FINAL FORMATIVE EVALUATION REPORT 2004–2006

FORMATIVE EVALUATION OF THE NATIONAL CERVICAL SCREENING PROGRAMME AND BREASTSCREEN AOTEAROA HEALTH PROMOTION SERVICES

REPORT TO THE NATIONAL SCREENING UNIT

APRIL 2007

Mihi Whakatau

E ngā iwi, e ngā mana, e ngā reo kārangārangā maha huri noa i te motu, Tēnā koutou

Mā koutou hoki i whakakii, i whakatinana ai i ngā kete e toru i kawea mai e Tāwhaki,
I whakamahana iho te wairua o ia, o ia, o tātou
Tēnā koutou

Ka tuku atu ngā mihi maioha ki a koutou ko ngā Kaimahi, ngā Kaiwhakahāere, me ngā Rangātira i hāpaitia te mana o te National Screening Unit i te manaakitangā, te awhi, me ngā tautoko ki a mātou o te roopu nei o Kāhui Tautoko.

Ko te tūmanako, mā ngā mahi nei i whakakaha ai ngā pūnaha o te National Screening Unit kia piki ake te āhua o ngā mahi kua whakarewahia e.

Nō reira, ngā mihi ki a koutou ngā whanau, ngā hapū, me te iwi

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Whakakape – Disclaimer

This report was prepared by Kāhui Tautoko Consulting, Wellington for the National Screening Unit. The information contained in the report is primarily intended for the use of the National Screening Unit. While every effort has been made to ensure the accuracy of this document, Kāhui Tautoko Consulting gives no indemnity as to the correctness of the information or data supplied by third parties.

Nōu te rourou, nāku te rourou, ka ora ai te iwi

With your basket, and my basket,
we will achieve the best for our people

Ngā mihi – Acknowledgements

Kāhui Tautoko Consulting wishes to acknowledge the three formative providers, He Waka Tapu, Mana Wahine and Raukura Hauora o Tainui ki Tamaki, their health promoters, managers and staff who shared their experiences and time with us.

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WHAKARĀPOPOTOTANGĀ – EXECUTIVE SUMMARY

To be fully effective, BreastScreen Aotearoa (BSA) and the National Cervical Screening Programme (NCSP) coverage of Māori women needs to increase. To achieve this, focusing NCSP and BSA health promotion on the Māori women who are not participating in screening, is imperative.

This Final Formative Evaluation Report 2004–2006 is a summary of the activities undertaken over the previous three years with the three providers contracted to deliver breast and cervical screening health promotion under dual contracts. These Independent Service Providers (ISPs) have a dual contract to deliver both BSA and NCSP health promotion services, unlike the majority of the existing providers who have contracts to deliver either BSA or NCSP health promotion only.

Supporting the implementation of the contracts and the subsequent health promotion plans using kaupapa Māori models has been the focus of this three-year evaluation. The activities throughout the three years are outlined in this final report.

The three formative providers are Raukura Hauora o Tainui ki Tamaki based in Manukau, Mana Wahine, a collective of 7 providers based in the Wellington region, and He Waka Tapu in Christchurch.

For the three year evaluation, Kāhui Tautoko Consulting (KTC) were contracted to support the three providers in the implementation of their dual services in line with the objectives of an approved formative evaluation plan. While 47 consulting days were originally intended to provide support to the new providers over the three years, 50 days were used largely around documenting the establishment of the services under the contract, developing profiles of the providers, and then supporting the health promotion planning. However, support was also offered and taken up by the providers to assist in undertaking needs analysis of their community; understanding the NSU health promotion framework and population based approaches; establishing service processes related to NCSP and BSA standards; self evaluation of health promotion approaches; identifying any risks or barriers to effective service delivery; and other areas as identified by the providers (e.g. facilitating hui and supporting the hiring of new staff by participating in recruitment processes).

This final formative evaluation report is separated into three key areas: establishing the three new providers; infrastructure and support provided by KTC; and health promotion programme planning.

Establishing the providers' contracts and services

All three providers commenced their new dual contracts in late 2004. A key finding from this formative evaluation is that during the establishment of contracts with new providers, it would be beneficial for the NSU to allow new providers to have 6 months from the contract start date to establish the contract, hire, train and induct staff, and build relationships with other key stakeholders specifically other BSA or NCSP providers in their areas. Furthermore, new providers would benefit from the NSU taking the lead in clarifying the roles, responsibilities and service boundaries of newly contracted providers, particularly in areas where there are current BSA and NCSP services, to avoid confusion, potential competition, duplication or unintended overlap of services.

Finally, ensuring contracts are negotiated and signed so that payment of funds can occur before any delivery of service, would reduce provider concern over absorbing establishment costs such as advertising positions and planning. This would also ensure a smooth transition into planning and service delivery.

Infrastructure and support to providers

As part of the formative evaluation objectives, KTC developed a profile for each provider in December 2005 from a series of onsite visits with each of the providers. These profiles documented the infrastructure of each organisation (including the governance, management, financial stability and viability, quality management systems, organisation planning methods, information systems, human resources and risk management) and the profiles were updated by the providers in 2006.

