in order to improve community health and wellbeing (Kretzmann & McKnight, 1993; Raeburn et al., 2007). However, empowerment and capacity building goals are not easily reconciled within short project time-frames (Laverack & Labonte, 2000). Further key differences between 'top down' vs. 'bottom up' approaches are listed in Table 2.1 (page 17).

Lavarack and Labonte (2000) highlight that even though most community development workers aim to identify and include community concerns by using empowering processes which build community capacity ('bottom up'), they are often tethered by their organisational project cycle timelines and by the exigencies of evidence-based programmes initiated from 'top down' (Laverack & Labonte, 2000; Lovell, Kearns, & Rosenberg, 2011). Laverack and Labonte, therefore, propose the parallel track model. Though 'top down' and 'bottom up' are oversimplified terms, for the ease of discussion in this study they will be referred to, to indicate the positions of power of the actors.

Table 2.1 Key differences between top-down and bottom-up approaches

	Top-down	Bottom-up
Root/metaphor	Individual responsibility	Empowerment
Approach/orientation	Weakness/deficit Solve problem	Strength/capacity Improve competence
Definition of problem	By outside agent such as government body	By community
Primary vehicles for health promotion and change	Education, improved services, lifestyle	Building community control, resources and capacities toward economic, social and political change
Role of outside agents	Service delivery and resource allocation	Respond to needs of community
Primary decision makers	Agency representatives, business leaders, 'appointed community leaders'	Indigenous appointed leaders
Community control of resources	Low	High
Community ownership	Low	High
Evaluation	Specific risk factors Quantifiable outcomes and 'targets'	Pluralistic methods documenting changes of importance to the community

Source: based on Felix et al. Labonte and Boutlier et al. as cited in Lavarack and Labonte (2000, p. 256).

The key differences of the motivations and definition of problems between 'top down' and 'bottom up' approaches are identified in Table 2.1. As depicted community control and ownership is contrasted by the two approaches.

Parallel track

The parallel track model (Laverack & Labonte, 2000) includes a 'programme track' and an 'empowerment track' in order to accommodate community empowerment in a 'top down' CHD programme. The 'parallel track' model suggests that CHD workers concurrently negotiate a dichotomy in the practice of effective CHD work between seemingly top down vs. bottom up programme goals. Looking at Figure 2.2 the 'parallel track' requires a skilled facilitator to ensure links occur between programme and empowerment tracks at each stage of the programme development (see Table 2.2 below). These links ensure that learning is achieved through consultation at each step.
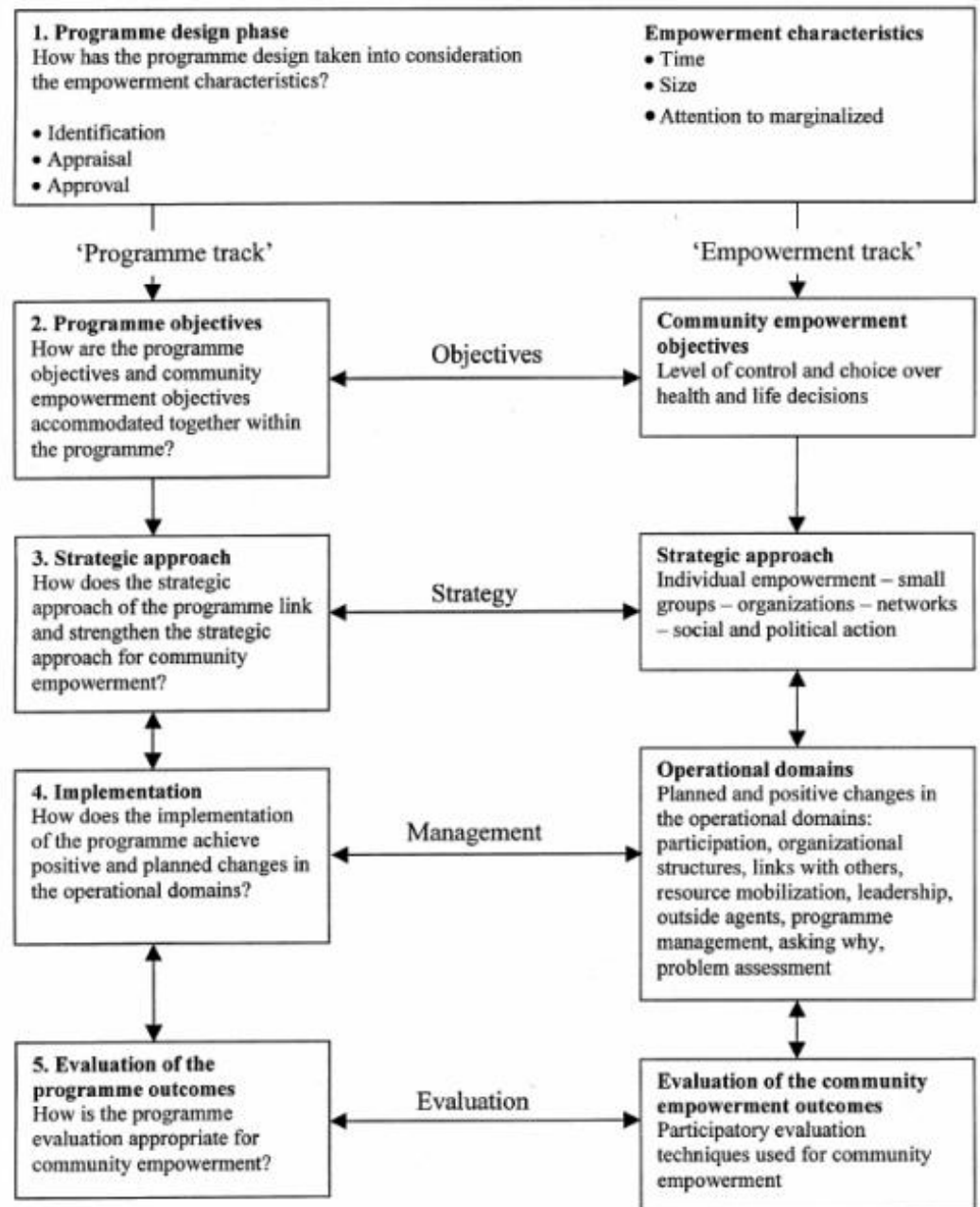
Figure 2.2 A planning framework for the accommodation of community empowerment within a top down community health programme (Laverack & Labonte, 2000, p. 257).

The 'parallel track' model presented above depicts the two tracks and outlines each stage of the consultation process. Lavarack and Labonte (2000) suggest the health development worker is the facilitator of this consultation process. However, within this model, the evaluator could also undertake this role. Fetterman (2007) describes the role of the evaluator as the 'critical friend' who provides accompaniment to all stakeholders involved in the evaluation to assist them to build

their capacity to evaluate their own programmes. In the long term, one of these roles could be ensuring funding agencies and providers develop sound processes from the start; ensuring extensive consultation about programme logic with all stakeholders (Fetterman, 2007; Jennifer C Greene, 2006; House & Howe, 2000; Howe & Ashcraft, 2005; Patton, 2011; St Leger, 2008).

2.2.3 Action and learning dimension: single vs. double loop learning

Evaluation practice has changed considerably in the last forty years from an activity carried out by independent external evaluators largely to satisfy compliance, to one which supports the inclusive processes of dialogue, action and reflection by all stakeholders in the evaluation processes (Adams & Dickinson, 2010; Cousins & Whitmore, 1998; House, 2005; Howe & Ashcraft, 2005; McKegg, 2011; Patton, 2011; Stevenson et al., 2002). These inclusive processes of evaluation are carried out in ways which are seen to be appropriate to the particular context and which aim to co-construct and exchange knowledge. Research indicates that when knowledge exchanges are fostered in CHD programmes it is likely that such programmes will facilitate more practical but effective decision-making capacity building and collaboration (Fetterman, 2007; Howe & Ashcraft, 2005; Mertens, 1999; Patton, 2008; Smits & Champagne, 2008; Torres & Preskill, 2001).

These changes to evaluation practice reflect Argyris and Schőn's (1996) theory on single vs. double loop learning. In single loop learning, once a problem is detected it is corrected to achieve a desired outcome – much like a thermostat which turns *off* when it receives information that the temperature is too hot or *on* when it receives information that it is too cold (Argyris & Schőn, 1996; Patton, 2011). Double loop learning on the other hand, moves beyond the single loop and involves inquiry into the underlying functioning and relationships of the whole system. This may involve critical scrutiny of assumptions, policies, practices and values with the intention of uncovering what led to the problem in the first place (Argyris & Schőn, 1996).

Hence, double loop learning provides new evidence to inform changes and adaptions which can be made to the system. Rather than focussing evaluation on outputs which fits with a single loop learning model, newer conceptions of evaluation for social betterment, empowerment and capacity building of community

groups which are the interest in this study, align well with Argyris and Schőn's (1996) theory of double loop learning.

In addition to a strengths-based approach, the parallel track and double loop learning, throughout this thesis evaluation in CHD in New Zealand is considered from an Appreciative Inquiry platform. In this perspective, each person is considered to have a unique contribution to make to the world. Hence, evaluation is seen as a whole systems approach, where the evaluator may act as an agent to negotiate the major tensions between 'top down' and 'bottom up' CHD programming identified by Lavarack and Labonte (2000).

The next section considers how evaluation may be viewed from the theoretical perspective of CHD workers and within evaluation theory. Firstly CHD approaches to evaluation are discussed followed by approaches from evaluation theory.

2.2. Evaluation Approaches

As noted, evaluation has been described as a process for making value judgments about an activity. However, there are many ways of approaching evaluation depending upon peoples' social, cultural, political and philosophical starting points.

2.2.1 Evaluation approaches within community health development.

Predominately community health models include a component for evaluation in the project cycle (Baum, 2008; Hawe, Degeling, & Hall, 1994; Nutbeam, 1998; Raeburn, 1996; Rootman et al., 2001). From a CHD theoretical perspective, seminal articles contributing to evaluation discourse include a paper on the progress, problems and solutions in evaluating health promotion (Nutbeam, 1998a); and a publication by the *WHO European Working Group on Health Promotion Evaluation* (Rootman et al., 2001). This literature identifies that evaluation can make a major contribution to health promotion practice if it involves using a wide range of approaches and models, and quantitative and qualitative methodologies (Nutbeam, 1998a; Rootman et al., 2001). These sentiments are similarly attested to in evaluation literature.

Though many models are presented in these publications, no one particular health promotion model or approach was considered by the above authors as being

appropriate for all programmes. For this reason no specific health promotion evaluation model is used for this thesis; rather, evaluation is investigated from the view of approach or the philosophical starting point: which is designed to "accommodate the complex nature of health promotion interventions and their long-term impact" (Rootman et al., 2001, p. 32). A selection of approaches which might be relevant for evaluation of CHD in New Zealand have been identified by the researcher and a concise description of each appears in the next section.

Raeburn and Rootman's (1998) PEOPLE[11] system was considered as a possible approach for this critique. The PEOPLE system locates community development as led and under the control of the community. This approach has been applied successfully for over 20 years in some areas in New Zealand (Raeburn, Akerman, Chuengsatiansup, Mejia, & Oladepo, 2007). The reason for not including this system, relates to the reality, as Raeburn and Corbett (2001) suggest, that most CHD initiatives are not controlled by community groups; rather the initiatives are controlled by external professionals. Raeburn and Corbett's PEOPLE system did not fit the reality of the CHD evaluations in New Zealand, sourced from academic databases for this critique, as these were found to be predominately agency led: that is not springing from community motivations.

As well as reviewing these CHD theories about evaluation, evaluation theories and practice, the sections below provide more examples of evaluation approaches used in a variety of contexts.

2.2.2 Evaluation approaches within evaluation theory.

Numerous approaches and various purposes of evaluation are also described in the evaluation literature. Patton relates more recently how in 1987 he counted one hundred names, each name distinguishing a different type of evaluation (Patton, 2000 p. 1). Stufflebeam (2001) later identified and categorised these into twenty two programme evaluation approaches. From an evaluation theory perspective, a small selection of approaches from the 'valuing' and 'use' branch of Alkin and Christie's

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[11]PEOPLE System - the letters of which represent People-centredness, Empowerment, Organisational and community development, Participation, Life quality and Evaluation (Raeburn & Rootman, 1998).

$(2004)^{12}$ theoretical tree (see Appendix F) have been identified by the researcher for this critique: empowerment (valuing), transformative (valuing), utilization focussed (use), and programme theory evaluation (use).

Two other approaches are also included in this study, these are described later in this critique – Patton's (2011) more recent *Developmental evaluation*, and, *Kaupapa Māori evaluation* – a New Zealand specific approach (Barnes, 2009; Bishop, 2005; Wehipeihana et al., 2010). All approaches were chosen because their philosophical underpinnings align well with CHD principles of capacity building, empowerment and social justice (Tineke A Abma, 2006; Barnes, 2009; Fetterman, 2007; Jennifer C Greene, 2006; Patton, 2011; Stufflebeam, 2001; Whitmore, Guijt, Mertens, Chinman, & Wandersman, 2006). These approaches will be described in the next subsection.

Table 2.2 Some Evaluation Approaches, Purposes, Methods and Designs

Approaches	Purposes (types)	Methods	Designs
Empowerment Transformative Utilization focussed Programme theory Developmental Kaupapa Māori	Formative Design Developmental Formative Implementation Process Outcome	Consultation Surveys Questionnaires Focus groups and others	Experimental Quasi experimental Case study and others

Adapted from Duignan (2009) p. 113 Easy Evaluation Workshop book

As outlined previously, there are differences between evaluation approach, evaluation type (or purpose) and evaluation methods. Table 2.2 above is to be read vertically rather than horizontally and clarifies the relationship between the selected approaches and purposes for evaluation. While it is acknowledged that there are

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[12] Alkin and Christie (2004) 'evaluation tree' (Appendix 6). Three different theoretical approaches to evaluation are represented as branches of the tree. These theoretical approaches are; methods (evaluators are guided by research methods which enhance knowledge construction); valuing (evaluators are concerned with the value and worth of data); use (evaluators are interested in the way evaluation information is used and who will use it).

other approaches and purposes for evaluation, these will not be discussed in this thesis. Likewise as this study is more focussed on approaches and purposes of evaluation little attention will be given to discussing evaluation methods or evaluation designs.

Community health development objectives for community empowerment, capacity building, improved health and social progress are not always evaluated using a fixed evaluation approach or with methods that have high scientific rigor such as randomised controlled trials and the like (St Leger, 2008). This is one challenge for those evaluating complex CHD initiatives: balancing the need for scientific rigor with longer term social outcomes more suitably measured by quasi experimental designs (Stufflebeam, 2001). Below is a brief description of evaluation approaches more aligned with quasi experimental design, which are more appropriate for evaluating the longer term social outcome objectives of CHD.

2.2.3 Evaluation approaches selected for this thesis.

A brief description of a few evaluation approaches selected for this study follows. These approaches were chosen in that they align well with a strength based framework, and they are often utilised deliberately to empower and build the capacity of all stakeholders ('bottom up' development) to participate in the evaluation. These approaches also relate to Argyris and Schőn's (1996) double loop learning in which evaluation involves stakeholders and these stakeholders determine how programmes are defined, and how they participate in the action, reflection and knowledge generation.

Empowerment evaluation.

Those using an empowerment evaluation approach aim to provide programme stakeholders with the necessary tools, skills and knowledge to identify their own needs and plan and implement self-evaluation of their programmes, with the aim of embedding this practice for the future. The evaluator often acts as a facilitator or a guide in these processes (Fetterman, 2007).

Transformative evaluation.

The reasoning underlying a transformative evaluation approach has to do with knowledge building. Knowledge is not considered to be neutral; rather it holds power and reflects social reality. One of the aims of the transformative evaluation approach is to use deliberate strategies to ensure marginalized groups have access to knowledge. Knowledge provides the means for marginalized groups to transform their social and external reality. Therefore transformative evaluation has been seen as a relevant approach for those doing CHD evaluation, as CHD programmes focus on such communities who suffer inequalities of health (Mertens, 1999).

Utilization-focused evaluation.

Patton's Utilization-focused evaluation model supports the premise that evaluation be judged by its utility and actual use (Patton, 2008). Evaluators using this approach consider at each step of the evaluation process how each action will impact on the *"intended use by intended users"* (Patton, 2008, p. 17).

Programme theory driven evaluation.

A program logic model developed by stakeholders often proposes causal relationships between programme activities and long term outcomes. A theory driven evaluation is usually guided by a programme logic model analysing whether the 'logic' or programme theory is aligned with intended outcomes (Davidson, 2005; Rogers, 2008).

Developmental evaluation.

Developmental evaluation is a long-term process which supports continuous improvement, adaptions and intentional change. A developmental evaluator works as part of the project team and facilitates discussions about evaluative data, logic and processes (Patton, 1994): "Developmental evaluation supports innovation development to guide adaption to emergent and dynamic realities in complex environments" (Patton, 2011, p. 1).

For the New Zealand-specific context an indigenous approach to evaluation and research is practised by some workers. It is referred to as Kaupapa Māori evaluation.

Kaupapa Māori evaluation.

Kaupapa Māori evaluation is a New Zealand specific evaluation approach. *Kaupapa Māori evaluation* is not one defined model, but a statement that broadly refers to approaches which have Māori control and ownership; meet indigenous/Māori needs and aspirations; and are carried out within an indigenous/Māori worldview. This worldview is likely to question the dominant culture and norms; aim to make a positive difference; and be transformative (Barnes, 2009; Bishop, 2005; Oliver et al., 2003; Wehipeihana et al., 2010).

The next section highlights further the New Zealand-specific cultural, social and historical context likely to inform evaluation practice.

2.3 New Zealand Context

Some of the unique social, bicultural and multicultural and political elements of New Zealand may impact on evaluation practice. As noted (page 8) in New Zealand the Treaty of Waitangi (1840) forms the mandate that underpins and guides formal and informal relationships and responsibilities between Māori (indigenous people of New Zealand) and the Crown. As well, this section also provides a brief history of community health development and evaluation specific to New Zealand.

2.3.1 Treaty of Waitangi.

As noted earlier, relationships and responsibilities between the Crown and the indigenous people of New Zealand (Māori) are formally recognized in the Treaty of Waitangi (Te Tiriti o Waitangi) signed in 1840. The Treaty and its implications for practice provides a unique yet "overarching point of difference" to those in other countries (Barnes, 2009, p. 3). The Treaty mandate of 'participation' 'partnership' and 'protection' (Bishop, 2005) effectively provides a framework for government policies, including those for CHD and evaluation practice.

Further, Treaty principles encompass "issues of ownership, control, equity, involvement and participation" (Barnes, 2009, p. 3) and address the following ethical issues:

> …rights, roles and responsibilities of researchers and Māori communities; the contribution that research makes towards providing useful and relevant outcomes; and addressing inequalities. All research in New Zealand is of interest to Māori, and research which includes Māori is of paramount importance to Māori (Barnes, 2009, p. 3).

2.3.2 Pacific Guidelines.

Pacific people have also identified guidelines which honour Pacific worldviews and guide research and evaluation practice with Pacific communities in New Zealand. Increasingly Pacific communities are expressing and practising their own models of health in response to Western medical models which they emphasize have failed to connect to their reality (Health Research Council of New Zealand, 2005; Newport, 2003)[13]. Models such as Fonofale and Fonua Pacific models of health were briefly mentioned in Chapter One.

2.3.3 CHD and New Zealand's social, bicultural, multicultural and political environment.

In New Zealand, data indicates that Māori and Pasifika peoples and other ethnic minorities are disadvantaged insofar as health, welfare and employment are concerned. The status of Māori and Pacifika peoples is reviewed below, followed by a description of the political context of New Zealand.

Bicultural and multicultural environment.