An important factor of the formative evaluation is that all three providers were not *new* organisations commencing their first service. Being *existing* organisations, each of the providers already had a range of experience (two of the providers already had breast and cervical screening health promotion experience), infrastructure, processes and systems in place. New organisations may have needed a greater level of managerial intervention to help them establish core business systems. The evaluation and support provided for infrastructure therefore focused on the quality of the infrastructure to support the effective delivery of screening health promotion services, rather than establishing it from scratch.

From these profiles and through the formative evaluation, a good model of service delivery for dual contracts would be a provider who displays a range of qualities (a list of these is included in the recommendations).

Health Promotion Planning

The intention of the new dual contracts was to plan health promotion activity based on Māori models, and for KTC to assist providers with implementing these models throughout the three years. However, due to a lack of time available to institute Māori models before the first health promotion plans were due, the providers did not want to rush the adoption of Māori models for their initial plans. Consequently the initial health promotion planning support was provided by the NSU for the 2004/05 and the 2005/06 plans, using the Ottawa Charter planning template provided by the NSU.

The NSU was keen to see the implementation of Māori models so in late 2005, KTC were asked to support the development of the 2006/07 health promotion plans. For this period, the providers were able to select a Māori model, or combination of models, that they felt reflected their kaupapa and philosophy, their organisation and their services. KTC worked with two of the three providers (one abstained from support around planning) to ensure that the health promotion plans demonstrated their:

- **model and approach** – and why it was chosen (including the extent they had used existing models or a combination of models)
- **evidence base** – identifying their community (both qualitatively and quantitatively), the needs in the region/community, needs of priority women, how they would work with other stakeholders
- **activities or content** of the plan – how the model had been interpreted in practice, what resources were required (human, financial, health promotion), how the plan met the NCSP and BSA standards
- **Reporting and Evaluation** – how the health promotion activities would be evaluated, how evaluation was factored into planning, reporting the activities against the plan.

While providers had historically been effective at describing activities they intended to conduct, the areas needing the most strengthening were in using a robust evidence base upon which to plan activities, and subsequent planning for the evaluation of those activities. Supporting providers to maintain the link from planning

and evidence to activities and evaluation, was the main area in which KTC believed it added value to the providers.

As the formative evaluation concluded midway through the implementation of the 2006/07 plan – and therefore midway in their implementation of a Māori-model based approach - it is impossible for KTC to ascertain the effectiveness of the health promotion services under the Māori models. This was not intended to be an impact evaluation in any case. An impact evaluation would be required in the next 2-3 years to determine the results of implementing the models in 2006.

The *process* of using Māori models to underpin a more robust planned approach has been successful in itself, as the providers have developed plans which have allowed them to deliver health promotion services to Māori women in a way that suits their philosophy, organisation and approach. The providers have more ownership and understanding of their plans, and believe they can implement they plans in a manner appropriate to their community. They have a greater appreciation of the need to link evidence to planned activities and to tailor activities under a kaupapa Māori model to suit a diverse Māori audience.

In short, they have been able to more comfortably describe what they intend to do without trying to 'fit' planned kaupapa Māori approaches into an Ottawa Charter framework. There is a saying from a Ngati Porou elder, the late Rongo Wi Repa, that '*when you do Māori things, think Māori'*. By basing their philosophy, approaches and activities to reach Māori on a Māori model, the providers have found that 'fit' and their chances of success are greater because the participants (both providers and women) understand the service better.

In summary, whilst the evaluation has highlighted some challenges for the NSU and the providers, overall it has been a positive process.

For the NSU, there are positive lessons learned for contracting new providers in the future, and in time, the NSU will be able to analyse and evaluate the results of implementing Māori models of delivery in these sites. Few other areas in the health sector have the opportunity to specifically evaluate the implementation of a Māori model with a specific service, across three different scenarios in terms of geography and providers. The NSU will gain valuable insight to implementation of models in different settings with different types of providers. Stronger planning and use of evidence by providers should also reap benefits for the NSU, because results will be able to be tagged to specific baseline evidence. The NSU should also benefit through

these 3 providers being better aligned to the national standards, when the time comes to audit the services.

For the providers, they have had the opportunity to implement Māori models in a specific service, and for at least one provider, the Māori model is now pervading other health promotion services in their organisation. NSU's flexibility has allowed the provider to adapt the model outside of screening health promotion services. Additionally, providers have been able to tighten up their infrastructure with advice provided; to develop policies and procedures that did not exist before; and to strengthen their service delivery through a better planned approach. Planning has definitely improved for the providers and undoubtedly this will also offer lessons for other parts of their business. Providers have also strengthened their own evaluation of activities and are aware of how best to use this information to improve plans for the future.

KTC believes that in the next 2-3 years, both providers and the NSU should see improvements in screening rates as a result of Māori models being promoted and encouraged by the NSU; and more robust planning and measurement by providers. We recommend the NSU plan for an Impact Evaluation of these services in 2008 / 2009 in order to determine this.

In respect of the formative evaluation, it is recommended that the National Screening Unit:

- NOTE and ACCEPT this is the final Formative Evaluation Report of the three new providers contracted to deliver dual NCSP and BSA health promotion for Māori women

<u>Contracting Process</u>

- CONSIDER establishing a contract start date that is beyond the completion of negotiations and signing of the agreements [versus starting a contract 1 September but not issuing or signing these until October / November]

- CONSIDER allowing at least 6 months from the contract start date for "Establishment" to include meetings and relationship building with NSU (attending centralised meetings, training etc), local Lead and other ISP providers, and recruitment of Kaimahi

- CONSIDER paying new providers up front 3 months worth of funding for new services to cover recruitment (advertising), project planning, travel and other administrative costs pending commencement of Kaimahi – so that new providers do not have to carry these costs internally if there are delays in contracts / funding payments

- CONSIDER facilitating the introduction and coordination of new service providers with existing service providers – to clarify roles, responsibilities and "who delivers what" to avoid duplication and confusion over roles

- CONSIDER when contracting for new dual services that a good service delivery model for breast and cervical screening is one that the organisation displays:

Delivers whanau services – does not necessarily have to have provided breast and or cervical screening before, or even health services;

Has a defined Management commitment to the contract (and to formative support if provided) – this includes a designated Manager responsible for the service who participates actively in NSU-initiated communications (e.g. teleconferences and meetings);

Strong planning skills that can develop an independent service plan while acknowledging the 'fit' with organisational plans;

Has strong established relationships within the community or has ability to build these very proactively;

Has clear policies and procedures of operation particularly for management systems and health promotion service delivery;

Demonstrates mechanisms to meet coverage;

Has ability to give effect to strong coordination when multiple parties or multiple sites are involved;

Has commitment to professional development of staff and makes it happen!

CONSIDER when contracting for any new service that requires a formative evaluation and to improve effectiveness, the NSU could include:

- Arranging for the provider to undertake a self-assessment of the formative support they think they need, for presentation to the NSU for approval (the provider needs assessment tool in the appendix could be used as a guide);

- Using the self-assessment tool to help the NSU define the contract deliverables for the consultant providing the formative support;
- Clarifying the formative evaluation objectives for both the provider and the consultant in both their contracts, helps both parties work to achieve the objectives of the formative evaluation and contribute accordingly;

Allowing the provider to have a 6 month establishment period would allow the self-assessment to be completed and be established with the consulting providing the formative support.

<u>Planning Process</u>

- NOTE that despite the original intentions for the 3 new services to be "innovative" and use new Māori models, that this did not occur until the 2006/07 year, therefore KTC were not able to evaluate the implementation of these plans

- NOTE that the 2006/07 health promotion planning process was extremely empowering, and the ability for providers to interpret the framework and templates was a positive step allowing creativity and innovation.

- CONSIDER allowing providers to continue to write and develop their plan in a way that suits their chosen model – as long as it contain minimum requirements (comprehensive needs analysis, meets the needs of priority women, provides detailed evidence, evaluation etc)

- NOTE that the "kanohi ki te kanohi" panel approach adopted by the NSU was positive in that it allowed instant feedback. However, when this is not feasible it is essential for providers to get timely feedback on draft plans so they can finalise and implement the plans before the deadlines specified in the contracts

- NOTE that providers should be given at least 3 months to produce a robust and innovative health promotion plan – incorporating tikanga based models – that allows them time to consult and involve their local Māori community, other Kaimahi and other providers

- NOTE that plans are better done AFTER Kaimahi have been recruited so that they are part of its development and design, as this will enhance their ability to implement the plan

- NOTE that NSU training, conferences and hui should not be scheduled during periods when providers are trying to plan or report on their services. It is too time consuming to be able to undertake both successfully

- NOTE that regular, user friendly NCSP and BSA data (in the same format) should be provided to providers to assist in undertaking their needs analysis for the health promotion plans.

Service Delivery Process

- CONSIDER developing a "suggested or possible" job description for use by providers, particularly new providers who do not already deliver breast and/ or cervical screening health promotion to assist in hiring of new Kaimahi

- CONSIDER developing an introduction to the BSA and NCSP standards and the expectations of the position, which would be made available to all new Kaimahi. This would be particularly useful for Kaimahi who start after the new training for health promoters has been completed for that year

- CONSIDER dual contracts for BSA and NCSP health promotion for Māori women.

- CONSIDER redeveloping the NCSP standards to align to the BSA standards to ensure easy implementation and alignment of health promotion services.

- PROVIDE a full set of all NCSP and BSA resources to each provider BEFORE they commence delivery of the services.

Key points for providers are also included in the recommendations.