Specifically, within a predominantly Western (positivist) environment, there is ample evidence to demonstrate that health inequalities mainly impact upon Māori and Pasifika peoples (Bishop, 2005; Durie, 1998; Smith, 2005). As noted Māori lag 11 years behind national mean life expectancy and Pasifika life expectancy is six years

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[13] New Zealand a country with a population of approximately 4 million made up of 56.8% European, 8% Asian, 7.4%, Māori, 4.6% Pasifika, 23.2% mixed ethnicities or other population groups (Statistics New Zealand, 2006).

lower than the average national figures (Counties Manukau District Health Board, 2008; Ministry of Health, 2002c).

Clearly, Māori and Pasifika peoples and other ethnic minorities experience the most inequalities of health in New Zealand. Both Māori and Pasifika peoples are more likely to live in the poorer areas and have life expectancies shockingly well below non-Māori and non- Pasifika. They are, therefore, the target of many CHD programmes (Ministry of Health, 2002a).

This thesis has a geographical focus in South Auckland, and 98% of interviewed participants were involved with evaluation of programmes in this area. Of those who live in South Auckland, a high proportion are Māori and Pacific people; 17% of South Auckland population are Māori (12% of all New Zealand's Māori population) and 22% of South Auckland population are Pacific people; (39% of all New Zealand's Pacific population) (Counties Manukau District Health Board, 2008; Ministry of Health, 2002c). People in South Auckland are disadvantaged on a range of health, social and economic indicators reflected in a deprivation index of five[14]. See Appendix G for NZ deprivation index map for the Counties Manukau District Health Board area.

Though this study does not deliberately review CHD programmes which target Māori or Pacific peoples, all participants were either from these ethnic groups or were involved in initiatives that targeted these groups. Discussion about the bicultural and multicultural nature of New Zealand is, therefore, especially relevant.

Political environment.

Government priorities and public policies influence where the government funding is channelled and how funding priorities are determined. In New Zealand the effects of a changing political climate and consequently the restructuring of the health sector has impacted on what sorts of initiatives are funded or not funded. In the 1980s, social policies influenced more collective arrangements between non-government

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[14] NZ Deprivation Index - This measure reflects aspects of social and material deprivation. The index combines nine variables from the Census of Population and Dwellings, including income threshold and income source, employment, qualification, and family type (Ministry of Social Development, 2012). The scale ranges from one to five (five being the most deprived).

organisations and Public Health Units to provide health promotion initiatives for a diverse range of issues such as physical activity, nutrition, and workplace conditions (Lovell & Neuwelt, 2011; Wise & Signal, 2000).

In the 1990s, the New Zealand National Government applied a competitive market approach to the health sector that involved the separation of policy, health service provision and health service purchasing, which increased a competitive contracting environment. This move facilitated a decline in collaboration within the health sector until the publication of the *Ottawa Charter for Health Promotion* in 1986 with its five action areas,[15] which influenced the Labour Government's (1998-2008) approach to health policy (Fear & Barnett, 2003; Howden-Chapman & Ashton, 1994; Lovell & Neuwelt, 2011; Wise & Signal, 2000). Under this government, the last major health reform was the establishment of twenty one District Health Boards, which were allocated funding according to their population base needs.

At that time, District Health Boards set up a number of Primary Health Organisations (PHOs), who then contracted providers to deliver health promotion activities (King, 2001; Lovell & Neuwelt, 2011; Wise & Signal, 2000). These changes opened the gate for providers which comprised of public (as part of hospitals), non governmental organisations, "Māori tribal and non-tribal organisations and community groups" to tender for contracts to deliver CHD programmes (Wise & Signal, 2000, p. 240).

This increase in the number of health service providers allowed more opportunity for Māori to provide "by Māori for Māori" culturally appropriate care for their own people (Lovell et al., 2011, p. 533). Fortunately, this health reform under the Labour Government (1998- 2008) had been aligned with and supportive of the Ministry of Health development scheme in the 1970s which had included; "infrastructure support, workforce development, service integration" and "accreditation and best

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[15] Ottawa Charter – The WHO's Ottawa Charter for Health Promotion provides a framework for developing and implementing actions to promote health in five action areas: Developing Personal Skills, Creating Supportive Environments, Strengthening Community Action, Reorienting Health Services, Building Healthy Public Policy (World Health Organisation, 1986)

practice" under the so called Māori Provider Development Scheme (MPDS) (Ministry of Health, 2009, p. 4).

As well as the political and funding changes which supported the increase in local providers (who were more likely to be connected to the reality of their own communities), the approach to addressing health inequalities also transitioned. This moved from a focus on the individual's responsibility for their own health to one which addressed the structural determinants of health using socio-ecological models (Baum, 2008; Kahssay & Oakely, 1999; Keleher et al., 2008). A socio-ecological model of health considers health as being affected by social and environmental factors; therefore, it integrates the social, interpersonal, community, organisational and public policies when addressing health needs (Robinson, 2008).

This approach to a programme or intervention is described in Gluckman's (2011) report to the Prime Minister of New Zealand as "one that leads to a positive change for individuals and collectives, who must also feel that their cultural (and other) needs have been valued…" (Fergusson, McNaughton, Hayne, & Cunningham, 2011, p. 296).

Currently, *The New Zealand Health Strategy* (2000) provides the basis for government health action and identifies priority areas to improve the health of the population; focusing on tackling health inequalities, and ensuring services are appropriate for people of varied socio-economic levels and ethnicities (Ministry of Health, 2000) - as briefly mentioned in chapter one. Further, thirteen population health objectives are identified, which address areas including nutrition, fitness and lifestyle diseases (obesity, diabetes cardiovascular disease); reducing smoking, alcohol abuse and illicit drug use; improving cancer, oral health and social outcomes; improving the health of those with mental illness; reducing violence and suicide; and improving child and family health and immunisation rates (Ministry of Health, 2000). There are also a range of strategies for tackling the inequalities of health in various population groups, including collaboration.

Community health development in New Zealand

Globally, community health development programmes are applied in diverse ways within a multitude of communities, each of which has unique characteristics (Baum, 2008; Dluhy & Swartz, 2006; Raeburn & Corbett, 2001). Targeted community health programmes aim to promote parity by improving health and wellbeing through facilitating behavioural changes via collaborative health promotion and health education initiatives (Baum, 2008; Felix et al., 2010; Kahssay & Oakely, 1999).

The importance of community collaboration and participation were formally noted at the First Primary Health Care Conference at Alma-Ata, 1978, as a means to achieve an "…acceptable level of health for all the people of the world by the year 2000" (World Health Organisation, 1978). Achieving these goals through primary health care strategies presents the challenge of efficient resource allocation, achieved by full engagement of local people in defining and prioritising their own needs (World Health Organisation, 1978). The term "*community involvement in health development*" was first coined as a basic principle of health care and promotion at the World Health Organisation (WHO) regional meeting in 1985 (Kahssay & Oakely, 1999; World Health Organisation, 1986) .

As an example, in New Zealand, community involvement was promoted in a Health Care Otago funded diabetes initiative (Murphy et al., 2003). Here, Māori health workers negotiated a change to a more appropriate location for a hospital based service for Māori clients. Another example is the *Lotu Moui* initiative which facilitates collaboration and partnership between Counties Manukau District Health and various Pacific churches and their Pasifika communities (Counties Manukau District Health Board, 2012). *Lotu Moui* uses active partnership with church leaders, local organisations and communities to deliver health messages and programmes such as healthy eating and physical activity, aligned with Christian teachings (Counties Manukau District Health Board, 2012).

According to Chile (2007a):

> Prior to European colonisation and settlement of Aotearoa, Māori, like most indigenous peoples around the world were engaged in the development of their communities, which ranged from whanau (extended family) to hapu (villages and sub-tribes) to iwi (large tribal areas). (p. 40)

In New Zealand, the development and role of formal community development practice historically and philosophically includes three strands. The first strand being programmes developed by the state; the second strand being collective social action by individuals, groups and organisations to address issues of marginalised groups; and the third strand relates to Tangata Whenua (Māori indigenous to New Zealand) efforts for active self-determination (Chile, 2007b; Durie, 1998; Nash, Munford, & O'Donoghue, 2005).

Also identified are growing efforts by community development providers to be respectful of and responsive to cultures and ethnicities different from their own backgrounds and experience (Chile, 2007c; Munford & Walsh-Tapiata, 2005). The development of these latter 'strands' is expressed in Māori (Pacific and other ethnic) holistic models of health and wellbeing. These models acknowledge the relationships between individual participants, cultural groups and wider society and are influencing community development and evaluation theoretical frameworks (Durie, 2001; Suaalii-Sauni et al., 2009; Tu'itahi, 2009).

Evaluation of community health development in New Zealand.

Over the last 25 years there has been an increasing demand for formalised evaluation of "public as well as private investments, processes, practices and programmes" (Saville-Smith, 2003, p. 16). Further Saville-Smith (2003) identified three developments particular to New Zealand which influenced this demand. First, due to the underinvestment in research and social research in the 1980s and early 1990s, university graduates of the social sciences found fewer employment opportunities available in the pure social sciences and found more opportunities to use their skills in formal evaluation.

Secondly, the development of information technology and its widespread use, affordability and functions for data collection, storage and relatively quick analysis - critical for many evaluations - provided evaluators more capacity to meet demands of commissioning agencies. Thirdly, shifts in the 1980s and 1990s by government to privatize and contract out previously key components of government business necessitated a whole raft of contracting relationships, often with associated expectations for evaluation to provide evidence of outcomes.

The expansion in the demand for evaluation is also reflected in the increase in the number of professional evaluation organisations. Mertens (2005) notes that "before 1995, only five regional and/or national evaluation organizations existed in the world" (p. 125). By 2006, close to 50 evaluation organisations were listed (Donaldson & Christie, 2006). In New Zealand there is one evaluation organisation which is the Aotearoa New Zealand Evaluation Association (ANZEA).

Evaluators' philosophical values set the basis for their practice. Since the mid-1970s, in line with the shifts in CHD philosophies, the principles of empowerment, social justice, collaborative and participatory engagement have motivated and inspired some evaluators' practice of evaluation. Patton (2011) has recently described evaluative activity that encompasses a developmental process of on-going and systematic learning, negotiated through discourse and action as projects evolve, as an example.

These quite recent types of evaluative endeavours are more sensitive to community, cultural and social contexts and are inclusive in their processes of dialogue, action and reflection by all stakeholders; and aim for collective knowledge co-construction and knowledge exchange. These processes improve the chances of instrumental use, effective decision-making, individual and community group capacity development, programme development practices and social betterment (Fetterman, 2007; Howe & Ashcraft, 2005; Mertens, 1999; Patton, 2008; Smits & Champagne, 2008; Torres & Preskill, 2001).

Recent developments in evaluation in New Zealand.

In the last decade indigenous evaluators are defining evaluation practice specific to their own communities. Indigenous evaluators play a crucial role of also challenging Western notions of what is of value and importance: They are, therefore, more able to acknowledge and support indigenous communities to synthesise traditional knowledge with contemporary knowledge. For example, in New Zealand, in books and journal articles, Māori evaluators describe systems and processes and ways of working that are appropriate within the New Zealand context (Barnes, 2003; Gariba, 2008; Wehipeihana et al., 2010). Such indigenous and developmental approaches to evaluation align well with Arygris and Schőn's idea of double loop learning in which evaluation becomes an active alive process where holistic inquiry and learning informs next steps in programme development (Patton, 2011).

New Zealand evaluators also collaborate with colleagues around the world and with other evaluation associations for professional development, joint conferences, reporting and publications (Adams & Dickinson, 2010; Barnes, 2009; Davidson, 2005; Lunt, Davidson, & McKegg, 2003; Patton, 2011; Wehipeihana et al., 2010). The professional association ANZEA, which in 2012 had 350 members provides an umbrella organization that caters for the unique working environment, and the historical and bicultural context of New Zealand (ANZEA, 2012). ANZEA provides an avenue for debate and the development of evaluation discourse which challenges and integrates global development practice and research among New Zealand based evaluators (ANZEA, 2012).

As outlined previously, there is a difference between evaluation approach, evaluation purpose and evaluation methods. Often, the concepts are mixed when discussing evaluation. All three concepts are, however, linked. In practice, evaluators may incorporate elements of several approaches which they see fit with stakeholder purposes and programme needs, rather than following strictly only one particular approach (Bledsoe & Graham, 2005). Likewise, in New Zealand, evaluation practice as described by Lunt et al., (2003) in their edited book *Evaluating Policy and Practice: A New Zealand Reader*: "…local evaluation practice can be

seen as eclectic, continuously innovative, and containing a diverse range of theories and methods…" (p. 245).

Any evaluation carried out in New Zealand needs to consider impacts on and for Māori linked back to the three principles of partnership, participation and protection of the Treaty of Waitangi (1840). Some guidelines to incorporate Māori perspectives on evaluation were developed by Ministry of Māori Development (Te Puni Kokiri) (1999) and practice within these communities has been outlined by Māori evaluators such as Barnes, Weipehana and others (Barnes, 2009; Bishop, 2005; Wehipeihana et al., 2010).

Types of CHD programmes that may be evaluated in New Zealand.

Community health development programmes in New Zealand have addressed issues which aligned well with the aforementioned New Zealand Health Strategy (2000). Issues addressed have included lifestyle diseases such as heart disease, obesity, diabetes, healthy eating and physical activity, which have formed the largest grouping (Coppell et al., 2009). Initiatives to address addictions such as gambling, smoking, and alcohol (Huckle. et al., 2005) were also represented. A smaller number of initiatives addressed social, economic and structural issues such as housing, social capital and community development (Adams, Witten, & Conway, 2009).

Examples of New Zealand CHD initiatives also provide evidence of CHD practice considerations designed to be appropriate for the social realities and needs of indigenous groups. Cultural based CHD programmes include, for example, marae-based programmes; church-based programmes and school-based programmes (McAuley et al., 2009); programmes run by Māori for Māori (Harding, North, Barton, & Murray, 2011); and wider cross-countries collaborations such as the *Pacific Obesity Prevention in Communities Project* in NZ, Australia, Fiji and Tonga (Schultz et al., 2011).

Evidence from the New Zealand literature.

A literature search of scientific data bases such as Ebsco, Eric and Scopus sourced a small number of articles, (approximately 100) about community health programmes in New Zealand. Fewer than twenty articles specifically described the evaluation

35

component of these programmes. Further searches of Ministry of Health websites retrieved just over ten evaluation reports from the last ten years. Clearly, there has been much more evaluation of CHD activities going on in New Zealand. However, it is highly likely that these reports are not available for public review; they may be held within government and nongovernment offices, or published in other forums.

This is unfortunate from the point of view of evaluation being a cumulative and knowledge generating process. Given the large number of CHD providers contracted to provide and evaluate health services, the dearth of published articles in this space was disappointing though somewhat expected. My assumption that evaluation of CHD would be approached from a philosophical starting point of empowerment, transformation and community capacity building - all principles of CHD programmes - while true in theory, did not follow through to what is happening in practice.

As will be demonstrated below with the exception of two evaluations, most examples for this critique were sourced through academic data bases, and reported evaluation purposes of measuring programme processes and outcomes. The evaluations sighted did not include the aims of empowering and building the capacity of local communities to evaluate and take charge of their own programmes. These approaches to evaluation possibly fit more with those from the 'use' branch of the evaluation tree - programme theory evaluation or utilization focussed evaluation. A limitation of this critique, as mentioned above, is that the small number of evaluation reports available through scientific data bases cannot be considered representative of all CHD evaluations.

The majority of New Zealand CHD evaluations found in journal articles reflected community deficit and disease models rather than strength-based approaches to CHD and evaluation. For example, the language used to describe the interventions evaluated, indicate whether evaluations were located within a strength based or deficit based model; most fell into the latter category for example *'reducing harm'*, *'stopping violence'* or *'preventing'* falls, weight gain or *'controlling'* of diseases such as diabetes. Only a small number represented an evaluation of social outcomes, such as a community development project that aimed to improve social

connectedness at the *"neighbourhood level determinants of health"* (Adams et al., 2009, p. 140).

Of the first group mentioned above (lifestyle diseases), approximately half reported using experimental designs, such as randomised controlled trials (RCT) that measured programme outcomes such as: cost effectiveness of a school based healthy eating programme (McAuley et al., 2009), preventing weight gain for women with young children (Lombard, Deeks, Jolley, Ball, & Teede, 2010) and a community based physiotherapy service for sub-acute stroke patients (Lord, McPherson, McNaughton, Rochester, & Weatherall, 2008). Scientific processes were chosen as appropriate to measure these biomedical issues.

As noted evaluation approach, purpose and methods (and designs) are linked. The purpose of evaluation is generally described as a means to determine the value, quality and worth of something. Most of the evaluations highlighted above approached evaluation from an accountability and lesson learning perspective, with half (of these) using rigorous and scientific methodology such as RCTs. Two considered relationships, participation, partnership, and capacity building to be an important part of evaluation. One reason why there were not more evaluations which were classified as empowering and inviting community participation could be that such concepts are not easily reconciled within funder-driven top-down frameworks, as suggested earlier by Lavarack and Labonte (2000); or that more innovative initiatives are not reported in the scientific journal space.

2.4 Application

Earlier, several elements such as relationships and consultation; participation; partnership and collaboration; capacity building and empowerment were identified and how these are applied in different ways according to whether the CHD programme and/or the evaluator are operating within 'top down' 'bottom up', 'strengths-based' or 'double loop learning' paradigms. For example, relationship building can be viewed as an important way of ensuring cooperation and participation in agency-led initiatives (top down). Or this can be seen as a starting point in the process of community consultation to identify values relevant to communities as part of intervention and evaluation design.

37

2.4.1 Relationships and consultation.

People are the critical factor in any social, cultural or health development (MacLachlan, Carr, & McAuliffe, 2010). As MacLachlan and colleagues (2010) propose: "Development is what happens when relationships strengthen for the common good; it has a moral dimension and can best be achieved by processes that are emancipatory" (p. 6).

Relationships support and improve the delivery of CHD interventions by ensuring all actors are working together. The vast body of CHD and evaluation literature reviewed identified that building relationships based on trust and mutual respect was critical to successful evaluation (Abma, 2005; Bledsoe & Graham, 2005; Chile, 2004; Cousins, 2001; Davidson, 2005; Dykman, 2002; Fetterman, 2007; House & Howe, 2000; Kahssay & Oakely, 1999; Labonte, 1992; Laverack, 'Ofanoa, Nosa, Fa'alili, & Taufa, 2007). Developing relationships involved building trust between outside actors and local communities, and between community members themselves (Adams et al., 2009; Voyle & Simmons, 1999).

Taking time to ensure evaluation processes add value for local representatives is considered an important step in this process (Adams et al., 2009; Barnes, 2009; Cunningham, 2003; Newport, 2003; Raeburn & Corbett, 2001; Voyle & Simmons, 1999). The time element is also important when involving community participants and other government agencies. Time is needed to encourage them to participate fully in the decision making or evaluation plans (Adams et al., 2009; Schultz et al., 2011).

The quality of relationships and level of trust and respect, impact on the degree of dialogue and level of participation in evaluative processes; the methods chosen, the production of knowledge; and the ability to embed sustainable evaluation practices. A key element in fostering participation is the use of deliberate strategies to develop trust and foster collaborative relationships with local communities. This also assists the identification of individuals in the community who have the capacity to lead others and have a passion to be involved in social betterment projects, project implementation and evaluative activities (House, 2005; Laverack & Labonte, 2000; Mertens, 1999; Munford & Walsh-Tapiata, 2005).

Relationships also reflect the dynamics of power, privilege and social reality which are particularly important when engaging with communities from cultures different to one's own (Munford & Walsh-Tapiata, 2005; Wehipeihana et al., 2010). Evaluators suggest the reasons for mistrust and suspicion felt by community groups may well relate to the residual effects of colonization felt by Māori, or the negative past experiences of government funding recipients (Durie, 1998; Munford & Walsh-Tapiata, 2005; Rochford, 1997; Voyle & Simmons, 1999). These factors impacted also on how much time was needed for evaluators/researchers to build trust, and consult and achieve agreement on appropriate evaluation designs and processes (Adams et al., 2009; Coppell et al., 2009; Harding et al., 2011; Murphy et al., 2003; Simmons, Voyle, Fou, Feo, & Leakehe, 2004; Voyle & Simmons, 1999). Schultz et al., (2011) noted that community consultation and project planning, which included evaluation design, between academic researchers and community representatives took an average of a six month period to complete.

The organizational processes involved in setting up partnerships, and engaging with Māori in CHD or other programmes are discussed by Voyle and Simmons (1999). However, Bishop (2005), Smith (2005) and Wehipeihana et al., (2010) suggest that models and step-by-step guides do not help someone from outside the culture make 'sense' of the reality of another community, or how to interpret data, or to predict impacts (Bishop, 2005; Smith, 2005; Wehipeihana et al., 2010). In short, can appropriate value judgements be made by someone outside the culture who is very distant from the thinking, processes or worldview of the group being evaluated?

Additional challenges for evaluators include how to negotiate consensus. Evaluators, therefore, have to use their facilitation skills to ensure participation by all stakeholders in any community consultation process (Adams et al., 2009; Guijt & Shah, 1998).

The evaluator needs to ask critical questions to foster evaluative processes by facilitating the process in an "action research cycle of planning, implementing and reviewing, setting up a recurrent feedback loop between evaluators, community representatives and programme implementers" (Adams et al., 2009, p. 146; Fetterman, 2007). As St Leger (2008) suggests, the evaluator can play the role of

protagonist who negotiates with the community group and can provide empowerment to the CHD workers themselves by asking the critical questions from an evaluative point of view. This support could assist CHD workers to link empowerment goals with agency led cycles at all stages of the project cycle, as shown in Lavarack and Labonte's (2000) parallel track model illustrated earlier in this chapter.

2.4.2 Participation.

Power dynamics are also evidenced by how participation is envisioned and evidenced in CHD programmes. "Participation is a complex, dynamic, relational and political process of negotiation in which groups with differing interests and agendas vie with one another for power" (Baum, 2008, p. 482). Morgan (2001) suggests: "Participation tends to be at once alluring and challenging, promising and vexing, necessary and elusive" (p. 229).

Coalitions between funders and the community participants can identify indicators of change and potential expectations (Wallerstein & Duran, 2006). Over time, participation and dialogue between those groups are likely to influence processes and the CHD initiative direction in a dynamic manner, responding to various challenges and agendas of all parties involved. Participation by community members is also suggested to be empowering in itself for participants, and is expected to ensure productivity of the programme and its sustainability once the funder exits in the future. This is explored more fully in empowerment section.

Ideals for building relationships which engender participation, as described above, are challenging to achieve in the 'real world' of CHD. It is clear that CHD with empowering and capacity building intentions takes time - suggested by some to be a minimum of two years for a community that has already begun the process of change and up to and five years if the community has not (Raeburn, 2001). This process needs to be supported by realistic funder and project time expectations.

Project and funding timelines can assist community groups by providing structure for programme planning, evaluation and partner collaboration. This could also have the opposite effect. That is, create tension, constrain action, hinder progress and

negatively affect the amount of community participation, especially if funder-driven project cycles are too short or do not allow for enough preparatory planning and community consultation. Batten and Holdaway's (2011) study found funder and project timelines influenced community participation/nonparticipation in a community garden project and its evaluation in New Zealand. In addition they evidenced the tensions and difficulties negotiating between 'top down' funder initiated programmes and 'bottom up' community empowerment when short project cycles did not allow time for the project to develop.

Batten and Holdaway's (2011) realistic account highlights the challenges and 'messiness' of initiating projects with community groups. Connecting with the rhythm and flow of the community realities ensures community participation in the project but this proved challenging for CHD workers in that study. Evaluation was not included in initial planning and consultation with the community. If it had been, it may have provided some initial structure to the whole process. In this project the level of participation of the community was affected by externally set project timelines; the length of time it took to achieve consensus; general seasonal changes which affected when and what planting could be started; and evaluation planning which was not considered till nine months into the project. By the time an evaluation plan which helped to shape the project was put in place, some people were already disheartened with how long it was taking to get the programme off the ground, others had lost interest and those who were left had the pressure of meeting deadlines in a short period of time. At the end of the programme, despite the community realising that the project had not achieved what it set out to do, they (the community) were confused that the funding was rolled over for another year. This shows that evaluation could have been supportive of community participation if it had been part of earlier project planning.

2.4.3 Partnership and collaboration.

The discussion earlier about 'top down' and 'bottom up' initiatives also relates to collaboration and partnership. In the absence of a 'parallel track', how much the communities are involved and participate in CHD initiatives falls along a continuum where, at one end, communities are minor contributors to the other end where

41

initiatives are community controlled (Minkler, 1997/2002; Morgan, 2001; Raeburn & Corbett, 2001; Trickett, RyersonEspino, & Hawe, 2011). The former involves actions that are more likely to be experienced as 'done' or 'consumed' by the community and the latter devolves the balance of power to the community (Raeburn & Corbett, 2001; Trickett et al., 2011). According to Raeburn and Corbett (2001), most CHD initiatives are found in-between these two points on the continuum, and are primarily under the control of professionals who see community participation as a strategy to achieve professionally prescribed and decided goals.

Having context specific or cultural specific evaluations has been seen as an appropriate approach in inter country studies to foster partnership and collaboration. The usefulness of results from these types of studies for others wanting to apply these findings in other contexts warrants further investigation. The experience of the *Pacific Obesity Prevention in Communities Project,* a collaborative project across four countries - Tonga, Fiji, New Zealand and Australia, involving academic researchers and local country representatives – reinforce the need for research planning and time management relevant to the country-specific context (Schultz et al., 2011). The prevention project did meet the objectives to build the research capacity of local people. However, in Fiji it was found that the researcher group had unrealistic expectations about how long it would take for the initial planning stage and to train local people to carry out research and evaluation (Schultz et al., 2011). Based on their experience, researchers also suggest backing up partnerships (including government partnerships) with formal signed agreements which outline a clear programme of work and responsibilities for each stakeholder at the beginning of the project.

Working in diverse community health development contexts can provide challenges and pressures which impact on participation, relationship building, and successful partnerships between agencies and the community. In fact, as Adams et al., (2009) outline, evaluation processes and evaluation designs need to fit the local context and accommodate the often diverse, complex and longer term objectives of CHD programmes. The evaluation plan in that project included formative, process and outcome evaluation and demonstrated how essential it was to involve

participatory consultation with all stakeholders in an action research cyclic loop of planning, action and reflection.

Participatory processes of consultation have value regardless of evaluation outcome (Adams et al., 2009). Adams and colleagues (2009) suggest that formative evaluation could be appropriate in CHD and other complex settings as this helps build community capacity to understand programme formulation, ensuring sustainability once programmes have been developed on a sure footing.

2.4.4 Capacity building.

One aspect of a strengths-based approach, as outlined earlier, is building community members' capacities to take charge of their own health. According to Raeburn et al., (2007), community capacity building, is strongly associated with empowerment. In practice, empowerment or capacity building extends to "… almost any activity in the community health promotion domain…" (Raeburn et al., 2007, p. 85). The use of the term 'community capacity building' springs from a philosophical starting point where people are viewed as resourceful (have assets and strengths). Hence left to their own devices, communities can drive the processes of their own development if assisted to build skills or competence in whatever they are trying to achieve (Raeburn et al., 2007).

Lovell et al., (2011) agree that these principles and values underpin health promotion but wished to understand the relevance of capacity building for health workers who carry out this work in the field. Even though Lovell and colleagues did not look at evaluation, they found that study participants considered community capacity building to be part of their everyday work as health promoters and "as a central tool for achieving health promotion goals and its principles" (Lovell et al., 2011, p. 537). Regardless, health promoters found it difficult to shift "to a socio-ecological model of health where the needs and expectations of communities may not be compatible with the goals of evidence -based health promotion" (Lovell et al., 2011, p. 538).

2.4.5 Empowerment.

Another aspect of a strength based approach is empowerment. Empowerment relates strongly to community capacity building, by promoting the value of social justice. As stated by Israel et al., "Empowerment in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations" (Israel, Checkoway, Schulz, & Zimmerman, 1994, p. 153). Essential for empowerment and community capacity building is a shift in the location of power from CHD agencies to community. Empowerment also requires a shift to a socio-ecological model rather than an evidence-based one as suggested earlier.

Empowerment and community capacity building, whether expressed directly or indirectly within CHD project goals, are longer term processes not easily reconciled or measured within projects that have a short project cycle. These gradual developmental processes, on average, take more than two years (Laverack & Labonte, 2000). While some CHD workers are reconciling their practice between 'top down' vs. 'bottom up' in day to day practice, using Laverack and Labonte's (2000) 'parallel track' offers some strategies for CHD providers caught between 'top down' agendas and 'bottom up' agendas to facilitate empowerment goals by negotiating this dichotomy at various stages of the programme cycle.

2.5. Concluding Comments

The focus of this literature review was confined to academic journals and gives one perspective of evaluation in CHD, albeit a rather narrow one. Narrow because, as mentioned earlier, only a small number of published reports about evaluation are reported in this space. Those that were reported were predominately concerned with biomedical outcomes and used experimental designs, with only a few evaluations seen to be for the purpose of assessing social outcomes. Could it be that it is hard to shift health sector funding to a socio-ecological model? Judging by the articles sourced, evaluation of CHD appears to be still located within a scientific biomedical model. Sites other than academic data bases would probably yield more evidence of community based initiatives.

The literature reviewed suggests that the ideal practice of CHD programmes is that these are planned by the funder and aim for collaboration or partnership with community groups. However, whether this resolves the issue of where power is located is debatable in the complex CHD reality. That is, after consultation with community groups have taken place, final decisions still rest with the CHD agency that holds the funds on behalf of the government agency.

Predominately the evaluations sourced could be described as evolving around one of Argyris and Schön's (1996) self-fulfilling 'single loops'; located in a deficit based frame. That is, problems are found, solutions are applied to the problem in terms of the programmes, and then evaluations provide evidence of how well these problems have been addressed. In light of the evidence, programmes may then be adjusted and applied again or a new solution is applied to an old perceived problem. This 'single loop' is rather a different framework from current theoretical perspectives adopted in this thesis which spring from a philosophical stance based on strengths-based and systems thinking which this research suggests are more suited to evaluation in CHD.

Evaluations that facilitate progression out of 'single loop' learning to 'double loop' learning must surely be happening in New Zealand; however rarely are they reported in academic data bases. Longer term, more powerful forms of CHD which aim to empower communities and build their capacity to take charge of their own health are not easily predicted, controlled or measured using more scientifically rigorous methods (Nutbeam, 1998a). While it has been suggested that mixed methods and a range of approaches are relevant for the evaluation of CHD programmes, it could also be that resultant tensions between scientific rigour and programmes with softer empowerment and capacity building goals are not easily reconciled.

Undoubtedly empowering approaches to evaluation are practiced in New Zealand. Working in partnership, or collaboration which truly includes community participants, is a challenge. It takes special people facilitation skills to negotiate diverse interests and also involves moving between funder and community groups. Lavarack and Labonte's (2000) parallel track is a framework that evaluators probably already use but could be a useful guide for health promotion workers. The parallel

track may provide some clarity for health workers and evaluators working in the CHD setting as to how they can facilitate both top down project cycle planning, while including and empowering and building the capacity at grassroots level.

CHAPTER 3: RESEARCH METHODOLOGY

This chapter outlines the methods and processes used in this study to explore evaluation in CHD settings in New Zealand. The following sections outline the research approach and rationale for this study; methodology and methods used; ethical considerations; a description of participant selection and data collection processes and participant demographics is explained. Finally, the interview process, data analysis procedures and study limitations are outlined. The research questions were: *What kinds of evaluation strategies are practiced in CHD contexts in New Zealand?* And *What are the elements of successful evaluation?*

3.1 Research Methodology

The researcher standpoint in this study was not one of an objective observer with a preconceived agenda of a rigid linear progression of steps, but one of creating partnerships in the investigative process. This reflexive stance is particularly appropriate for researchers working in New Zealand and honours the principles of partnership, participation and protection of the Treaty of Waitangi (Durie, 2001; Health Research Council of New Zealand, 2005; Hudson, Milne, Reynolds, Russell, & Smith, nd).

Qualitative inquiry has been seen to suit the complexity of a naturalistic setting requiring participatory engagement with those who have first-hand experience. Holloway and Wheeler (2004) suggest that "Qualitative research is a form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live" (p. 3). A qualitative approach using Appreciative Inquiry was used in this study to focus on successful evaluation experiences in order to answer the research questions.

In the 1980s, Cooperrider and Srivastva (1987) saw the potential for Appreciative Inquiry as an action research method to be a vehicle to foster social innovation and social transformation (Cooperrider & Srivastva, 1987). More recently, Neumann's (2009) study of *Appreciative Inquiry in Aotearoa New Zealand: Practitioner Perspectives* identified: "the point of AI [Appreciative Inquiry], is to elevate human beings to unlock their own potential" (Neumann, 2009, p. 115).

47

Appreciative Inquiry was chosen as an approach for this research because the philosophical framework and the process of inquiry employed supports the values of, and motivations for, CHD: participatory evaluation practice, and social betterment. These values are aligned with strengths approaches that focus on capacity and resourcefulness rather than lack and deficiency (Laverack & Labonte, 2000; Maser, 1997; Minkler, 1997/2002; Nash et al., 2005).

Processes of Appreciative Inquiry shift attention and action away from problem analysis to a climate which fuels imagination and innovation through success stories. Reflecting on these stories about strengths, resources and capabilities can then become the foundation for future personal and collective social transformation (Cooperrider & Whitney, 2005; Whitney & Trosten-Bloom, 2003). These approaches value people as the drivers of their own development.

Aligned with a constructivist approach where knowledge or 'truth' is considered to be co-constructed through participants' experiences and visions of future possibilities (Bellinger & Elliott, 2011), the Appreciative Inquiry process of change is narrative based. And although it is adapted to each unique environment, the process generally flows around a four stage cycle of activity often called the 4D model. The first stage, 'Discovery' (inquire), aims to uncover and value what is already present in the organisation/group. The second stage, 'Dream' (imagine), builds on what has been described in the 'Discovery' as a basis to imagine what it would be like to have this more often. The third stage, 'Design' (innovate), is where participants are asked to identify one of their success stories or dreams to use as a basis for the future. The fourth stage, 'Destiny' (implement), is where participants are encouraged to commit to what they explained in the design stage (Cooperrider & Srivastva, 1987; Whitney & Trosten-Bloom, 2003).

While there are numerous settings where an Appreciative Inquiry approach has been the method of choice, such as organisational settings, organisational development, and change management (see Cooperrider & Srivastva 1987), there are now other settings, such as health, agriculture, education, evaluation and many more where Appreciative Inquiry is employed (Bushe & Kassam, 2005; Hammond & Royal, 2001; Knibbs et al., 2010; Preskill, 2007; Watkins & Mohr, 2001). Some

examples of its application include Reed (2006),who used Appreciative Inquiry as a framework for exploring care for children with complex needs (Reed, 2006); and Hall who used Appreciative Inquiry in a youth centred development project in South Bronx in America (Hall, 2001).

New Zealand examples of use include *Hands across the Water: developing dialogue between stakeholders in the New Zealand biotechnology debate*; an initiative which used Appreciative Inquiry as one of the approaches to get various stakeholders in the biotechnology debate talking together (sponsored by the New Zealand Ministry of Research Science and Technology) (Cronin & Jackson, 2004; Neumann, 2009). Another example is a *Kaupapa Māori* analysis of Appreciative Inquiry by Cram (2010) which "highlighted the method's compatibility with Kaupapa Māori and its potential as a method for researching with whānau"(Cram, 2010, p. 11).

Appreciative Inquiry is usually used with groups of people. A review of the literature revealed no descriptions of practical guidelines for structuring Appreciative Inquiry research designs for individual semi structured interviews (Hammond & Royal, 2001; Reed, 2007). The findings of Neumann's (2009) study of *Appreciative Inquiry in New Zealand:Practictioner Perspectives* suggest that rather than focussing on the concrete applications of the model (4D cycle), there is cause to reconsider interpretations and applications of Appreciative Inquiry and embrace the underlying humanistic values (Neumann, 2009).

"The appreciative frame looks for ways to do more of what works" (Hammond & Royal, 2001, p. 176). The types of questions asked in Appreciative Inquiry can be transformational, as Boyd and Bright (2007) suggest: "every inquiry is an intervention, which means that the images embedded within the very questions we ask have enormous potential for unlocking, possible, actionable answers" (p. 1025). Therefore, by enquiring about successful evaluation experiences, it was hoped in this study to unlock answers through the interview question guide.

Appreciative Inquiry has been criticized for its focus on success at the expense of ignoring problems. Preskill and Catsambas (2006) refute this claim as, in their view, questioning from a positive framework supports participants to express

themselves fully, including what has not worked well. It was hoped in this study, that Appreciative Inquiry would reveal other insights, and discover unexpected or unintended information.

This study did not directly target Māori and Pacific people, however, it was expected that some of the participants would be Māori or Pacific because these groups are often the focus of CHD programmes. Wehipeihana, Davidson, McKegg and Shankear (2010) propose that engagement with Māori and Pacific cultures (by others) requires "deliberate, purposeful and responsive attention to culture and cultural context" (p. 188).

3.2 Research Method

Three sets of actors are considered: the funders, the programme providers and external evaluators. They are each important to the CHD process in different ways. Hence, clarifying the roles each play, and the interactions between them, can help us to better understand how evaluation is important for CHD and can provide insights in how to better utilize evaluation that supports the aims of CHD.

The Manukau region was chosen as a focus for this study firstly because the researcher lives in this area and is interested in examining how evaluation and CHD practice in her local area is building the capacity of communities and is empowering. Secondly, the South Auckland Manukau region is classified negatively in government health statistics, and in the NZ Deprivation Index, as one of the lowest socioeconomic area in New Zealand (see Appendix 7 for NZ Deprivation map). This means there is more likely to be a large pool of potential CHD initiatives which have been evaluated from which to select a sample. Thirdly, significant numbers of Māori and Pacific peoples live in these areas and could be involved in CHD initiatives and their evaluation. This means that if they are selected as research participants, the indigenous and Pasifika view will be included in the study.

This study aimed to investigate how funders, evaluators and CHD providers negotiate the dichotomy between 'top down' approaches to disease prevention and lifestyle change, with empowerment discourse and models for current CHD that have evolved in response to the Ottawa Charter. In particular, this study proposed to

understand the extent to which CHD evaluation practice matches what is espoused, what the current literature says about evaluation in this setting and how the practice reality is described by evaluators, CHD funders and providers.

Of particular interest was how the elements for successful evaluation described in theory are applied in practice.

3.2.1 Ethics.

Before any fieldwork was carried out, ethics approval was obtained from the Auckland University of Technology Ethics Committee (AUTEC) on 19 October 2011 (See Appendix A**).**

Throughout this research, consideration was given to the five core principles of ethical conduct outlined by Tolich and Davidson (2011): voluntary participation, do no harm, informed consent, avoid deceit, and anonymity or confidentiality.

Though this research did not target Māori or Pacific people, Māori and Pacific were recruited as participants. Mindful of 'doing no harm', the research design was aligned with guidelines suggested for Māori and Pacific health research outlined in Health Research Council publications (Health Research Council of New Zealand, 2005a; Hudson, Milne, Reynolds, Russell, & Smith, nd). The process of an Appreciative Inquiry methodology also supports the stance of 'doing no harm' as it encourages mutual respect and partnership between all those involved in the inquiry; appreciating strengths rather than searching for problems. The researcher is not assuming to be an expert, and the participants are not treated as experimental subjects.

The issue of anonymity or confidentiality is particularly challenging in New Zealand, which Tolich and Davidson (2011) suggest should be thought of as a small town. That is due to New Zealand's small size, descriptions of participants' programmes, employment status etc. may lead to them being identified by others. While all care was taken to protect the anonymity of participants, as the South Auckland CHD context is an even smaller subset of New Zealand, it means that some readers may think they identify participants or participant organisations. What

the researcher could guarantee participants is that their privacy and confidentiality would be respected.

3.2.2 Participants.

Participant selection criteria.