1. WHAKATŪWHERATANGĀ – INTRODUCTION

Māori and Pacific women's coverage and participation rates for both BreastScreen Aotearoa (BSA) and the National Cervical Screening Programme (NCSP) are around half the levels required for the screening programmes to be effective for these populations.

For BSA, the current target is to screen 70% of eligible women every two years (NSU 2004a). For the NCSP to be effective the programme needs coverage of 85% of eligible women over a three-year period (NSU 2000). Consequently, Māori females have twice the breast cancer mortality rate and four times the cervical cancer rate of non-Māori females (Ministry of Health 2006).

The National Screening Unit (NSU) is responsible for the planning, national co-ordination, funding and evaluation of both programmes, which are underpinned by a 'well women' focus. These two cancer screening programmes contribute to reducing the burden of cancer, and health promotion is an essential component of both programmes (NSU 2004b).

In early 2004, Kāhui Tautoko Consulting (KTC) Ltd was contracted by the National Screening Unit to undertake a three year Process, Impact and Formative Evaluation. This combined evaluation aimed to provide information about the BSA and NCSP health promotion services to increase the coverage and participation of Māori and Pacific women in these services.

The formative evaluation consisted of providing support to three new providers in the development of their dual contracts to deliver both breast and cervical screening health promotion simultaneously[1]. Each of the three providers operates on different structural models - one is a network of seven providers located across a wide regional area; one is a single entity in one location; and one is a well established provider with satellite sites in different communities. This fact in itself provided the NSU with the opportunity to test the dual service contracts in different settings and with different structures.

[1] Existing service contracts cover either BSA or NCSP health promotion services, and not both services. These dual contracts were the first issued by NSU to combine health promotion for both programmes for priority women.

The three providers included in the formative evaluation were:

- Mana Wahine – Wellington / Hutt Valley / Wairarapa (an umbrella entity made up of 7 members):
    - Kokiri Marae Keriana Olsen Trust, Lower Hutt
    - Whaiora Whanui Trust, Masterton
    - Ora Toa Health Clinic, Porirua
    - Hora te Pai Health services – Paraparaumu/ Waikanae
    - Te Ngawari Hauora Trust, Wellington
    - Maraeroa Marae Health Clinic, Waitangirua, Porirua
    - Koraunui Marae Hauora, Stokes Valley, Lower Hutt
- Raukura Hauora ki Tamaki – Manukau, Auckland (Raukura Hauora has other sites in other communities outside of Manukau)
- He Waka Tapu - Christchurch

This report incorporates the findings over the three years of the formative evaluation. A separate report has been completed for the process and impact evaluation.

1.1 Scope

1.1.1 Structure

Section 1 of this report outlines the scope and provides background information to provide a context to the findings of the evaluation. The methodology and approach behind this evaluation are included in **Section 2**. **Section 3** documents the findings of the formative evaluation while **Section 4** analyses the findings against the objectives of the formative evaluation. Lastly, **Section 5** provides recommendations for the future contracting of new providers.

1.1.2 Definition

Formative evaluation is gathering information in order to plan, refine and improve the programme (Waa et al, 1998). This type of evaluation ensures the programme is based on stakeholders needs and that the programmes are using effective and appropriate materials and procedures (Health Communication Unit, 2006).

Further, formative evaluation ensures independent constructive input into the programme development, by assessing the decisions that are being made and providing regular, formal feedback to the programme and its funders (Lunt et al, 2003).

1.1.3 Goal of the formative evaluation

The overall goal of the formative evaluation was to:

> *'Support the development of effective models of service delivery with new ISPs to increase Māori coverage and participation in NCSP and BSA, and explore effective models of service delivery".*

As the goal indicates, the main intention of the formative evaluation was to assess "effective models" of service delivery. These Independent Service Providers (ISPs) have a dual contract to deliver both BSA and NCSP health promotion services, unlike the majority of the existing providers who have contracts to deliver either BSA or NCSP health promotion only.

The intention of the National Screening Unit (NSU) was to allow some flexibility to providers to apply different approaches and methodologies – particularly Māori approaches - to deliver their health promotion services. The formative evaluation then involved support for these different approaches and models, and for the evaluator to provide information to the NSU to assist in the design and funding of effective screening services in the future.

In order to achieve these goals, KTC approached the formative evaluation in two key areas: firstly, support the infrastructure of the organisations to ensure they had robust systems in place, and secondly, to support programme planning, development and delivery.

1.1.4 Objectives

As defined by the NSU, the objectives of the formative evaluation were to:

Identify and describe how, and if, the diversity of the providers delivering screening health promotion services contributes to their effectiveness;

Demonstrate and describe the contribution that NSU can make in the development of new providers (in the future) from the beginning to assist with service planning, design and delivery;

Ensure the stakeholders' – NSU, KTC and the providers themselves – expectations and knowledge are shared;

Add value to the screening programme through an effective health promotion framework applied with new ISPs;

Demonstrate and describe how other strategies are integrated with the provision of screening health promotion services – in particular the Primary Health Strategy;

Māori Health Strategy He Korowai Oranga, the NZ Health Strategy and the NSU Strategic Plan;

Identify those areas that ISPs need or desire support in (from NSU), when commencing delivery of health promotion services in screening, and during the delivery period – to enhance their effectiveness in well planned health promotion planning and activities.