Participant selection criteria included: evaluators (external and community health funders, and providers who evaluate their own programmes) who prefer using participatory evaluation approaches; and evaluators who have completed evaluations of CHD initiatives in the last six months in the Manukau region. Participants' age, race, or gender were not considered to be relevant criteria for this study. Size of CHD providers was also not one of the criteria but it was hoped to get a range of age, race, gender and size of funding and provider organisational structures. Although length of time involved in evaluation is likely to influence evaluation practice, it was not initially included as one of the selection criteria. Fortunately all participants had been doing evaluation for over a year and had some experience, with one practising evaluation for over ten years.

Sampling/recruitment.

The plan was to have a sample of nine participants[16]: three evaluators, three programme providers and three funders to provide a representative sample of each group. With the expectation that evaluation practice of community health development initiatives may be influenced differently by whether the evaluator was 'external' and 'internal', including participants from both these locations was considered important. A pool of six evaluators, one funder and one programme provider, which met the above criteria were identified through professional networks, internet searches and personal contacts. Further participants were identified using snowballing sampling (Israel, Eng, Schulz, & Parker, 2005). That is, study participants were asked to suggest others who met the criteria of the study to be approached by the researcher.

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[16] The suggested number of interviewees suggested for Masters degree by AUT staff was six to eight in total.

Each participant was contacted first by email to introduce the researcher, the aims of the study and to invite them to be part of the study. In this initial email contact, a face to face meeting or phone call to discuss the proposed research further was offered.

Six evaluators were approached in this way with the following responses: one did not reply; one was unavailable, one initially agreed and had a phone meeting for one hour but withdrew before the interview when their work commitments increased. Three evaluators agreed to a phone discussion and then agreed to be part of the study.

One funder was approached as described above and a further three funders were identified through snowballing, internet searches and personal contacts with the following responses: two funders did not reply; one funder initially agreed but then was too busy to participate. The fourth funder was available. The researcher had an initial face to face meeting with this funder, followed by the formal interview.

One programme provider was approached as above, a further three were identified through snowballing, internet searches and personal contacts. Two agreed to a follow-up face to face meeting and, following this, agreed to be part of the study. One agreed through email contact to be part of the study.

The total participants recruited for the study was three evaluators, three programme providers, and one funder.

Demographics of Research Participants.

Three categories of participants were recruited for this study: three professional evaluators who evaluate CHD initiatives, one funder of CHD programmes, and three providers of CHD programmes. Selecting participants from these three 'groups' provided a fuller representation of the kinds of evaluation that is happening in community health development in New Zealand. Table 3.1 (page 52) shows the demographics of the research participants.

The funder and providers for review shared that they were predominately involved with programmes targeting Māori and Pacific people in South Auckland. These programmes focussed on knowledge, attitudes and behaviour change in efforts

to improve health and wellbeing, in line with CHD models. The funder and the three providers all evaluated programmes of this type which they were directly responsible for as programme managers or fund holders, though one of the providers contracted in external evaluators occasionally when time and money allowed. Two of the providers were Tongan, one ran initiatives for Tongan people; the other Tongan provider ran programmes open to all. The third provider was Pakeha, from a larger organisation. This provider had a team of CHD workers from different cultural backgrounds and ran programmes for Māori, Pacific, and other ethnic minorities predominately, but also ran programmes for all ethnicities.

Table 3.1 Demographics of Research Participants

	Age	Male	Female	Ethnicity	Years of practice	Employment
Evaluators	25-40	1	2	2 Māori 1 Pakeha	3-10+	1 Self employed 2 non-profit organisations
Providers	25-50	1	2	2 Pacific 1 Pakeha	2 +	Non-profit trust
Funder	25-30		1	1 Pakeha	2+	Governmental agency

All participants had been involved with evaluation in CHD. The three evaluator participants contracted to various organisations to carry out evaluation work in the Auckland region and other areas in New Zealand. Table 3.1 illustrates the demographic details of the participants. Two evaluators were Māori who worked with Māori initiatives; one evaluator was Pakeha and described working with a range of ethnic groups including Pacific people. Only one of the external evaluators described evaluation of a South Auckland initiative. Programmes evaluated by this group within CHD settings aimed to improve health and wellbeing and improve evaluative capacity of the organisations where they worked. As part of their professional practice these evaluators also evaluated in areas other than CHD.

3.3 Procedures

For this study, the researcher decided to lean more towards an approach of embracing the philosophy of Appreciative Inquiry of 'appreciating' and 'valuing' for the individual semi structured interviews – that is, based on a 4D model approach, rather than following the 4D model rigidly. This use of Appreciative Inquiry allowed more flexibility in the interview process with the three essentially different groups of evaluators, programme providers and the funder. Interview question guides are attached in Appendix E. These semi structured interview processes gave participants the freedom to respond to questions in whatever way they chose (Bowen & Martens, 2005; Wilson & Hunt, 2000).

Considering the ethnic backgrounds of the participants, the researcher sought mentoring from cultural advisors to guide these processes appropriately: Panetuku Rae for Māori (Tainui, Ngati Te Ata, Ngati Tiipa, Ngati Naho, Ngati Tamaoho) and Peggy Fairbairn-Dunlop for Pacific (Samoan). Both mentors were known to the researcher, are familiar with CHD and have understanding of the cultural reality of the South Auckland area.

Because of tight time frames and that few people were accessible for a pilot, the interview questions were peer reviewed and adjusted accordingly. However, the researcher adopted a flexible approach to the semi-structured interviews; shifting the interview schedule and questions if this became necessary as the interviews progressed. Only minor changes were made during the interview as necessary, such as the order in which questions were asked or sometimes an irrelevant question was omitted.

Two weeks prior to the interview, participants were emailed the participant information sheet, the consent form and a sample of indicative research questions, so that participants had some written information on which to base their consent; and so the questions could initiate reflection about successful experiences prior to the interview.

Participants were provided with written consent forms, information sheets and a copy of interview questions again at the time of interview. Copies of these documents appear in Appendices B, C and D. Verbal explanations about the

research and the consent process were carried out before beginning interviews. The researcher assured participants that their privacy, confidentiality and anonymity would be maintained at all times. They were also advised that they could stop the interview or withdraw from the research at any time. Following these discussions the consent forms were signed. Interviews were carried out at a place of participants' choice and lasted, on average, approximately one hour; six interviews were at the participant's workplace and one at a nearby café. Interviews were all digitally recorded as agreed by participants.

Appreciative Inquiry 4D processes as described earlier were used as the framework for interview questions for the one on one interviews with evaluators, programme provider staff and the funder as a foundation for sharing positive experiences. All interviews were digitally recorded by the interviewer.

3.4 Data Analysis

Digital recordings from the interviews were first transferred as a media software file to the computer and transcribed by the researcher into Microsoft Office Word 7 TM. This process helped to familiarise the researcher with the responses. Following transcripts were emailed to the participants for verification and alterations, as agreed in the interview process. Following participant amendments where necessary, data analysis processes to identify themes began. Data was put into a database and coding focussed on answering the research questions while being open to other ideas that became apparent in the process. There was value in having participant-identified themes. Data analysis included manually coding and sorting themes using post it notes; review of participant identified themes and rereading transcribed notes at various times to check themes identified.

Although it takes considerable skill to conduct semi structured interviews and this was challenging, Appreciative Inquiry proved to fit well with the research questions and the epistemology of the study.

CHAPTER 4: FINDINGS

This chapter presents the findings from the semi-structured interviews carried out with three evaluators, three programme providers and one funder about their experiences and practices of evaluation in CHD settings in New Zealand.

The findings are presented in three sections. First, there is a representation of how the participant groups describe evaluation approaches, purposes and methods used in their practice of evaluation in CHD. Second, participant descriptions of what they saw to be the elements of successful evaluation are outlined. These indicate the priority these participants placed on the elements of partnership, participation and relationships in CHD evaluation. The third section discusses the influences the funding environment, political and economic factors have on evaluation practice in CHD in New Zealand.

A total of seven participants who all evaluate community health development were involved in this study. They included: three evaluators, three programme providers and a funder. Details of their demographic characteristics and professional affiliations are outlined in Chapter Three.

Section 4.1: Evaluation Approaches, Purposes and Methods Used

4.1.1 What kind of evaluation is practiced in New Zealand Community Health Development settings?

This section includes findings about evaluation approaches used – the philosophical values informing evaluation; evaluation purpose; and evaluation methods described by study participants. The findings from evaluators (E), providers (PP) and the funder (F) are presented separately for each of the sections.

Evaluator evaluation approaches (E).

Participatory evaluation approaches were used by all evaluators. One evaluator related this to the cultural and social uniqueness of New Zealand compared to larger countries such as America.

He suggested that:

> *"...New Zealand evaluators are quite innovative... because we have got some quite unique circumstances..." (E3).*

Two Maori evaluators explained the relevance of New Zealand history, the Treaty of Waitangi and how these informed their personal values to their chosen approaches:

> *"... recognition of the Treaty,...that has sort of an impact on... the ways that we work...." (E3).*

Of the seven participants, only these two evaluators mentioned the Treaty of Waitangi as important to their work.

One evaluator (E1) directly named a number of participatory evaluation approaches from evaluation theory. These were participatory evaluation, developmental evaluation, transformative evaluation and Appreciative Inquiry. Another evaluator described her approach to evaluation as like "walking the journey" with the community:

> *"...we walk the journey ... we support them quite extensively to understand evaluation and evaluation processes and the purpose and methods of evaluation..." (E2).*

All three evaluators were in agreement that it was important to be able to work alongside people and respect local knowledge motivation and desires or to facilitate capacity building. One: stated

> *"I rely heavily on people's perceptions and views on things...cause I think what people think drives their action and behaviour so that produces change in the world..." (E1).*

Further E2 stated that it is important for her to work in ways which do not harm:

> *"...we practice evaluation... that does no harm, that's a big factor when you go into Māori communities... not only do we not practice evaluation that is harmful, we practice evaluation that contributes to the capacity of the community...and my colleagues practice evaluation is to empower, it's to empower the people that we are working with ..." (E2).*

At the same time, E1 was critical about the overemphasis on participatory evaluation approaches as the approach of choice because sometimes participatory

approaches may not be relevant for all projects or be of benefit for the community involved:

> *"...sometimes I think some projects go on about participatory evaluation when it's not actually needed for the goals of that project and it's just a trendy thing at the moment. You have to look carefully at what you are trying to achieve... if you are trying to build... help support a community organisation to... be more sustainable as an organisation, help them become evaluative in their thinking ...that's one thing and if you're trying to do a project in a community setting whether it involves street barbeques or whatever it is ....what are you trying to achieve through engaging people in evaluation? I think you need to ask that question is it worthwhile for them? ... what would be worthwhile for them...?" (E1).*

Provider evaluation approaches (P).

Unlike the three evaluators who perceived that CHD evaluation should involve empowerment, capacity building and partnership with local communities, providers approached evaluation with the purposes of measuring the outcomes of the programme and providing evidence for improving service delivery; and reporting for accountability purposes to satisfy the funder. Hence for this group, building community capacity for evaluation could be a second priority after funder compliance and programme improvement.

PP1 saw that participatory types of evaluation where the evaluator is involved with the community (that were described by E1 and E2) as being more aligned to research and 'not appropriate' for evaluation of a programme:

> *"... Anything that you do has an impact and it may not be the impact that you had planned you would hope that your evaluation would reinforce in a positive way what people have got from the programme but that's not your aim in evaluating the programme.... I mean some of your more specific research practices where there is more participation where the researcher is involved well that's intervention stuff and that has its own philosophies behind it. Specific evaluation of a programme comes out with a result hopefully did the programme work and evaluation of the evaluation might tell you more about whether that reinforced it..." (PP1).*

All providers strongly suggested that those in programme leadership roles need to keep in mind what type of evaluation was required by the funder. In PP1's view, the funder therefore drives the decisions about which evaluation types ought to be used.

Funder evaluation approach (F).

The funder described their evaluation approach as funder prescribed - where programme providers were expected to report on funder-identified programme objectives and outcomes:

> *"...We give our funding recipients reporting templates ... on those templates are kind of a set of predetermined questions that the our organization has come up with ...the community group is required to kind of fit... the evaluation of their programme into those questions or into the confines of those questions..." (F1).*

At the same time, when this funder became aware that their prescriptive approach did not work, F1 established new ways of collaboration, working together with communities at the outset of a project to define measures of success:

> *"... it's a good learning curve for our organization because we need to be more responsive to what our communities want and how they perceive things to be, so there needs to be a willingness on our part to allow that to happen...I think that's really the main thing, getting the group involved... getting them defining their own measures of success..." (F1).*

These findings suggest that funders may be willing to be flexible to accommodate community voices and aspirations in their evaluation projects and processes.

4.1.2 Purposes of evaluation in community health development.

Evaluator evaluation purposes (E).

Evaluators described evaluation purposes as moving a project forward, and building the capacity of providers and community groups to ensure the sustainability of evaluative processes and CHD initiatives:

> *"...the process of evaluation that you are using...you want it to be beneficial for the people involved, you want them to get something out of it, but also if you do it well, it can actually move a project forward or have a transformative effect on the people and also the wider project ..." (E1).*

E1 believed that they practiced transformative and developmental evaluation. Moreover, E2, a Māori evaluator, consistently related the purpose and practice of evaluation as closely linked to the purpose of building the capacity within an

organisation to enhance the sustainability of projects through building robust systems, processes and procedures as well as building organisational infrastructure:

> *"...I've been sort of focused on, building sustainability through good, robust systems and processes and procedures and helping to build their infrastructure and stuff like reporting and risk management strategies ...and being able to do their own little evaluations and make sure they are reviewing their needs assessments you know making sure that the programme, the services they are delivering are still meeting the needs..." (E2).*

Unlike the other two evaluators, E3 described how the purpose of the evaluation for the non-profit organization he was working with, was to validate the programme outcomes to attract funding from other sources. E3 however indicated the influence of the current government had gone back to focussing on problems and was based on deficit models.

Evaluation purpose, therefore, depended on the vision of the funder. The preference for evidence based practice by funders also strongly related to what evaluation was considered appropriate by the funder impacting on what type of evaluation was expected:

> *"...government stuff...[they think] there is no evidence base for this so we can't fund that' and they are always thinking... they could get in trouble for this and that.... which means.... at the end of the day they are just doing the same old same old and evaluating the same old same old because they don't want to get out of the box..." (E3).*

Provider evaluation purposes (P).

Compared to evaluators, providers emphasized process and outcome evaluation for programme improvement and accountability. PP1 referred to evaluation designs that had been adapted to suit the purpose of the evaluation. For example PP1 considered process evaluation in the CHD context as relevant to validate programme design and delivery for external audiences in order to secure and attract more funding. PP2 also used process evaluation for an annual review to ensure quality of the programme and to *"...make a difference in our community..."* in promoting the communities health and wellbeing.

PP2 and PP3 also described the purpose of evaluation as outcome evaluation, to measure physical improvements achieved by participants such as; 1) individual

achievement (weight loss); 2) the promotion of a healthy lifestyle; and 3) a means to ensuring the programmes were financially resourced:

> *"... one is evaluation of the participants themselves and in that essentially our philosophy is that ...they're coming to us ...for us to help them to improve either their lifestyle, or their health or other sort of associated factors in terms of healthy living..." (PP2).*

Ensuring and attracting funding are often mentioned as the 'key' reason to do either outcome or process evaluation. PP1 explained that from a *"... wider perspective evaluation is... a way of justifying the funding".* Likewise evaluations need to be conducted at different stages of the programme, before, during and after the programme is completed.

It was clear that some frustrations and tensions were likely to happen when there were differences of ideas of how to measure "success" between the funder and programme providers qualitatively or quantitatively:

> *"...the qualitative stuff is fine its fantastic often it's the quantitative things that are probably getting in the way a little bit because the measures that our programme utilises are not necessarily the measures that they [the funder] are wanting to tick off..." (PP2).*

Funder evaluation purpose (F).

The funder was interested in evaluation outcomes that evidenced tangible changes in participants' knowledge, attitude, and individual behaviour which promoted healthy lifestyles.

4.1.3 Evaluation methods.

E1 described that as part of developing evaluation skills with the group, they identified the logical basis for the programme by following through, from short term to long term, outcomes in relation to the community's goals which reflected the values of the group (programme logic modelling).

This process was carried out over a period of time:

> *"... The processes that we used ....we used a kind of logic modelling approach ...ask people to look at the values underpinning what they're doing ...so I try to surface the values behind the project..." (E1).*

E1 described how they built evaluative thinking with clients, engendering more participation of stakeholders in the evaluation processes itself. They used different methods to measure success in efforts to shift evaluation away from a traditional compliance approach:

> *"...we are just trying to build the kind of reflective practice in that department and come up with some more interesting ways to measure effectiveness and to see what's going on ... that's trying to shift people away from that kind of compliance approach to evaluation ... getting groups involved in doing the evaluation themselves..." (E1).*

A wide variety of examples of evaluation methods were described by evaluators, providers and funders. These included using photo essays, focus group discussions, observation, games (when working with younger groups), structured and semi-structured surveys, and observations. Most participants in the research were looking for more creative and appropriate methods to gather data, relevant to the context, as they found this captured more about the success of the programmes:

> *"...we are encouraging groups more to submit photos and to speak to our communications person to try and come up with like a media story to demonstrate what they are doing in another way..." (F1).*

In F1's view, the lack of knowledge and skills for evaluation meant most projects used a standard prescribed format using rigid frameworks:

> *"...because people don't always know how to do it.... that's the sense that I get ....we look for quite, kind of rigid frameworks to use in the absence of anything else ..." (F1).*

PP3 believed evaluators must be flexible in their approach and methods used in the evaluation, understand what the evaluation was for, use language appropriate for programme participants, and provide an environment which enabled evaluation participants to participate:

> *"...the person who [is] leading the project has to understand the evaluation and being part of that and make it easier for people to think of it.... I'm not saying to people we need to evaluate this I say ...your feedback is valued because we need that to help this one so it is a kind of give and take..." (PP3).*

Participation was a common thread in research participants' description of the kinds of evaluation that they practiced. It is obvious with the evaluation methods described that evaluators, providers and funders were aiming to engage with

programme participants to understand more about the programme. Evaluators and the funder were also considering participatory evaluation methods as ways of building community capacity for evaluation and to ensure programme sustainability. Participation is a term that implies many levels of engagement and is closely related to the chosen evaluation approaches and purposes as well as personal values and motivations of all the stakeholders.

Section 4.2: Elements of Successful Evaluation

The questions about the elements of successful evaluation revealed participants' motivations and values which informed their practice of evaluation. Evaluator motivations and values were linked to social change, empowerment, community capacity building, accountability and lesson learning. These emerged as determinants of how successful evaluation was viewed. Other identified elements considered necessary for successful evaluation were professional expertise, flexibility and the ability to balance funder and community expectations.

4.2.1 Personal motivation, philosophies and values.

Evaluators (E).

All three evaluators, said that in most situations, have had the power and opportunities to practise evaluation which aligned with their personal philosophies and values. They all agreed that the important elements of successful evaluation were building trust, having integrity, honesty and openness, and creating a learning environment. Evaluators believed that influencing social change and building local capacities were key goals in CHD activities.

Two evaluators believed in the promotion of social change and community based capacity building beyond compliance types of evaluation. E3 may have had these views but they were not expressed directly in the interview.

E2 describes how:

> *"...we practice evaluation that contributes to the capacity of the community ... part of the process will be about supporting those communities or groups to identify what would be...of maximum benefit for them to learn or take up... through the experience of us delivering evaluation..." (E2).*

Further, empowerment and building evaluation capacity would ensure evaluation was sustainable within the organization once the evaluator finished his/her contract.