1.2 Other work related to the evaluation

1*.2.1 Process Evaluation*

The Process Evaluation involved the current providers contracted by the NSU to provide health promotion services for breast and/or cervical screening. The purpose of this process evaluation was to document, firstly, the range of activities and approaches used by health promoters to reach the target population, and secondly, the linkages and processes health promotion teams have established with other relevant service providers. Lastly, KTC visited each of the providers twice over the three years, and conducted an email survey in between to document changes made over time, why these were made and the impact of these changes.

1.2.2 Impact Evaluation

The purpose of the Impact Evaluation is to gain an understanding of the attitudes, behaviour and awareness of women in relation to the Breast and Cervical Screening Programmes. The findings of the initial focus groups indicated that women (from all ethnicities) primarily receive information about smears and mammograms from their Doctor/ General Practitioner (GP). However this information was not always enough to sufficiently prepare the women for their screening experience. Further focus groups were undertaken to identify specific issues for Pacific women. The final Process and Impact Report was presented to the NSU in December 2006.

1.2.3 Literature Review

To inform all components of the evaluation, KTC undertook a review of literature in 2004. This review highlighted that there are a number of barriers to consider in the development of appropriate health promotion strategies for both Māori and Pacific women. These barriers arise from personal, cultural and spiritual beliefs of women as well as their social and economic environments. The review also acknowledged that community development strategies were successful only when significant time was

invested in becoming familiar with the community and establishing the trust of the target population. Success has also occurred where ethnic-appropriate health promoters are utilised, and the community have had some input to the development of strategies (Kāhui Tautoko, 2004).

KTC also reviewed the Māori NCSP and BSA resources in 2005 and developed the new resources for both programmes.

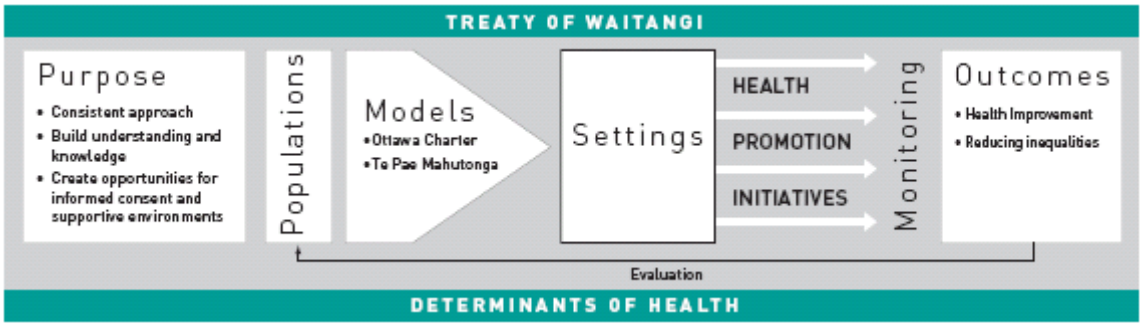
1.3 Background to screening health promotion

1.3.1 The screening pathway and programme logic

For this evaluation, KTC utilised the NSU's model as our intervention logic. Our understanding of NSU health promotion was based on this model. The NSU framework states that:

> *... the model for health promotion in screening programmes summarises the direction of health promotion activity and demonstrates the interdependence and necessity of integrating the determinants of health, the Treaty of Waitangi principles of partnership, protection and participation and health promotion models in order to effectively meet the needs of the under-screened and unscreened population*. (NSU 2004c)

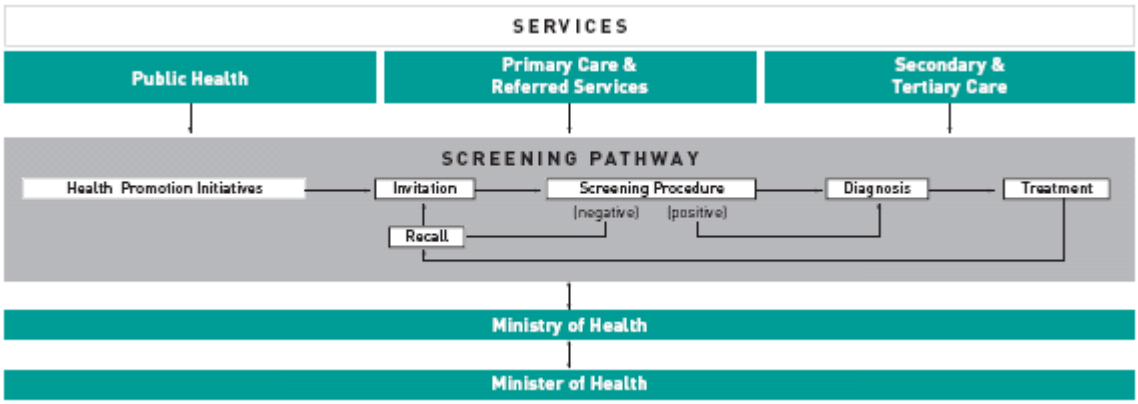
Figure 1: Model of health promotion in screening programmes



Source: National Screening Unit 2004c

KTC understands that this model fits within the logic of the wider screening pathway, which is represented in Figure 2.