> *"...it's to empower the people that we are working with, it's to build their capacity to share the skills, and knowledge and tools and techniques so that they can try to utilise them on-goingly, you know, after we have gone, so that they are building these evaluation, well building evaluation knowledge, building evaluation practice and embedding it in their own organisations as part of their normal everyday practice... I'm talking about real simple basic evaluation tools and techniques... nothing major..." (E2).*

E2 considered that building skills and knowledge helped community groups to be clear about the purpose and rationale of service delivery, current community needs and contractual requirements were described as building integrity:

> *"... know why and how what you are doing is still relevant. One of the best ways to be confident in what you are doing is to know why you are doing it. Don't just keep doing it because you are contracted to ...do it because there is a need and you are abreast of those needs and you are reporting on them you are reporting on the changes and the shifts...you can't do that without evaluation ...if you want to keep stakeholder buy in strong, you need integrity so you need to be building your integrity all the time, because really that's your bread and butter, your integrity..." (E2).*

Likewise, respecting peoples' values, ways of thinking, self-determination and motivations was also seen as a key to successful evaluative processes. E2 for example believed that:

> *"...People contribute when they believe that they are valued and what they have to contribute is valued, I don't think you can overdo that..." (E2).*

Further, E2 said, that honesty, openness, good communication, integrity and trust were the basis to building a common interest to change a situation or "improve a situation" and ought to reflect authenticity and a genuine intention to build trusting and respectful relationships between evaluators and communities.

E1 also identified that positive or strengths-based approaches were important elements:

"..authenticity and genuineness about the desire for change…" (E1).

All participants valued a learning environment which enabled the groups they were working with to identify and reflect on challenges. Successful evaluation was described as not how well the evaluated initiative was carried out, rather how well the groups reflected on challenges and learnt from these:

> *"…you know successes are one thing ….but it's the failures really …. that's the real learning … what went wrong, why did it go wrong, what were some of the strategies that you considered, why did you consider them, what did you end up doing, and what was the outcome, what was the result, what, afterwards upon reflection, could you have done better or differently, you know, if you had done some minor adjustment could you have had an even better outcome, and those are the things that people tend not to reflect on, or don't have time to… really. People tend to be focussed on, if they are at all… on the successes and the really good outcomes which is great but… and it's really hard to get people to highlight the failures and the challenges and the issues because … it's human nature to see that as a weakness or scary, not as a potential not as a learning opportunity or as something of real potential value, not just to others but to the organisation…" (E2).*

Providers (P.).

Successful evaluation was described by providers in a number of ways including providing a quality service, having a funder who was interested in the same objectives, and good professional and leadership skills. Providers, like evaluators, also recognised that successful evaluation also meant learning about what hadn't worked as a way to improve programme design and delivery.

Compared to the three evaluators, providers may have less flexibility in the formulation of their project and evaluation processes: processes are typically tied to contractual obligations with funders. However, PP2 valued getting the quality of service, programme development, delivery and pre developed assessment tools 'right' for themselves and their purposes:

> *"…from our point of view its …we want to get the quality of service right first…we have confidence really that what we are saying and what we are doing is something of a high quality and something of a high standard…" (PP2).*

PP2 described how their programme had arisen from a community initiative; a 'bottom up' initiative. Then, by formalising their systems, they had been able to hook into funding. This was a difference between this provider and the other providers in the study, who had all developed programmes in line with funders' expectations. A key point here was that funding can change the impetus of how a programme is structured and delivered:

> "...we put processes in place ...it wasn't driven by funding and I think if it had been the other way around where we found out that there was some funding we would have as is usually the case we would have tried to structure something so we could get the money but we were fortunate enough at least that we were doing something that was attractive to funders..." (PP2).

PP2 and PP3, both Pacific providers, talked about how their professional expertise and skills were of benefit in ensuring successful community projects and evaluation processes:

> "... I think for any project if you do health projects...like if it's a nutrition one, your expertise will always be respected and expected to drive[n] it ....your values that you add into it is highly valued by the people ...health expertise... your skills and work experience from what you do kind of link in for these work ..." (PP3).

Programme providers believed it was important that good leadership skills were embedded in the project management and programme evaluation. However, one Pacific provider working with her community found this added more demands added to her project management role, as there were limited capacities in her team to carry out evaluation:

> "... but it's always that I think the leadership and the people who manage the project is always the key one. There is so much that you want to do, and you know you can do it, but whether you have the time to manage that, and if you delegate works for people to do and you come back to evaluate those kind of things that hasn't really have a defined process for people to go through..." (PP3).

PP2 described that funders and providers having a shared vision about CHD was seen to be an element which contributed to successful relationships and successful evaluation:

> "One of the good strengths about the teams that we are dealing with [with]the funder is that they do have a very community focus in the way that they do it and because our approach is very similar we haven't sort of had clashes -where there is a clash of values in the sense .That we are not assessing something based on a business plan or business model you are

assessing something in terms of community effectiveness.. So I've found in our conversations in our discussions with the funder they've been very very good to talk with… We are on the same page and also it is very clear as to what their expectations are in terms of the qualitative results of the programme" (PP2).

PP3, who was also of Pasifika descent, described that when working with her own community, she was able to locate herself within that community. The deeper responsibility felt by educated Pacific providers to their own communities was also clearly evident. This suggests that Pacific providers carry a greater responsibility than providers or evaluators who may not be connected culturally with the community they work with:

> *"...when you work with a Pacific community…there's a big difference between you as part of the community and you coming in as the guest speakers.... I always say to people as a Pacific person working with Pacific people sometimes my role is more like not only as an professional or an academic but also this is the ground level of the people I deal with …" (PP3).*

PP1 described the motivation for evaluation in terms of pragmatic reasons; *"...you are justifying money that you are given…"* to satisfy the funder with a 'top down' approach. This had proven successful, as evaluative evidence provided to the funder meant the programme was more likely to have continued funding. On the other hand, PP2 felt that some groups who received funding were not always held as accountable as they could be for the social and economic outcomes of the project:

> *"...For us so we'll do it, while there is a level of accountability in terms of reporting…this is tax payer money… that if we are using that money then we should be giving value for money and but also making a difference with it…"*
> *(PP2).*

All three providers agreed that their motivations for evaluation were because it was fundamental to the success of their work at an organizational level. In addition, PP1 said that evaluation should be an integral part of project design, management and planning allowing organisations to *"… review what we are doing so we can make changes.* Also, PP1 considered that evaluation could measure various aspects of the project:*"….often it's not just at the end measuring..."* but should take place before, during and after the project implementation.

In line with evaluator comments, PP1 also framed success in terms of projects and evaluations allowing opportunities to learn and facilitate future improvement:

> *"... successful evaluation can also show that it wasn't [successful] and I'm just as keen on knowing that something is not working as something that is ..." (PP1).*

Funder (F).

Although there was a strong indication that organisations must comply with prescribed reporting templates, the funder said that, on reflection, project success needed to be identified together with the community group. Thus the funder was caught between the desire to do things differently by being more responsive to community group needs, and being accountable to what their funder was expecting as described above:

> *"...we are giving you x amount of money how can we work out what is going to be a measure of success together... we'd said to them here's a report template so you need to fit it into our definition of success, I guess. So... when that sort of became apparent and that was at the end of the process when we'd received the reports it was an opportunity for us to sit down with the provider and say well what are some of the other changes that you've seen that you think show that this programme has been a success and also how could we if we were doing this again how could we make it easier for you to demonstrate that to us so, I guess it was just a case of needing to be more flexible...." (F1).*

The dilemma faced by the funder was also noted by one of the providers, PP1:

> *"...so because its inflexible in terms of we can't adjust it ... and that's what I mean about there is a dilemma for the funder I understand that they are stuck in a quandary in terms of they themselves are accountable for ticking off the right boxes to a government body and whoever else..." (PP2).*

4.2.2 Elements of Success in Practice.

As noted, participants outlined that they saw relationships, participation and partnership to be elements of successful evaluation.

Relationships.

Relationships were given high importance by evaluator participants. The ability to build and maintain relationships between people was seen to be one of the crucial

elements of successful evaluation. Relationships were described by a Māori evaluator:

> "...in the Māori context ...we have quite close a working relationship with the different levels... particularly with the Māori provider there its very close knit so everybody knows what everyone else is doing ...that's its one big organism, I suppose so I'm working at all levels all the time so you have the higher level management you've got the programme manager you have got the participants, you've got the stakeholders we are working with everybody..." (E3).

Relationships with others in the rest of the world was a concept that one evaluator thought was important for local community groups to consider as an impetus; that they should value and report well on their work, not just for themselves but as a service to others.

Evaluators and relationships.

E1 and E2, who used participatory evaluation approaches, perceived that genuine and safe relationships between the various people in the project itself are elements which impact on successful evaluation practice:

> "...Relationships are everything...effective relationships ... a huge focus is placed on developing and maintaining and protecting relationships...it's so critical, without relationships there is nothing..." (E2).

> "... and this kind of evaluation.... makes explicit that its actually people that drive things, and the dynamics within and among people... so how you can actually acknowledge those things in a way that is safe for everyone and constructive is key to good evaluation..." (E1).

E2 identified the supportive relationship she had with the project manager and staff that extended beyond scheduled meetings, as providing benefits for all:

> "... I have a totally open door policy for the project manager and her staff and just for them to be told that by me just really helps them emotionally ... Like I said it's all about the relationship and it has to be an authentic relationship ..." (E2).

E3 described the role of evaluation that includes participants' voices as being of positive benefit to the participants, giving them a chance to reflect on their experiences. This means that the evaluator has a relationship with the participants:

> "... I think for the participants ... it's a learning process for them as well through the reflection...they've lived the change but they haven't really

70

thought about it so it's giving them an opportunity to do that, and the space in which to do that as well, ... that chance to talk there is something about that opportunity for them to share their experiences there's something special about that as well ..." (E3).

Further, E2 outlined the role of evaluation, where good data has been captured, as not just of benefit to the participants on the programme but that the learning generated from the evaluation could make a contribution to others in the world:

"...evaluation is a mechanism ...for sharing...because my experience is unique...and it's the uniqueness that is the value ...so when I work with people I encourage them to be really quite purposeful when they are gathering data , and how they capture it, how they write it, how they use it, how they disseminate information, because they are the only ones doing what they are doing at that particular time, that moment... and it's really important that they understand that what they are doing ...has value, huge, unimaginable value for someone else, somewhere else, who might want to be doing what they are doing or who could actually benefit in some way by what they are doing ..., and once a moment is gone, it is gone... so yea it's really important to capture good data , capture you know, interesting learnings, new learnings and especially challenges and what you did to overcome that, what you did to address that..." (E2).

In addition, E2 identified that this view of evaluation placed individual experiences within a global context, and put individuals in touch with a wider vision of the impact of their small programmes:

"... I like helping people to see themselves in a global context, because that's not something people do is it ...we don't actually look at ourselves and what we do in terms of what role it plays in the world and what role it could potentially play in the world ..." (E2).

Evaluator E2 discussed the importance of having good relationships with her community by knowing you have a representative community sample to inform project staff and evaluators:

"...when you are working in the community you need a really good panel, ... or group of community people who are going to give you the best insight into those communities because your project manager that you are working with, or whoever you are working with, they are only one tiny perspective...and you really need as broad as possible community perspective..." (E2).

Collegial relationships with peers were also identified as key elements to successful practice:

"... I think it's really important that we utilise our peers.... I utilise my peers and my peers utilise me... you need peers that you can trust for really good problem solving..." (E2).

Providers and relationships (P).

PP2 described evaluation as a relationship; a relationship between provider and funder and what was happening in their programme. This relationship could have a positive or negative effect:

> *"... we regard evaluation as one of two things; one is it's a relationship ...you need to be able to give feedback; evaluation is a tool to use in terms of assessing just where you are at... and if it's done well and if it's done in an environment that's about being constructive, then I think evaluation can be very important. I think where evaluation becomes negative is when there's a level of distrust... then there's an inability to receive feedback and also an inability to give proper feedback and that's very difficult yeah and a bit counterproductive ..." (PP2).*

As described by the evaluators in the previous section, PP2 also recognized the need for good relationships. These relationships were nurtured by regular contact with the funder to ensure that providers were on track and could achieve the outcomes desired and it was found these regular meetings have a positive effect.

> *"... the relationships stuff is really really important because normally what would happen is you are expected to report back on a 6 month and a 12 month basis a lot can happen in that period of time and things can go wrong and things can go a lot better than expected so I think it's important that there is that regular feedback regular conversation taking place ... instead of us having to chase them to sort of have a meeting and talk about the programme...they have regularly come through and had a chat to us and then asked questions about how we are going and stuff and it's not them checking up or are you doing a good job or not, it's actually just saying look we are here to help do you have any questions would you like to just go through what you are doing anyway ..." (PP2).*

Relationships with funders.

PP2 discussed the value and importance of getting feedback from funders so they could improve what they were doing:

> *"...they do an evaluation of us, and their evaluations are kept separate from our understanding of it.... other than just occasional feedback ...we don't really know how they are evaluating us in terms of just the detail things, ...I think it is important that they get proper feedback in terms of how well they are doing and what things, whether... what they could improve on ..." (PP2).*

Participation.

Though all participants discussed evaluation that involved participation, there were different understandings and a range of ways participation was applied in practice by

the three groups: evaluators, programme providers and the funder. Two of the evaluators' philosophical values of social betterment and empowerment clearly supported participatory evaluation approaches to support community providers in planning and evaluating their own programmes; equipping them with the necessary knowledge, skills and tools to increasingly take ownership of initiatives; securing and maintaining funding; and ensure sustainability of the programme.

Programme providers described participation in relation to the use of participatory evaluation data gathering methods to obtain information from participants about the programme effectiveness and outcomes. Participation in this latter scenario was therefore more a method to extract information about programme outcomes, rather than involving community groups in building their capacity. The funder aimed to involve programme providers more in the programme planning and evaluation design on the one hand, but on the other hand was expecting certain outcomes to be met to satisfy funder accountability.

Partnership.

E1 identified the importance of community involvement in the evaluation process rather than communities having evaluation 'done' to them:

> *"... and more of the sitting alongside people in community settings helping them work through.... starting off with what they are all about because if you can pin evaluation.... which it needs to be pinned to this is.... what they're passionate about... what they're there for...how are you going to know you are getting there ?and how are you going to get there?, if you can punch it all around that ....then people say o yea yea... we need this, and then it becomes something that they want to do ....rather than you know... something that they have to do or other people come and do to them..." (E1).*

E3 identified that for a change in the evaluation expectations, there was a need for changes at government level about what programmes are initiated, what they are prepared to fund, and the types of evaluation that is then expected:

> *"... it needs to go back to the top people really it has to start at the top there needs to be some major policy changes and particularly around the sort of evaluation that they will fund ...a bit more scoping stuff and have a little bit more flexibility around sort of exploring new spaces..." (E3).*

Reframing ideas about compliance-type evaluation practices through training and exposure to good evaluators and resourcing evaluation was also identified by E1:

> *"...clearer understanding of the value of evaluation ... drumming up ... interest to evaluate and the understanding of why it's important to evaluate ... more exposure to people who are good evaluators... not just the traditional kind...there is room for more training around good evaluation practice ... involving communities more in the actual doing of evaluation and resourcing..." (E1).*

Providers considered it was important to be responsive to participant needs in evaluative processes as described by PP1:

> *"...sometimes conventional evaluation isn't measuring what you actually want to know... As far as the participant goes you have got things like culture , you've got language, you've got learning style slash communication style, you've got lots of status issues .... and it takes a while and you don't always get it right to figure out what relative positions people are in a room and it can be important for some groups..." (PP1).*

The funder showed interest in spending time to partner with providers in programme design delivery and evaluation:

> *"...time more time face to face... and sort of able to think outside the square...not imposing your own view/ standards...negotiating between funder and provider... flexibility....just time invested in the provider..." (F1).*
> *"...community participation, community ownership, I want to say responsiveness I mean sort ...with our organization to the community, flexibility, planning or being prepared to think about evaluation from the beginning, being realistic I think is another one..." (F1).*

The last word from the funder shows appreciation for building providers' capacity to think evaluatively, as they know what is best for their communities, because:

> *"...I think that in turn will assist them to get more funding from government organisations and high level organisations that require that kind of thinking to a degree ..." (F1).*

E1's word sums up this section very well:

> *"...I think you know you are doing it right, when people are lighting up ...they're energised rather than bored or deflated... I think evaluation gets a bad rap that it's just really boring and dry because people have all that baggage around it... that compliance stuff... "(E1).*

74

Section 4.3: Factors Influencing Evaluation Practice: the Politics and Economic Nature of Evaluation

4.3.1 Political environment.

All evaluators, programme providers and the funder agreed that their evaluation practice success was dependent on external factors. Two of these influences were the political and funding environment.

Evaluators – political influences and funding.

Evaluators felt that political and funder motivations influenced the way that programmes were often initially designed and implemented. They reported that sometimes this happened without adequate consultation with community groups or without much thought about the link between the programme and the expected outcomes. They said that often programme design and the outcomes expected are unrealistic or not possible within given timeframes or budgets. It then became challenging for programme leaders and evaluators to successfully evaluate outcomes which the programme was unlikely to achieve. Therefore, evaluation expected by the funder might not necessarily match the programme outcomes. Clearly without knowing how success is going to be measured it is difficult to do an evaluation.

Another evaluator described the contracting environment and how this had set up competition between providers. E3 called this a siloised climate, and that a more collaborative approach was needed amongst providers:

> *"... it's just such a siloised climate and we are trying to find the way out of that into a much more integrated holistic climate and environment with integrated and high trust contracts but you know, over the last 10, 20, or even 30 years, siloism has really become quite deeply entrenched, and ...the resources are so limited, it's inevitable that people are going to be highly competitive and highly possessive and highly protective ....and reluctant and resistant to sharing and collaborating... there's a major tension still and I'm working with a large number of providers – there's a lot of anxiety around funding you know, especially with this government ..... I really think.....that past administrations have got a lot to answer for, because providers only operate the way that they are allowed or expected to ...you know... they are only as accountable as they have been asked to be, to be fair...so change can be really hard after 2- 3 decades of operating in a certain way..." (E2).*

Providers – political influences and funding.

All providers expressed similar concerns about funding as E2. Evidence based practice is an important criterion for providers who wish to receive government funding, however PP1 considered that this lowered the level of project evaluation that may have been expected by funders:

> *"... did the programme actually work, did it run, did it actually work is something else altogether ...but a lot of these projects are set up in the initial planning they are set up based on best literature and best practice so theoretically someone else has validated what you are going to do already which is probably how you get away from doing evaluation yourself necessarily because its meant to be set up on something that is already legitimised..." (PP1).*

4.3.2 Funding environments.

Evaluators – funding environments.

The funder was seen as important by all research participants, yet the difference in the 'thinking' of the non-government funder and government funding and the types of interventions that they were prepared to fund was noted by E3 and E1 in the following two extracts:

> *"...and all the programmes [of the non-profit funder] were very innovative you know and so you know trying to do things in a different way because sometimes when you are working with certain departments they are not very innovative at all and actually they don't want innovation they just want to maintain that status quo and to a certain point they are scared of innovation because they see it as a risk you know and that was the great thing with x organisation they were in the position because it was their money to take a risk and that's one thing the government won't do they won't take a risk..." (E3).*

The evaluators maintained that non-government community funders were more likely to be focused on capacity building and funded more community-inclusive forms of evaluation. E1 gave an example of a community group that had received assistance to develop a funding application:

> *"...They had to develop a business plan to get some funding from the community funder and within that they had to do an evaluation plan ...so they had to look at their work and see how they were going to evaluate this ...to support them to become evaluators and get evaluative thinking in what they do...." (E1).*

Working with funders was therefore seen to be essential yet challenging. Some of the challenges faced by community groups with funders were identified by E1. E1 said that project criteria were set by funders without much thought for…

> *"...what they want to see happen and what success would look like in that project and how you might measure whether that funding, that resource is worthwhile or making a blind bit of difference..." (E1).*

E2 explained that the funded organisations were not necessarily involved or consulted early in the programme and evaluation planning especially on how to measure success:

> *"...I think from the outset... and this is also a failing, I don't believe the funders are involving the organisations that they are funding early enough and authentically enough in the design of the evaluation or even in the design of the project, the programme, so there is always going to be or often there is going to be a mismatch, there is going to be tension, and it's unfortunate that people end up having to work to the spec, the spec and the greater good might be two different things, but people have to fulfil the spec, they have to fulfil their contractual requirements and so there is that tension... so yea the focus and the emphasis is on compliance, not necessarily on good outcomes, and we are still, unfortunately, we are still trying to reorient from an outputs environment to an outcomes focus…" (E2).*

Providers – funding environment.

As with the evaluators' comments about funders' lack of forethought and the lack of involvement of providers and community groups in programme design and evaluation, PP1 and PP2 talked about the tension of balancing many projects with small pockets of funding from different funding sources. Each funder was described as having separate expectations of evaluation and that evaluation expected was not generally resourced within the funding for the project:

> *"...evaluation takes a particular skill set it also takes money if you haven't got that skill set and you haven't got the time for, say you haven't got somebody on site who has the skills and the time to do it, or you have got to pay them, or you have to employ somebody to do it from the outside or design an evaluation, even if you collect the data yourself you still have to put it together in a report, and most funded projects don't have anything built into them to do evaluation.....moneywise or skill wise ...the capacity just isn't there in an organization...so if I budget for evaluation for a project then I'll ...probably looking at a 10-20k overspend on the budget against what we get in...it is actually a tricky sort of thing to build in if you are only being funded on a project by project basis…" (PP1).*

These tensions made evaluation more a 'tick the box' type report rather than an evaluation which captured some of the interesting learning that occurred or presents a reflective picture of the project itself:

> *"...and what I have found that like there is a lot of work is going out there... and maybe what you report on is not everything but cause... I think we all know that the community project that is done we go far beyond of what we are funded to do so the evaluation of that is not really a hard part because we know that's much more..." (PP3).*

PP3 and PP1 explained that even when there was no funding for evaluation from funders of CHD projects, there were still expectations that evaluation would be carried out. These expectations demanded further voluntary time from the providers and the community, and put further additional strains on providers' limited resources, and impacted on the types and quality of evaluation that could be done. Thus an evaluation exercise should be an integrated part of a CHD project fund. Giving separate funding to another body to do an evaluation was seen as unjust. PP3 highlighted the injustice around the funding of evaluations, in that groups from a university were resourced to come and do evaluation and were able to offer a small compensation to research participants, which in her mind affected the quality of the information received. Providers did not have access to these incentives for evaluation participants:

> *"...for the amount of travel they have to do, the time they have to spend on the phone and like so, yea so it's the kind of things you can't ... but you think you have a component we all know when you look there somebody will be given multi-something dollars to evaluate the project and those components should come as part of the project... and train people how to do ...Like if I look at my group I know there has been projects that have been evaluated and people come and get participants for example if it was evaluated by a university, they come in and they give petrol vouchers to people to come ....and that's good but then you have other components like if you say you need 100 people and then you end up you give 20 dollars voucher to everyone that's 2 grand and if that one could have come as part of the component then people come the voluntary do that and take ownership of it and people will think of it and more real with what they have..." (PP3).*

Funder – funding environments.

The funder described the challenges of working with diverse groups but showed a willingness to be responsive to community groups and collaborate about measuring success together:

> *"There is huge variance in the groups that we fund, some will always fit into that model which is you know our requirements and theirs overlap nicely whereas other groups they are very distinct ...I think that's really the main thing getting the group involved... well getting them defining their own measures of success. I think that our organization needs to be.... it's a good learning curve for our organization because we need to be more responsive to what our communities want and how they perceive things to be, so there needs to be a willingness on our part to allow that to happen..." (F1).*

4.4 Findings Summary

Evaluation is practiced within and influenced by, a variety of contexts. These can be described as macro level - that is, the socio-political landscapes within which evaluators operate, and their cultural landscapes of origin; or micro level – the evaluator's own values and perspectives. In addition the agency networks with which evaluators interact may be either macro or micro in scale. However, the personal perspectives of evaluators will most likely be practiced within micro contexts, that is, within the orbit of the individual stakeholder. These elements I have summarized in Figure 4.1.

Socio-political and cultural contexts (Macro)

Networks and their interactions (Mainly macro contexts)

Personal values and perspectives (Micro)
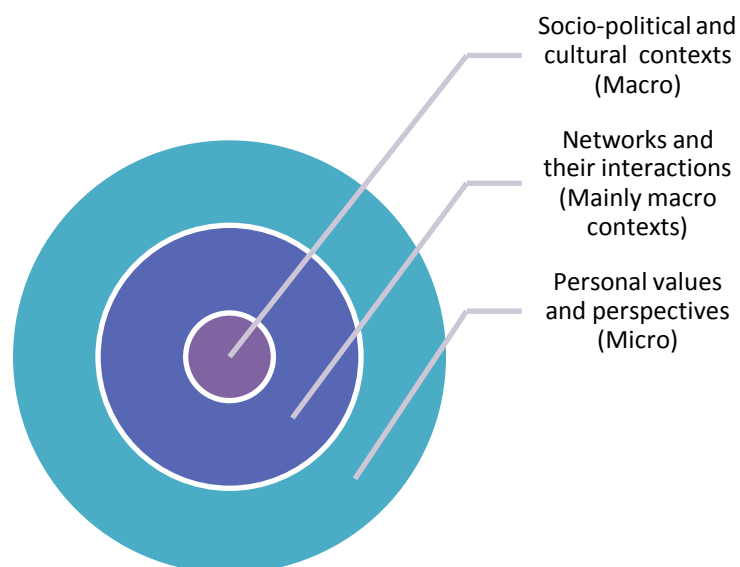
Figure 4.1 Networks of influence.

The interrelationships between the macro and micro levels are illustrated in Figure 4.1 as three concentric circles. The three levels all influence evaluation practice. For example as demonstrated in this study evaluators' personal values and perspectives determined which type of work they sought - within which socio- political contexts and with which CHD agencies. Alternatively, the programme providers' evaluation practice was more influenced by the socio-political factors and agency networks.

Within the findings it became apparent that:

- financial considerations especially shape the evaluation expectations of funding providers;
- for programme providers and the funder, values and beliefs about 'health' shape evaluation expectations;
- current funding schemes for resourcing evaluation in CHD are inadequate.

The motivations behind programme design and evaluation practice also influenced the perspective of the key actors as to how they described 'successful' evaluation. These elements for successful evaluation include factors such as relationships, participation and partnership.

The funder identified many ideas about redressing the power imbalance between the funder and provider which later would allow community involvement in programme planning and evaluation.

Training and education on how to do an evaluation were perceived by all participants to be the starting point for successful evaluations with community groups or community based projects.

CHAPTER 5: DISCUSSION

This research explores the philosophical and practical aspects informing evaluation approaches and practices in the community health development setting in Aotearoa New Zealand. This research asked: *What kind of evaluation is practiced in CHD contexts in New Zealand?* and *What are the elements of successful evaluation?* The thesis interprets the research findings in relation to and Argyris and Schőn's (1996) single and double loop learning, Cooperrider and Srivastva's (1987) appreciative frame and Lavarack and Labonte's (2000) 'parallel track'.

For reasons of clarity the discussion is divided into two sections structured around the two research questions, followed by comments on methodology and study limitations, and ending with concluding remarks.

Key findings from this study were:

- The personal, social, cultural and philosophical values of the three key actors - the funder, programme providers and the evaluators influenced the approach and what kinds of evaluation were practiced.
- The relationships of Māori evaluators and Pacific programme providers with their own communities were framed within relevant cultural norms in that they had a strong sense of belonging to the ethnic community at the same time as providing professional services. The role of the Pacific evaluators represented a double edged sword. On the one hand, their understanding of Pacific culture and community was a strength and a strong foundation for the programmes. However, on the other hand, the community had higher expectations of the kinds of support they could provide because they were Pacific.
- All participants were concerned with current funding schemes for resourcing evaluation within CHD.

Evaluation in community health development is about making value judgements about the worth or merit and quality of community health development initiatives. These value judgments are intrinsically linked to the philosophical values of those who are commissioning and carrying out the evaluation activity and to the socio-

81

cultural and political contexts where the evaluation is practiced. These factors were evidenced in this study to influence the approach and kinds of evaluation carried out in community health development settings in New Zealand and will be discussed further below.

Section 5.1 addresses the first question (what kind of evaluation is practiced in CHD contexts in New Zealand?), by first discussing the evaluation approaches and purposes of the three participant groups. Secondly, this section correlates the kind of evaluation approaches to the various contexts: political, funding, cultural, and New Zealand and the Treaty of Waitangi.

The second section (section 5.2) then provides a discussion about the second question (the elements of successful evaluation); in terms of relationships, participation and the evaluator's role.

The next section (section 5.3) reviews the strengths and limitations of the methodology used in this study, followed by some concluding remarks (section 5.4) which highlight the key points in this thesis. Finally, based on the issues identified, the chapter concludes with some suggestions for the way forward, including a summary table (Table 5.3) which outlines some key actions to address those issues.

5.1 The Kinds of Evaluation Practiced in Community Health Development Contexts in New Zealand

Evaluation approach and purposes.

The purpose of evaluation determines what evaluation approach is relevant for that specific context. By including the different perspectives of the funder, programme providers and evaluators this study provides three essentially different perspectives. These are summarised in Table 5.1 below and will be discussed.

The providers' approaches to evaluation were strongly linked to the political and funding context in that when a group receives funding they are also agreeing to meet certain accountability objectives. (The links between evaluation approaches and funding and political contexts is discussed further in the next section). The providers' evaluation purpose was primarily to measure the value and worth of the

programme (programme evaluation) to meet the accountability requirements of the funder. At the same time their approach to process and outcome evaluations was linked to informing programme development for improving their service delivery to the community. Within the constraints of funder requirements, some providers put thought into carrying out data gathering processes which were appropriate for each particular context. In this way they were particularly interested in providing a relevant, worthwhile and effective service to the community.

Table 5.1 Results Summary Table of Evaluation Approaches and Purposes

	Evaluators	**Programme Providers**	**Funder**
Approaches	Participatory Walking the journey Capacity building Transformative, Appreciative inquiry Developmental Kaupapa Mâori	Funder driven Improving service delivery	Pre tailored by funder Funder, however, wants to accommodate community voices and build capacity of community to evaluate

Purposes	Build evaluative skills and capacity
	
	Strengthen integrity of programme
	
	Building the sustainability of initiatives
	
	Moving a project forward
	
	Mâori Development
	
	Outcome
	
	Process
	
	Accountability
		Programme evaluation
		
		    Outcome
		
		    Process
		
		Programme improvement
		
		Accountability
			Programme evaluation
			
			    Outcome
			
			    Process
			
			Build evaluative capacity
			
			Building sustainability
			
			Accountability

The results table above (Table 5.1) illustrates the similarities and differences in the approaches and purposes of evaluation between the evaluators, programme providers and the funder and will be discussed below.

83

The external evaluators described evaluation approaches as being informed by their own personal philosophical values for social justice and empowerment. These evaluators sought contracts with organisations which held similar values. This may indicate that these evaluators if working outside health agency settings, would not experience the 'top down' vs. 'bottom up' tension likely experienced by the provider or the funder.

External evaluators described approaches from theoretical evaluation frameworks such as Developmental evaluation, Transformative evaluation or using an Appreciative Inquiry approach. Māori evaluators were concerned with enhancing Māori development (often described as Kaupapa Māori evaluation though not directly 'named' by participants in this study as such). These evaluation approaches have in common the appreciation for existing local knowledge and values. They also provide a supportive learning environment for the communities to generate their own evidence, for informing decisions about future action. Thus the power of planning and managing the evaluation lies with the community themselves. In short, the community members take charge of their own development (Barnes, 2009; Fetterman, 2007; Kretzmann & McKnight, 1993; MacLachlan, Carr, & McAuliffe, 2010; Morgan, 2001; Patton, 2008, 2011). The external evaluators using these approaches showed flexibility in drawing on relevant evaluation methods uniquely appropriate for each group. These inclusive and empowering evaluation approaches used by evaluators relate well to Arygris and Schőn's (Argyris and Schőn, 1996) double loop learning referred to earlier in Chapter Two. Rather than a focus on fixing problems as they occur, or trying to use a standardised evaluation approach for all programmes, a double loop learning approach investigates and adapts over time according to identified needs.

The funder provided an interesting 'in-between' contrast to the programme evaluation approach used by providers and the empowerment/capacity building evaluation approach used by external evaluators. In essence the funder was bound by a 'models and programmes' paradigm which often underpins government health agency expectations of community health development programmes. On reflection, this funder did indeed appear to have a 'programme track' and an 'empowerment track' as described by Lavarack and Labonte (2000), in that the funder seemed torn

between 'top down' agency-led initiatives and the potential these afforded for community empowerment. This type of tension has been a recurrent theme throughout this thesis and indicates that the analysis of such tensions could be a valid exercise for evaluators and CHD workers to bear in mind (English, 2010). Laverack and Labonte's (2000) 'parallel track' model could indeed prove to be a helpful framework in the community health development setting.

In this study, the funder showed that she was prepared to determine the measures of success of the programme (evaluation) together with the community and to accommodate quantitative and qualitative research methods. Like the external evaluators, the funder was also keen to build the capacity of community providers to evaluate their own programmes and to build programme sustainability. The funder's experience had shown that this process of working out goals together needed to be at the beginning of the project cycle to help frame realistic expectations of the programme for both parties. The idea of community engagement in all aspects of the project cycle is supported in health promotion literature (Hawe, Degeling et al. 1994; Rootman, Goodstadt et al. 2001; Raeburn, Akerman et al. 2007; Baum 2008).

Some providers also considered the context when designing evaluations. Nutbeam (1998) and Rootman and colleagues (2001) and others have also identified that evaluation can make a major contribution to community health development and health promotion if a range of approaches and models are used to suit the complexity of each situation (Nutbeam 1998; Rootman, Goodstadt et al. 2001). They also reinforce the idea of using quantitative and/or qualitative methodologies as appropriate to the context.

The use of a variety of approaches and methods is part of New Zealand evaluator practice (Lunt, Davidson et al. 2003). Lunt and colleagues in an edited book entitled *Evaluating Policy and Practice: A New Zealand Reader* stated that "…local evaluation practice can be seen as eclectic, continuously innovative, and containing a diverse range of theories and methods" (p. 245).

The way diverse contexts - political, funding, cultural, and New Zealand and the Treaty of Waitangi - affect approaches and kinds of evaluation are explored more specifically below.

Approaches and context.

On one hand the political, or socio cultural context determines what evaluation is considered appropriate. However, as shown in this study the chosen kinds and approaches to evaluation can also aim to influence or reinforce sociocultural and political contexts. For example Kaupapa Māori evaluation can reinforce Māori values and programme evaluation can reinforce a biomedical paradigm. In this way, evaluation is intrinsically linked to context.

Political.

The findings validate that the political context influences the funding of CHD and its evaluation because funding of CHD is linked to government changes and funding priorities. It was perceived by the research participants that political changes have resulted in less investment in research and evaluation in New Zealand. Participants in this study also noted that current government-led health agency evaluation is more focused on specific measurable outputs than learning and development, and the level of funding for health agency evaluation is being eroded[17]. While there are no written documents to evidence if this claim is true, if it is so, current funding for evaluation is at stake.

The changes in the New Zealand health structure such as the Government application of competitive market philosophies to the health sector in the 1990s which separated policy, health service provision and health service purchasing have increased the number of CHD providers who are contracting their services (Howden-Chapman and Ashton 1994; Wise and Signal 2000; Fear and Barnett 2003; Lovell and Neuwelt 2011), as noted in Chapter Two. As a result, even though there is more opportunity for local providers to apply for government funding to meet the specific needs of their community, sourcing and maintaining funder commitment to funded programmes in a competitive, changing political climate was described by providers as one of the underlying concerns. They found the constant need to source and maintain funding for CHD initiatives in competition with others put extra strain on

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[17] This was also confirmed by a number of evaluators at the recent Aotearoa New Zealand Evaluation Association (ANZEA) conference in Hamilton, July 2012. A number of evaluators at the conference described government cuts to health funded evaluation. One described that three out of four of their current health evaluation projects were cancelled recently (anonymous private conversation, 2012).

their ability to maintain service delivery. Applying regularly for small amounts of funding from a variety of sources was commensurate with the number of evaluations or reports that were then required by each of these funders.

Funding.

The research participants' descriptions of evaluation funding contexts highlighted differences between programmes and evaluations funded by government health agencies and those programmes and evaluations funded by non-profit funding agencies. The funders' motivations and philosophical values about health and well-being, therefore, appeared to influence which CHD programmes were funded and likewise the approach and purpose of evaluation which was considered appropriate for each setting.

Compared to government-funded health funders, not-for-profit community health development funders were more likely to invest in building community or group capacities for programme planning and evaluation. This funding context would suggest that development is about people not just about programmes. The approaches and types of evaluation used by not for profit funders, therefore, seem to align well with strength-based or asset-based approaches; where people and community groups are seen as store houses of potential assets and solutions to problems, rather than being viewed as a group with problems that need to be 'fixed' (Mertens 1999; Laverack and Labonte 2000; Borrup 2002; Chile 2004; Freire 2006; Fetterman 2007; Patton 2011).

Programme providers described the health agency funders' use of biomedical paradigms, including disease prevention, behaviour and lifestyle change, as the basis for programme planning and evaluation practices. The funding time frames were challenging in that programmes were funded for less than 2 years; giving insufficient time for the project to build community capabilities or to empower the communities to control and sustain the project once the funding ceased. Empowerment and capacity building is a process that takes more than two years (Raeburn and Beaglehole 1989; Labonte 1992; Kretzmann and McKnight 1993; Wallerstein 1993). Using a process at each stage of the project cycle, ensuring that all stakeholders are involved in the programme and evaluation process, such as outlined in Laverack and

Labonte's (2000) *parallel track model*, could provide an operational framework to reconcile 'top down' agency-led initiatives tied to shorter funding cycles while still accommodating processes of empowerment and knowledge and skill building in the community.

This research suggests that there has been a paucity of funding or skills for evaluation within the biomedical health agency space. While most providers saw evaluation as a way to improve programmes and to report on progress to funders they often did not have access to the financial or human resources available for evaluation. Though funders were encouraging community provider groups to plan and evaluate their own programmes, without funding or the necessary skills for evaluation, community providers were limited as to what evaluation was possible. This meant that evaluation ended up being more a reporting or compliance activity rather than a tool for community capacity building. Providers also did not have access to 'good' evaluators who could provide support and advice.

There are questions about who gets funding and resources for evaluation. For example, one respondent explained that while often community projects have little funding and resources for programme evaluation, a university group was able to access funding to carry out evaluation within that same community and could offer participants petrol vouchers in exchange for their participation. It could be that evaluation is not always seen as an essential part of service provision, rather as an external research activity that is funded separately. This, therefore, opens the possibility for collaboration between community projects and universities as has been highlighted by Liew (2011).

Cultural.

An important point of this study is that for an empowering approach to evaluation to be successful, it needs to be culturally sensitive or appropriate (Barnes 2003; Newport 2003; Bishop 2005; Wehipeihana, Davidson et al. 2010). In New Zealand, Māori and Pacific or other ethnic groups need to be able to define health according to their own terms; that is deciding for themselves their health needs and what is important for their wellbeing (Durie 2001; Newport 2003; Bishop 2005; Weightman, Ellis et al. 2005; Laverack, 'Ofanoa et al. 2007; Counties Manukau District Health

88

Board 2008; Barnes 2009; Pulotu-Endemann 2009; Tuʻitahi 2009; Kirkhart 2010). Māori evaluators within this study described using appropriate approaches successfully with their own communities.

It would, therefore, also be expected that Pacific CHD providers (and other ethnic groups) also may practice evaluation in line with Pasifika world views. However, the programmes and therefore the evaluations carried out by Pacific provider participants in this study were located within Western traditional 'mainstream' health outputs and outcome-based expectations as determined by health agency funders. Although these providers were encouraged by the funder to set their own goals (within the funding criteria) and were supported to present evidence in more creative ways, they still designed and evaluated their programmes in ways that satisfied the funder, related to the biomedical model.