Figure 2: The Screening Pathway and Roles of Different Services



Source: National Screening Unit 2004c

2. TIKANGA – METHODOLOGY

2.1 Approach

KTC utilised a kaupapa Māori approach throughout this formative evaluation. From our perspective, a kaupapa Māori approach means a commitment to wahine Māori and their whanau, and acknowledgement of the importance of Māori values, principles and te reo and tikanga Māori. The process, impact and formative evaluations recognised the challenges and specific issues in screening for wahine Māori. Our subsequent approach to this formative evaluation aimed to support the new providers in the delivery of their health promotion services to meet the needs of these priority women.

Rather than focusing on why Māori women may not participate in BSA and/or NCSP, the evaluation methodology aimed to support the health promotion providers to meet the needs of Māori women through effective and well planned health promotion. Consistent with Kaupapa Māori research, the findings of these evaluations can be used to reduce and eliminate ethnic disparities in screening and therefore improving the overall health status of Māori. (Curtis, 2004).

KTC considered our role to be two-fold:

- to support the providers to understand the NSU's health promotion planning requirements, meet the programme standards and audit requirements and to facilitate sharing of ideas and best practice.
- to be supportive and available, if and when, the providers required on an as needs basis when carrying out their planning and implementation of the dual services.

2.2 Method

As a formative evaluation, this methodology gathered information to plan and improve the health promotion programmes. The methodology for this evaluation was qualitative and consisted of three main methods:

- *Reviews of the organisation*: 'kanohi ki te kanohi' process to assess the organisations capacity and determine the level of support required. Eight key areas considered crucial for a well established provider were identified in

order to determine the level of support required. The criteria used in the Provider Needs Analysis is listed in Appendix I

- *Provider interviews and Discussions*: with health promoters, managers and relevant staff throughout the three years on a regular basis. These were held quarterly with each of the providers
- *Combined provider Hui*: to allow the three providers to come together to share knowledge, ideas and progress with their programmes. The initial meeting was held in July 2005, followed by a meeting in May 2006 and a final meeting in December 2006. Note that KTC did meet with the providers in late 2004, though this meeting was facilitated by the NSU.

All interviews were conducted during onsite visits and these meetings were recorded through written notes. Meeting minutes were taken for all group hui. Provider update meetings were held as required and two meetings were held for the health promotion planning with phone, email support provided in the intervening periods.

Data was also collected through official NSU and provider documents, and all three providers were asked to submit any relevant documentation about themselves. This included their own official documentation, initial proposals for the contract, draft health promotion plans and meeting minutes among others.

All survey tools were developed with feedback from the NSU project team. The Technical Advisory Group provided support and advice to KTC throughout the three years from a consumer, Māori research, health promotion, and methodological perspective.

Analysis of the information gained through this formation evaluation was carried out using the QSR N6 database where applicable. The qualitative data gained has been analysed against best practice (organisational review), by each case study and then by the processes involved in the formative evaluation.

Three reports precede this fourth and final summative report. The providers were consulted on the draft report and their feedback has been included.

2.3 Planned versus actual formative activity

As part of a larger Process, Impact and Formative evaluation, KTC had allocated 47 consultancy days to meet the formative activities required in the contract. A total of

207 days had been allocated between all three evaluations. However, to meet the needs of this formative contract a total of 50 days were provided through support to the new ISPs, writing reports or meeting with the NSU (more detail provided in section 3.1).

The original planning for the project was that all providers were new entities and would therefore need direct managerial level support to establish their infrastructure. Days were allocated for this infrastructural support work. Once it was known that the providers were not new entities, but were existing organisations that already had experience delivering health services, KTC's role changed from helping to establish infrastructure, to measuring the quality of that infrastructure and providing support where any improvements could be made.

The dual contracts were established to allow the three formative providers to utilise innovative models in order to plan and deliver their breast and cervical screening service. KTC's main role throughout the formative evaluation was to assist and document the processes used to determine how effective and useful the new Māori models were for planning for dual contracts. As explained in this report, the providers used the current planning approach and template based on the NSU's Ottawa Charter framework for both the 2004/05 and the 2005/06 years. Additionally the NSU provided the health promotion planning support to the 3 providers in these years. KTC's expected role in health promotion planning did therefore not occur until the third year of the evaluation. As a result, KTC activities focused on other support needs as defined by the providers.

So as not to duplicate the support or advice provided by the NSU, KTC did not engage with providers in the first two years of health promotion planning, so instead, focused on gathering information and documenting the activities and issues that providers were experiencing and providing other related support (more detail provided in section 3).

3. NGĀ KITENGĀ – FINDINGS

This section begins by documenting KTC's actions over each year of the three year evaluation. It then documents the findings of the following activities:

- establishing the providers
- infrastructure and support
- health promotion programme planning

3.1 Formative support provided by KTC

Throughout the three years, KTC offered the following aspects (taken up as deemed necessary by the individual providers):

- effectively identifying their community (through robust needs analysis), planning activities to meet the needs of the community and evaluating and reporting on their progress
- understanding the NSU health promotion framework and population based approaches;
- establishing any service processes and in particular around the NCSP and BSA standards
- self evaluating their work to enable on-going improvements to the health promotion programmes.
- identifying any risks or barriers to effective service delivery
- any other relevant area as deemed necessary by the provider.

A large amount of the support was provided through the quarterly meetings with each of the providers on-site. At the same time there were three meetings where the providers were able to come together as a group with KTC. These group meetings provided an opportunity for KTC to share any information to the group as a whole, while each of the providers was able to share their experiences and knowledge with each other.

<u>YEAR ONE: January 2004 – December 2004</u>

During this period, KTC used 11 days to:

meet with each of the providers twice;

attend a joint meeting with the providers and the NSU;

meet twice with the NSU and;

write a separate implementation plan.

The meetings with the providers that occurred in late 2004 involved consulting on the draft implementation plan; clarifying roles (NSU and KTC); discussing the needs and expectations for the formative evaluation; and documenting the establishment of the contracts e.g. challenges, progress, contracting, recruitment etc.

By late 2004 when KTC commenced its evaluation, not all of the providers had signed their contracts with the NSU. The providers therefore preferred not to have formative support until their contracts were signed, and they felt it was too early to fully identify their needs. While health promotion planning processes and approach were discussed, at none of these meetings were KTC involved in supporting actual planning (as NSU were providing the support around health promotion planning).

KTC provided He Waka Tapu with a copy of its paper 'Quality Management Systems - Accreditation options for Māori providers' to offer some suggestions for accreditation that they were interested in. KTC also provided an infection control manual for the clinical Whanau Ora service which works in tandem with the health promotion services and which had overlaps with cervical smear services.

KTC met twice separately with the NSU to discuss the formative evaluation and used five days for reporting which included drafting an implementation plan for the formative evaluation (separate to the implementation plan for the process and impact evaluations).

<u>YEAR TWO: January 2005 – December 2005</u>

In the second year of the project, KTC provided a total of 21 days of consultancy time, this included meeting the NSU a total of 7 times, and meeting three times with each of the providers to:

complete the provider needs assessment tool;

identify the necessary support required (in terms of training, planning, policies and procedures etc);

discuss their quarterly progress and activities through three visits to each of the providers.

KTC met with He Waka Tapu in:

March 2005 to document the activities for the first formative report,

October 2005 to commence the development of the provider profile, document planning for 2005/06 and reporting on the previous years activities

In addition there was a proposed meeting in December 2005, and although this meeting was cancelled, KTC completed the provider profile and discussed using the 2006/07 health promotion plans - by phone and email. KTC also reviewed qualitative research on 'strategies to promote cervical and breast screening resources' completed by the health promoters at He Waka Tapu, and provided comment on this. KTC also reviewed the plan for the Ngai Tahu Collaborative project.

KTC met with Raukura Hauora o Tainui in:

March 2005 to discuss the 2004/05 health promotion plan, completing their regional community profile and the importance of building evidence of their community, and the health promotion framework.

August 2005 to discuss planning, regional collaboration, their quarterly activities, recruitment and workforce development

December 2005 to complete the provider profile, discuss their most recent activities and discuss health promotion planning support for Raukura. At the time the Manager was planning on implementing an integrated model for all health promotion teams at the organisation (due to change in management this did not occur)

KTC met with Mana Wahine:

April 2005 to discuss their planning processes, the issues with the Hutt DHB over their subcontract and their training and planned activities for the coming year

August 2005 to discuss planning; Support to Services supporting documentation; Governance and management of Mana Wahine; the activities to date and other related issues. KTC provided a draft policies and procedures manual for the Mana Wahine governance team to consider, amend and adopt;

December 2005 to complete the provider profile.

The first planning group meeting between KTC and all three providers was held in July 2005 at KTC offices in Wellington, and the providers came together to share knowledge, approaches and experiences in the first year of their contract. This meeting involved each of the providers presenting their plans, reporting on activities to date and lessons they had learned up to that point. At this meeting the providers

expressed their concern over the fact they had not yet been able to utilise Māori models for planning due to time constraints. Time constraints had mostly arisen because the deadline for submitting plans came very shortly after the providers had finalised their contracts with the NSU, thereby not allowing sufficient time for them to consult on Māori models and plan a new approach.