A 'top down' approach to community health development underpinned by western or 'mainstream' paradigms could provide a barrier for Māori and Pacific providers who want funding to pursue culturally appropriate models for improving the health and wellbeing of their communities. Evaluators who are experienced in empowerment and capacity building models could provide empowerment and support to both groups to shift established unhelpful paradigms and to negotiate between these cultural and contextual tensions (St Leger, 2008). These findings may indicate that more funding for evaluation training and support is required in order to support the development of more culturally appropriate and empowering forms of evaluation in CHD, particularly within the health agency funding context.

New Zealand and the Treaty.

Both Māori evaluators in this study considered the Treaty of Waitangi principles important foundations for their evaluation practices. Further, when opportunities arose these evaluators deliberately had chosen to work with Māori groups or communities to build capacities and facilitate empowerment within the groups. Surprisingly, the Treaty of Waitangi was not mentioned by non-Māori participants in relation to their practice of CHD evaluations. As noted at the beginning of the thesis (chapter one), and expanded more fully in Chapter Two, New Zealand has unique social, bicultural, multicultural and political elements which impact on the theoretical

and practical perspectives of the evaluation of CHD. This was considered important because in order to be effective, CHD and evaluation needs to adapt and respond to local community realities.

As noted in Chapter Two, the Treaty of Waitangi forms the mandate that underpins and guides formal and informal relationships and responsibilities between Māori (indigenous people of New Zealand) and the Crown. The Treaty and its implications for practice provides "the overarching point of difference between research and evaluation in New Zealand and research and evaluation outside New Zealand contexts" (Barnes, 2009, p. 3). Indeed, all research in New Zealand is of interest to Māori, and research which includes Māori is of paramount importance to Māori (Bishop 2005; Barnes 2009; Hudson, Milne et al. nd). The Treaty, therefore, is relevant irrespective of whether or not CHD initiatives are targeting Māori or non-Māori (Kingi 2007; Barnes 2009; Hudson, Milne et al. nd).

It could be that other participants did not discuss the Treaty of Waitangi because in their minds, it was unnecessary to mention, given that it is part of policy documentation and an assumed part of practice; especially if the interview participant carried out their work with an attitude of respect for all people as part of their personal philosophy (which would include appreciation of the Treaty of Waitangi principles).

Another possible reason for not expressly naming the Treaty could be that the Treaty is only referred to by non-Māori when forced to in official documentation or to be 'politically correct' in certain situations. Hopefully, this assumption is not correct as this would mean that the evaluation of some CHD initiatives would be disregarding a crucial element of cultural humility essential for those non Māori working with Māori and other ethnic communities. This would impede any incentive to provide empowerment and capacity building for Māori, Pacific and other ethnic minorities as mentioned earlier.

In summary, different approaches and kinds of evaluation were used by the different participants. Although the CHD funder and providers showed an appreciation for a wider definition of health and the necessity for longer time-frames, in reality programme planning and evaluation were aligned more with quantitative

methods and focused on compliance and output-driven reporting to meet funding requirements from within a disease prevention and lifestyle change model. Externally contracted evaluators in this study appreciated local community values and were able to assist communities to bring these values to evaluation practice, and programme design and delivery. While the funder was motivated to approach evaluation in this way, she was limited by operating in a paradigm of disease prevention.

In essence, the process of integrating community values into programme design, implementation and evaluation can be acknowledged as a means to promote a balance of power and control between funders, providers and the community, by appreciating the assets unique to the individual community. Significant training and education are needed to facilitate 'good' and culturally relevant evaluation practices, to develop an evaluation workforce in New Zealand that practices empowering and inclusive evaluation methodologies. The benefit from more exposure to evaluation of this type aligns well with CHD principles noted throughout this thesis.

The factors which impact on successful evaluation also are related to the approaches, purposes and contexts of evaluation and are discussed below.

5.2 Elements of Successful Evaluation

There is strong theoretical evidence about the necessary ingredients for successful community health development and its evaluation, including such elements as relationships; participation; partnership and collaboration; and community capacity building and empowerment (Hawe, Degeling et al. 1994; House and Howe 2000; Stufflebeam 2001; Hood 2004; Abma 2005; Davidson 2005; Greene 2006; Wallerstein and Duran 2006; Fetterman 2007; Barnes 2009; Patton 2011).

Some of the elements already identified in Chapter Two are also important for successful evaluation, such as it taking time to build trust and relationships; and the quality of the relationships. The participant responses are outlined in Table 5.2 and discussed following.

Table 5.2 Summary of identified elements of successful evaluation

Evaluators	Providers	Funder
o Relationships o Building capacity o Empowerment o Sustainability o Personal integrity o Trust based o Honest authentic genuine o Learning environment	o Relationships with funders o Good quality of service o Health expertise skills o Values o Funders on the same page o Evaluation skills o Accountability o Learning from what doesn't work	o Relationships o Community partnership and community ownership o Working out success together o Flexibility to do things differently – learning environment o Spending time with providers

Overwhelmingly, relationships was identified by participants as one of the elements for successful evaluation (Table 5.2). The above table summarises the responses of the participants to the question about successful evaluation.

Relationships.

Even though these comments are included towards the end of this discussion, relationships was one of the crucial elements for successful evaluation identified by all participants.

Relationship building is especially important in communities who may have had research and evaluation 'done' to them rather than 'with' them in the past (such as Māori communities), as outlined in Adams' and colleagues' (2009) study reviewed in Chapter Two. They suggest that the quality of these relationships, and the level of trust and mutual respect evidenced, impact on the degree of dialogue and the depth of participation within the evaluative processes, the methods chosen, the production of knowledge and the ability to create sustainable evaluation practice.

One of the significant findings about relationships has already been identified in the last section. That is, the degree of relationship CHD funders, providers and

evaluators saw between themselves, their practice of evaluation and the Treaty of Waitangi.

Another finding from this study was the distinct difference in the relationships Māori evaluators and the Pacific programme provider had with their own ethnic communities compared to non-Māori and non-Pacific CHD workers. Within Māori contexts this was described by one evaluator as having connections with whānau (extended family groups) at all levels, from programme participants to the Chief Executive Officer, not only for the period of the contractual arrangement. Connections formed during the evaluation were honoured from then on.

This is a significant difference compared to those evaluators or programme providers in other cultural settings who have more opportunity to 'step in' to a community and then 'step out' again when the contract is over. Though trust and acceptance may be more easily established early on for Māori with Māori groups and Pacific with Pacific groups because of ancestral connections, this study showed that there is a deeper and enduring responsibility and accountability expressed by Māori and Pacific evaluators and programme providers for their own communities. For example a Tongan provider who worked elsewhere fulltime expressed this deeper responsibility to use her professional skills in service to her community. However willingly this was undertaken, unsaid, and often unacknowledged by funders and providers, it is their personal time and energy that is sacrificed in order for those in this position to do this work with the people they care about the most.

It is evident then that the Māori and Pacific workforce are a precious resource, and face greater challenges (and possibly greater rewards) than their non-Māori or non-Pacific colleagues in that their professional roles and family, cultural and spiritual relationships are intertwined.

Participation.

In this study, the ideas about when to use participatory evaluation were discussed. Providers considered they were using participatory methods of evaluation by involving participants in extractive process to gather information for themselves or

the funder to satisfy accountability, organizational learning and programme improvement objectives.

The choice of evaluation approach depends on the intended purpose of the evaluation. In this study, providers (and one evaluator) identified that participatory evaluation may not always be necessary or appropriate for all types of evaluation; particularly project evaluation. It was thought important to consider what the community participants would get out of being involved in the evaluation and how this was going to be financially resourced in the initial project design and evaluation plans. As this study has demonstrated, evaluation is not generally resourced as part of programme funding; therefore participatory approaches may not always be possible even if they are considered appropriate.

Even though this was a small sample of evaluators, it provides evidence that some evaluators who work in CHD settings approach their practice of evaluation from the point of view of empowerment, social justice and equity.

Evaluator role.

Evaluators described their role in many ways; particularly as facilitators of processes that create relevance and interest in evaluation in the long term. Evaluators used words such as 'guide', and 'critical friend' to describe this role. They viewed their role as assisting communities to build their own knowledge and understanding about what difference they were making, in order to make decisions themselves for their future. Fostering this approach to evaluation helped to build integrity, accountability and confidence to act within community endeavours.

St Leger (2008) suggests that funders and providers need empowering too. One evaluator had an open door policy which helped programme managers feel emotionally supported. This provides evidence that a 'skilled' evaluator can have a special role to play in helping community health development funders and providers. By facilitating and guiding evaluation processes, the evaluator can ensure the right questions are asked early on. These descriptions of the role of evaluator are described in literature (Wenger 2000; Greene 2006; Fetterman 2007), and were evidenced in this study in the New Zealand context.

The evaluator role in empowering forms of evaluation, such as described and outlined in Chapter Two (e.g., empowerment and transformative evaluation), requires a high level of people skills, honesty, integrity, cultural humility and the ability to deal with complexity (Mertens 1999; Fetterman 2007). Fetterman (2007) describes the evaluator role as that of 'a critical friend'. Empowering and capacity building is a long term process. Rootman et al., (2001) consider that the evaluation approach must be one that can "accommodate the complex nature of health promotion interventions and their long term impact" (p.32). This finding also provides weight to the argument previously stated that evaluators can be utilised more to empower CHD workers in negotiating the parallel track (Laverack and Labonte, 2000).

In summary, determining the value and importance of an evaluation is a complex process that relies heavily upon the values of those making these judgments as well as the social, cultural and political contexts and the location of the various actors (House 2005; Julnes 2012). While CHD workers aim to empower and build the capacity of community groups through their CHD initiatives, evaluation approaches which could strengthen these aims – that is, empowerment evaluation strategies – are not necessarily utilized. Although it is expected that evaluators, programme providers and funders may not always be able to use empowering approaches because of the organizational context and values of the matter being evaluated, in this thesis, I propose that these empowering and capacity building approaches to evaluation clearly support the principles of the CHD philosophy to improve health and community wellbeing. That argument alone was the raison d'être for this study.

5.3 Comments on Methodology

It is important to share experiences that others can learn from; therefore comment is made here about Appreciative Inquiry as a research methodology.

Appreciative Inquiry was a useful theoretical framework for data gathering and also proved to be a useful approach for reviewing findings, in that it provides a positive lens through which to focus on strengths and possibilities. Appreciative Inquiry is usually used with groups/focus groups rather than as an approach with individuals as was used in this study. On reflection, although it did prove to create a

positive framework for both the interview participants and for the researcher, a focus group may have enhanced the experience for the participants in that as a collective the experience could have been more powerful in creating a future practice together.

One of the positive aspects of this study is that the researcher, by routinely and regularly delving into the literature, has now gained a broader understanding of the successes and challenges of evaluation in CHD.

One of the limitations of this study is that evaluators were recruited according to the criteria that they practiced participatory type evaluation approaches (that is social justice, empowering, transformative). This potentially presents a biased viewpoint of the kind of evaluation that is occurring in community health development settings. This criterion was deliberate as these processes are in line with community health development principles of equity, social justice and empowerment. However, on reflection it may have been more appropriate to include evaluators who used other approaches such as theory based evaluation; in order to have an evaluator sample that was more comparable to the programme providers.

The small sample size of this study also means that these findings are not generalizable; nevertheless it does give some indication of evaluation in CHD and the relationships between the two professional practices - evaluation and community health development. Having only one funder participant was a limitation which did not present a representation of this group. Having three different perspectives about the purposes of evaluation proved to provide much more diverse and richer information. Perhaps, by having more funder perspectives represented, the differences could have been further explored.

5.4 Concluding Remarks

This research provides understanding of how evaluative practice has the potential as a tool that can be utilized to realize some of the aims of CHD practice.

As has also been shown in this study, from an evaluation theoretical perspective there is a large amount of literature which explores participatory evaluation approaches, such as empowerment, transformative, responsive and the like; approaches which have been identified in previous sections as being appropriate and

complementary to CHD philosophies and practices (Mertens 1999; House and Howe 2000; Cousins 2001; Abma 2005; Miller and Campbell 2006; Wallerstein and Duran 2006; Fetterman 2007; Gariba 2008; Coryn, Noakes et al. 2010; Greene, Johnson et al. 2010). As discussed in Chapter Two, community health development literature suggests that there is no one fixed approach that is relevant in every context (Hawe, Degeling, & Hall, 1994; Rootman, 2001

Firstly, the findings of this study reinforce these ideas about evaluation from the evaluation and community health development literature: that there is no one particular approach to evaluation which is suitable for all contexts. However, for the purposes of community health development which aims for 'health development', it seems clear that empowering, transformative and culturally appropriate approaches to evaluation support that aim. These approaches to evaluation have been successfully applied by some evaluators working in community health development settings in New Zealand, as evidenced in this study. However, as this study has also shown, these empowering approaches may not always be relevant for providers given the evaluation purpose and the specific set of circumstances present such as funding, skills and resources available for evaluation.

Secondly, as noted when working with ethnic communities, it is considered important to incorporate evaluation approaches which relate well with the world views of these groups (Bishop, 2005; Cram & Kennedy, 2010; Newport, 2003; Pulotu-Endemann, 2009; Tu'itahi, 2009; Wehipeihana, Davidson, McKegg, & Shanker, 2010). Including the perspective of Mâori evaluators and Pacific programme providers in this study gave voice and insights for those working with these communities. Mâori evaluators were successfully approaching evaluation from their own philosophical world view relevant to their own ethnic realities. As was demonstrated in this study, these approaches include the community's values and the people's voice which makes them appropriate for community health development initiatives in different cultural contexts. These examples of empowerment and capacity building evaluation approaches provides encouragement for non-Māori in CHD settings to move beyond the prescriptive biomedical programme models and evaluation designs.

Thirdly, I argue that the quality of CHD and evaluation practice (with purposes of social betterment) need to be informed by compatible principles such as the participation, partnership and collaboration of all stakeholders in programme design, implementation and evaluation processes (Fetterman, 2007; Greene, 2006; House & Howe, 2000; Patton, 1994). Both CHD providers and evaluators need to be sensitive to relevant yet specific social, cultural, and political contexts. More training is needed to inform evaluation practice based around the principles of partnership, participation, collaboration, relationships, capacity building and empowerment.

Fourthly, applying these ideals can be more challenging within the complexities of diverse community settings (Trickett, Ryerson & Espino et al., 2011). In practice, despite these desires to involve communities more, challenges to balance this with funding compliance expectations and policy directives can be complex (Cracknell, 1996). What this research has shown is that providers are under-resourced financially and skill-wise to carry out evaluation. The provider's descriptions of evaluation in a 'health agency' setting involved the provision of reports on quantitative outcomes rather than involving evaluative processes which capture elements of the programmes that are more relevant and meaningful to the community. Evaluator participants described that non-government funders outside the direct health sector provided a more progressive approach to evaluation which aimed to build community groups' capacity to plan, evaluate and apply for funding. These non-profit organisations were investing in experienced evaluators who had the skills to assist groups to get more funding.

Given that some of the CHD and evaluation concepts and values such as participation, collaboration and partnership, relationships, capacity building and empowerment are important to both fields, more studies are needed that examine the reflections of these philosophies in practice. More training is needed around good evaluation practice, to assist community advisors to support community groups, and develop leadership. More funding is needed for evaluation. Good evaluation involves the art of asking the right questions, helping people to form questions, involving communities in more of the doing of the evaluation and resourcing that.

5.5 The Way Forward

My study explicitly reviewed current evaluation practices used for CHD initiatives and highlights successes and challenges as these can be used to inform future practice (refer to Appendix I). Better knowledge of these factors determining successful evaluation practice in CHD settings will improve the practice of evaluation in CHD. It will also inform planning for prospective training and provide some insights into how evaluation can be used as a tool for promoting social justice, building evaluative capacity within the community, and advancing empowerment-concepts and values important to both fields. CHD and evaluation are connected and overlap as has been demonstrated. The Ministry of Health does recognise that there is a need for evaluation capacity building in the community and has been resourcing free training for community providers by evaluators from SHORE, Massey University for over ten years in New Zealand (Adams and Dickinson 2010). This study indicates that this training may not be meeting the demand for training from the numerous CHD providers that are now providing services.

Given that some of the concepts and values important to both fields are connected and overlap, and the increased demand for funders, providers and community groups to evaluate their own initiatives, it is hoped that these results will provide insights into some of the considerations for building evaluative capacity within this context, to advance empowerment, social justice and equity for those community groups who suffer the most disadvantage in New Zealand.

By understanding more about the challenges facing community health development workers it is hoped that more funding and training will be made available that will advance empowerment, social justice and equity for those community groups who suffer the most disadvantages in New Zealand.

As well as the project evaluation practised by providers, the empowering forms of evaluation such as developmental, transformative, and Mâori working with Mâori (Kaupapa Mâori evaluation) have been perceived by evaluator research participants

to be relevant and working well in the complexity of community settings in New Zealand.

In my view, empowering and responsive approaches to evaluation have the potential to recalibrate relationships between all stakeholders (funders, providers, evaluators and community representatives). My intention, therefore, has been to explore what approaches to evaluation of community health development initiatives in New Zealand are considered relevant in this space. In this thesis, it is concluded that ideally at least, evaluation should be perceived as a systems wide, on-going, cyclical process of action, reflection and consultation including all stakeholders. Moreover, evaluative processes must be flexible, adaptive and ensure that CHD programme decisions are informed by systematic learnings identified by the community, rather than predetermined finite closed goals determined by external stakeholders.

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M E M O R A N D U M
Auckland University of Technology Ethics Committee
(AUTEC)

To:	KateMcKegg
From:	**Dr Rosemary Godbold** Executive Secretary, AUTEC
Date:	19 October 2011
Subject:	Ethics Application Number 11/271**The role of evaluation in community health development.**

Dear Kate

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 10 October 2011, subject to the following conditions:

    1.   Amendment of the Information Sheets as follows:

        a.   Use of the current wording for the section on concerns as given in the Information Sheet exemplar in the Ethics Knowledge Base (http://www.aut.ac.nz/research/research-ethics/ethics);

        b.   Inclusion of the researcher's business telephone number in the contact details.

AUTEC wishes to commend the researcher on the thoroughness evidenced in the application and the clear presentation of the research.

I request that you provide me with a written response to the points raised in these conditions at your earliest convenience, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires written evidence of any altered documents, such as Information Sheets, surveys etc. Once this response and its supporting written evidence has been received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application.

When approval has been given subject to conditions, full approval is not effective until *all* the concerns expressed in the conditions have been met to the satisfaction of the Committee. Data collection may not commence until full approval has been confirmed.   Should these conditions not be satisfactorily met within six months, your application may be closed and you will need to submit a new application should you wish to continue with this research project.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found at http://www.aut.ac.nz/research/research-ethics/ethics).

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Yvonne Glenda Williamsonygwilliamson@gmail.com, Peggy Fairburn-Dunlop

Evaluator Participant Information Sheet

Date Information Sheet Produced:

15 October 2011

Project Title

Evaluation in Community Health Development Programmes

An Invitation

My name is Yvonne Williamson and I am a student at AUT University. You are invited, as an evaluator of community health development programmes, to participate in a study which will explore your experience of evaluation. This study is part of a Thesis for a Masters of Public Health at AUT and will be supervised. My desire is to hear your stories and experiences of evaluation. This is an opportunity for you to voice the realities of being an evaluator using participatory approaches in community health development settings.

What is the purpose of this research?

The purpose of this research is to investigate 'What kind of evaluation is practiced in community health development contexts and what role does it play in creating 'space' for individuals and community groups to generate knowledge, engage in discourses and participate in social action in these settings?'.

This research will complete the requirements of a Masters of Public Health, and I aim to publish the findings locally and internationally.

How was I identified and why am I being invited to participate in this research?

You are invited to participate in this study because you are an evaluator of community health development programmes.

What will happen in this research?

Participation in the study involves a face to face interview at your office that will be digitally recorded. In the interview you will be encouraged to talk about your experiences and your practice of evaluation.

After transcription of the recordings, I will supply you with a copy of the data and ask you to verify my perceptions of your experiences.

What are the discomforts and risks?

I acknowledge that revealing some experiences may place you in a vulnerable position if these experiences were to be disclosed to anyone else. For this reason you will have autonomy as to what parts are shared and with whom. You will be reminded that you do not have to answer any questions that will cause you discomfort.

How will these discomforts and risks be alleviated?

You can pause or stop the interviews and the study at any time; you will be reminded of this at every interview. In addition, you do not have to answer any questions that would cause you extreme discomfort. If you become too distressed, the interviewer will stop the interview, give you some time to recover, and ask you if you want to stop or continue.

I have included below, contact details of an organisation that provides counselling if you have the desire to speak with a counsellor or health professional, below is the websites/contacts available to you:

-AUT Health and Counselling Wellbeing: http://aut.ac.nz/student-life.student-services/help-and-advice/health,-counselling-and-wellbeing/counselling --this site offers both face-to-face and online counselling services. Phone: (09) 921 9992 (City campus) and (09) 921 9998 (North Shore).

What are the benefits?

You may benefit by talking about your experiences, being heard, and in the process assist our understanding of evaluative processes in community health development programmes. This may in turn be of help to policymakers, funding agencies and other community groups. The indirect benefit to you is an opportunity to advance the field of evaluative activities as I aim to publish the findings.

How will my privacy be protected?

To maintain your privacy, you will be asked to provide a pseudonym that will be used whenever your story is referred to in the write up. In addition, no individual details that might identify you as a participant will be revealed in the study.

Although full anonymity cannot be offered because the researcher will be interviewing you, confidentiality will be assured as only the researcher will have access to the data. All data and transcripts will be kept in a secure, locked cabinet in the primary supervisor's office.

What are the costs of participating in this research?

There are no financial costs to participating in the study. Your only cost will be time. It is estimated that the interviews may be 60-90 minutes long. There will be a follow up interview where you can read and verify what has been transcribed and approve who can have access to this information; this will take about 60 minutes.

What opportunity do I have to consider this invitation?

You have two weeks to respond after receiving the information sheet. You can contact me by email (yvowil76@aut.ac.nz) or my supervisor (contact details below) to find out further information.

How do I agree to participate in this research?

To participate, you need only fill in and sign the attached consent form. If there is no attached form, you can send me an email (yvowil76@aut.ac.nz) with details of how

you would like me to contact you (email, phone, postal address) and I will enclose a consent form. If you cannot email me, you can phone my supervisor (contact details below) and I will send you a consent form.

Will I receive feedback on the results of this research?

Yes. At your request I will send you a summary of the study's findings. It may also be published in a scholarly journal which can be accessed electronically.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors, Kate McKegg *kate.mckegg@aut.ac.nz*, 921 9999 ext 9689 or Peggy Fairbairn-Dunlop *peggy.fairbairn-dunlop@aut.ac.nz* 921 9999 ext 6203

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz* , 921 9999 ext 6902

Whom do I contact for further information about this research?

Researcher Contact Details:

Yvonne Williamson

yvowil76@aut.ac.nz

Phone: 0272067912

Project Supervisors Contact Details:

Kate McKegg

School of Public Health & Psychosocial Studies

921 9999 ext. 9689

kate.mckegg@aut.ac.nz

Professor Peggy Fairbairn-Dunlop

VaaomanuPasifika - Institute of Public Policy

921 9999 ext.6203

peggy.fairbairn-dunlop@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 20 October 2011.AUTEC reference number 11/271

Programme Provider Organisation Participant Information Sheet

Date Information Sheet Produced:

15 October 2011

Project Title

Evaluation in Community Health Development Programmes

An Invitation

My name is Yvonne Williamson and I am a student at AUT University. You are invited, as staff of a Programme Provider Organisation of community health development programmes, to participate in a study which will explore your experience of evaluation. This study is part of a Thesis for a Masters of Public Health at AUT and will be supervised. My desire is to hear your stories and experiences of evaluation. This is an opportunity for you to voice the realities of being a part of an evaluation that used a participatory approach.

What is the purpose of this research?

The purpose of this research is to investigate 'what kind of evaluation is practiced in community health development contexts and what role does it play in creating 'space' for individuals and community groups to generate knowledge, engage in discourses and participate in social action in these settings?'.

This research will complete the requirements of a Masters of Public Health, and I aim to publish the findings locally and internationally.

How was I identified and why am I being invited to participate in this research?

You are invited to participate in this study because you are staff of a Programme Provider Organisation of community health development programmes.

What will happen in this research?

Participation in the study involves a face to face interview at your office that will be digitally recorded. In the interview you will be encouraged to talk about your experiences of evaluation.

After transcription of the recordings, I will supply you with a copy of the data and ask you to verify my perceptions of your experiences.

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What are the benefits?

You may benefit by talking about your experiences, being heard, and in the process assist our understanding of evaluative processes in community health development programmes. This may in turn be of help to policymakers, funding agencies and other community groups. The indirect benefit to you is an opportunity to advance the field of evaluative activities as I aim to publish the findings.

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How do I agree to participate in this research?

To participate, you need only fill in and sign the attached consent form. If there is no attached form, you can send me an email (yvowil76@aut.ac.nz) with details of how you would like me to contact you (email, phone, postal address) and I will enclose a consent form. If you cannot email me, you can phone my supervisor (contact details below) and I will send you a consent form.

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Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors, Kate McKegg *kate.mckegg@aut.ac.nz*, 921 9999 ext 9689 or Peggy Fairbairn-Dunlop *peggy.fairbairn-dunlop@aut.ac.nz* 921 9999 ext 6203

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Researcher Contact Details:

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peggy.fairbairn-dunlop@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 20 October 2011.

AUTEC Reference number 11/271

APPENDIX D

Consent Form

Project title: *Evaluation in Community Health Development Programmes*
Project Supervisor: *Kate McKegg and Professor Peggy Fairbairn-Dunlop*
Researcher: *Yvonne Williamson*

○   I have read and understood the information provided about this research project in the Information Sheet dated 15 October 2011

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○   I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○   If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○   I agree to take part in this research.

○   I wish to receive a copy of the report from the research (please tick one): Yes○   No○

Participant's signature:

....……………………………………………………………

Participant'sname:

....……………………………………………………………

Participant's Contact Details (if appropriate):

Phone :………………………………………………………………………………...

Email :………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 20 October 2011 AUTEC Reference number 11/271

Note: The Participant should retain a copy of this form.

Demographics and Indicative Interview Questions for Evaluator and Programme Provider Organisation Participants

Demographic details (Optional)

Age:………………………

Race:…………………….

Ethnicity:………………….

Questions

- How would you describe or define evaluation (and evaluative activity) that is practiced in New Zealand community health development settings?

- How would you describe the kind of evaluation (and evaluative activity) that is practised within your organisation

- What role does the evaluation play in this setting

The following questions will be asked according to the 4D model of Appreciative Inquiry.

Discovery/ Inquire

Question: Think about a time when you were doing some form of community based evaluation that from your perspective went well:

- *what was the setting?*

- *what were the processes?*

- *what was the high point in that process?*

- *What was it that you valued about this time?*

- *What was it about this time that made you feel it was going well?*

- *How did this evaluation feel to you?*

- *If you were going to do more of this type of evaluation what are some of the building blocks to get there*

- *What do you think were the high points of the evaluation for community participants?*

- *What do you think was of value to community participants?*

Dream/ Imagine

Question: If we imagine that all community based evaluation could be more like this and occur more often:

- *What would it be like to have more of this?*

- *What kind of evaluation structures and processes would be happening?*

- *What roles, skills would evaluators have?*

- *What are the practices that contribute to community knowledge generation and empowerment to participate in social action?*

- *What role would evaluation play in these scenarios*

Design /Innovate

Question: For this to happen what might need to be in place in the evaluation community and community health development arena and in personal practice of evaluation:

- *What policies?*

- *What values?*

- *What principles and factors?*

- *What systems?*

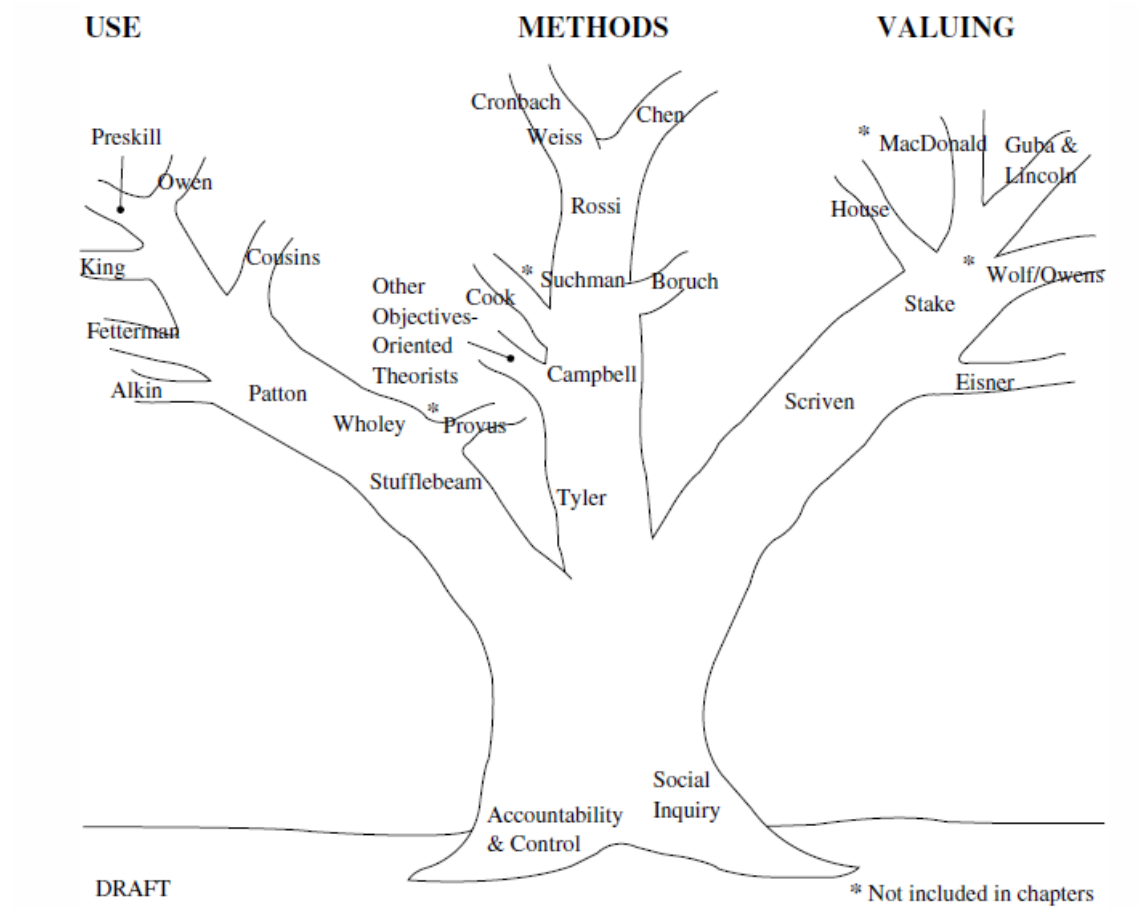- *What people?*

Destiny/Implement

Question: Think about all the elements mentioned about evaluations that worked well, and the vision of future practice that embodies these values, principles, processes and structures that allow community groups to generate knowledge engage in discourses and participate in social action:

- *What are some of the key building blocks to ensure this for the future?*

What are the elements that enable community to be actively involved in knowledge generation and empowered to participate
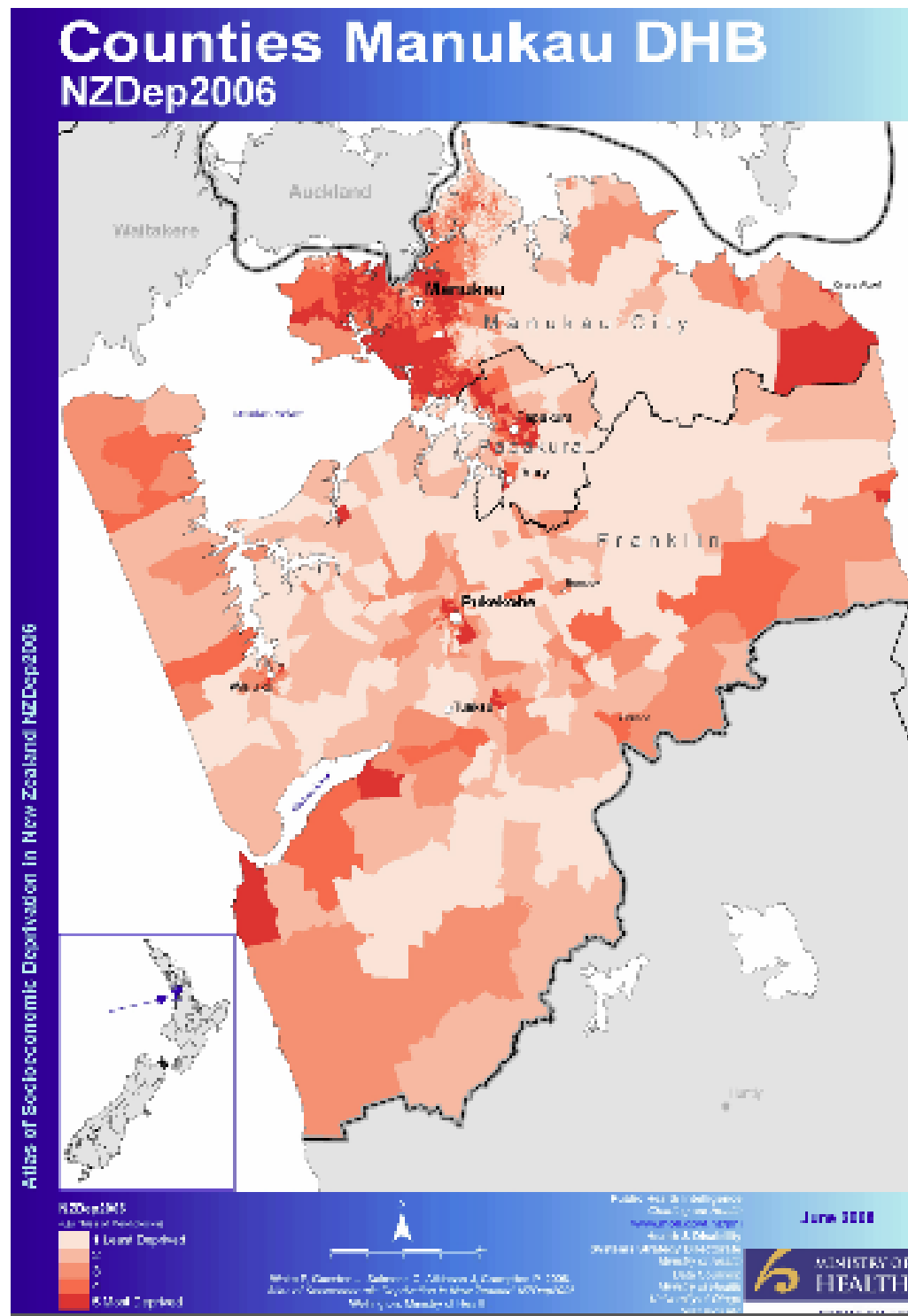
APPENDIX F

Evaluation Tree

USE   METHODS   VALUING

Preskill
Owen
King
Cousins
Fetterman
Alkin
Patton
Other Objectives-Oriented Theorists
Wholey
* Provus
Stufflebeam

Cronbach
Weiss
Chen
Rossi
* Suchman
Boruch
Cook
Campbell
Tyler

* MacDonald
Guba & Lincoln
House
* Wolf/Owens
Stake
Scriven
Eisner

Accountability & Control
Social Inquiry

DRAFT

* Not included in chapters

(Alkin & Christie, 2004, p.3)

132

NZ Deprivation Index

(Counties Manukau District Health Board, 2012). The depth of colour
indicates the degree of deprivation- the darker colour-the most deprived

APPENDIX H

Respondent profiles

Evaluator profiles

The evaluators in this study have been working in New Zealand ranging from three years to over ten years; their ages ranged from 25 to 60. There were two females; one Pakeha and one Māori and one male who was Māori. One evaluator worked as a freelance evaluator in a variety of projects, ranging in scale from larger projects with Government agencies, local bodies, to smaller non-profit community providers. Two evaluators were contracted to non-profit evaluation organisations that provide evaluation in the Auckland region and New Zealand wide. They also provided evaluation for a range of programmes from non-profit organisations and Government agencies. Both Māori evaluators in this study delivered evaluation predominately within Māori communities. The Pakeha evaluator provided evaluation for a range of ethnicities. The focus of evaluators' discussion was about their general approach to evaluation and more specifically about examples of successful evaluation practice in New Zealand. Only one of these evaluators gave a specific example of evaluation that involved a community health development initiative that included South Auckland. The other evaluators gave examples of evaluation in other parts of the North Island one for a Māori and the other a Pacific initiative. All evaluators practiced evaluation in the CHD context as well as in other sectors including education, social policy and business.

Programme provider profiles

All programme providers in this study were all based in the South Auckland area. One provider was a Pakeha woman and two providers were Tongan, one male and one female. Ages of participants ranged between twenty five years to fifty five years. Two individual providers ran church based programmes, funded by government agencies and catered for target groups of 300 or more people and their

families. These programmes had been running for more than two years and aimed to encourage physical fitness and healthy lifestyle changes. The third provider was much larger in size than the first two described, with a team of workers of around 20 people of various ages and ethnicities. This provider focused their service provision particularly on health promotion and health education, as well as research. This provider received funding from a variety of sources, including government, private health or research funding.

Funder profile

As noted, only one funder out of three agreed to participate in this research. The funder participant in this study, female Pakeha aged around twenty five years is based in South Auckland and is from a large government agency with a budget in the millions that funds a range of activities aiming to improve health and wellbeing of the population. This participant had been in this role for one year. This funder allocates money to community groups yearly for community initiatives which aim to increase knowledge about healthy eating and activity with the hope that this will change attitudes and behaviour to include more healthy living practices as a prevention strategy against unhealthy lifestyle diseases. Projects for community groups with at least one hundred people were funded by this funder.

Table 5.3 Summary Table of Identified Issues

Issues identified	Effects	Proposed Actions
Empowering forms of evaluation including (Māori working with Māori) are working well in the complexity of CHD context	Provides more community led positive development, and sustainable ongoing results	Health agencies could take courage from these examples to use other evaluation approaches with the support of skilled evaluators
Evaluation within CHD settings is generally not resourced as part of project funding	Puts more strain on those in leadership roles and negatively affects time and money which could go into service delivery	Identification by funders when evaluation is really necessary and this is funded accordingly. (A report may be sufficient for some projects)
Resourcing and training for evaluation capacity building is not meeting the needs of providers	As above	Funding and more free training for providers and support by experienced evaluators
Funders and providers with empowerment aims are bound by shorter term 'top down' agency led project cycles	Goals of the project may be subverted to meet shorter term outcomes Human resources needed to continually source and maintain funding and meet funder expectations	Parallel track model may provide an operational framework. A skilled evaluator could provide a facilitatory role to negotiate between funder and provider objectives to set realistic time frames
The Treaty of Waitangi is not an expressed part of practice	It could imply that the Treaty principles are already an embedded part of practice or suggest a lack of true understanding about partnership, participation and protection of Māori interests	Ensure that Treaty principles are part of any community health development discourse and action where possible
Pacific providers encouraged to set goals but still bound by a funder operating within a biomedical model and disease based deficit framework	Without funders appreciating other ethnic views of health and well-being there will be little impact on improving health of these populations	Dialogue about redefining health and appreciation for a wider definition of health A need to give more control to Māori , Pacific and other ethnic minorities for their own initiatives
Māori and Pacific workers have deeper and long term engagement with their own communities	Māori and Pacific CHD workers and evaluators professional and personal relationships are intertwined These responsibilities involve longer hours and 'burnout' is possible unless supported	Recognition of this important and demanding work by resourcing evaluators well and recognizing longer time frames may be needed