KTC also met with the NSU on:

18th February 2005 to discuss the progress of the three formative providers in relation to their contract and implementation, and to hear any NSU identified issues or feedback;

2nd June 2005 to discuss using Māori models and the possibility of the providers using these models for planning from 1 January 2006 onwards;

19th September 2005 to discuss the potential for the Te Pae Mahutonga model being used by providers; to assess progress with KTC meeting the NSU objectives and ensuring NSU satisfaction, and to amend the implementation plan where directed by NSU;

28th September 2005 to discuss progressing the formative evaluation, reporting requirements and the planning process with the providers for the coming year

1st and 3rd November 2005 to discuss the support being provided to the formative providers; possible extensions on the formative evaluation (due to previous delays and likelihood that the new Māori model approach would not be implemented until the 3rd year of the evaluation instead of the 1st year), and to determine KTC's role with the next providers' health promotion plans that were due;

8th of November 2005 to receive a schedule of NSU staff names, roles and responsibilities (up to that point there had been staff changes at NSU and the formative providers had become confused about who to deal with on specific issues, so the NSU produced a helpful schedule of staff and roles); the principles and guidelines that KTC would use when supporting the providers through the development of their health promotion plans using Māori models; and also determining the activities in line with the contract to be completed through 2006.

During this period KTC wrote the following reports:

the first formative evaluation report (April 2005) which documented the first year of the formative evaluation including the contracting process, health promotion planning, recruiting new Kaimahi and implementation of service to date;

the second formative report (August 2005) documented the quarterly activities of the providers including the health promotion planning, resourcing and their views on the findings of the 2005 Impact Evaluation Report and any other related issues;

the third formative report (December 2005) documented the provider profiles (details are provided in section 3.3 of this report), their programme design and delivery and their planning for 2006/07.

YEAR THREE: January 2006 – December 2006

Towards the end of 2005, the NSU agreed that providers could adopt Māori models – if they wished – for the 2006/2007 health promotion planning round. This decision was received enthusiastically by the three providers and all agreed to adopt Māori models and use this as the basis for their plans. Draft plans were due in May 2006 for the 2006/2007 year and KTC offered its support to the formative providers in developing these plans based on their chosen model(s) and the offer was accepted by two of the three groups. The third decided to develop the plan without assistance from KTC.

During the final year of the formative evaluation in 2006, 18 days of consultancy time were utilised to support the successful development of health promotion plans using Māori models. KTC focused on ensuring that providers' 2006/07 health promotion plans were:

- evidenced based;
- directly linked to the needs of priority women;
- inclusive of self evaluation;
- able to identify who their stakeholders and other providers in the region were and how they were going to work with them;
- able to describe their personnel and infrastructure;
- underpinned by a robust intervention logic;
- able to reflect how they met the NCSP and BSA health promotion standards;
- clearly reflective of their chosen Māori model.

KTC met twice face to face with He Waka Tapu on:

15th March 2006 to discuss Te Pae Mahutonga and their template, activities and concepts, and to contribute to production of their plan;

30th March 2006 to assist in the recruitment of a new Kaimahi and provided support around reporting on health promotion plans to the current Kaimahi.

KTC also peer reviewed and provided comment on the draft health promotion plan by email and telephone before the plan was submitted by them to the NSU.

KTC met with Mana Wahine on four occasions in:

13th February 2006 with the Chairperson and Coordinator who identified internal issues with the Mana Wahine coordination, and asked KTC to facilitate a session with all members of Mana Wahine to improve the situation;

2nd March 2006 where KTC facilitated the discussions between the members to ensure they were all committed to the kaupapa, and discussions were held around the role of Mana Wahine, of the member organisations, the managers' roles of each organisation, the role of the health promoters and the role of the Coordinator;

22nd March 2006 where it was confirmed that the Mana Wahine Coordinator's role had been confirmed - based on the previous meeting – and had been adopted. There were also general discussions on the planning for 2006/07 and advice provided on the draft approach intended at that stage;

19th April 2006 involving a meeting between Mana Wahine and the DHB to clarify roles and responsibilities within the region and the current subcontract. KTC also facilitated a session around needs assessment, reporting and evaluation and how the needs of priority women were intended to be met through the plan. KTC also provided a copy of the literature review to help with the evidence based being used for the plan.

Following this meeting, KTC reviewed the draft health promotion plan by email and provided comments where necessary.

KTC met with Raukura Hauora in March 2006 to discuss Te Pae Mahutonga, and following the session, their Management indicated that support was no longer required as they felt confident to prepare their plan without assistance from KTC. At the request of the NSU, KTC returned to Raukura Hauora in June 2006 to again provide some support with their health promotion planning.

KTC also developed a self evaluation tool for the providers to measure their own progress towards meeting the goals in their plans (the self evaluation tool is included in Appendix II).

The third and final combined provider meeting was held at KTC offices in December 2006. The providers had requested support around the BSA and NCSP standards so KTC developed a guideline to support providers in preparing for their audit for the service. The guide offered advice for both the organisation and the health promotion team on best practice to assist them to address both NCSP and BSA standards; the applicable contract requirements; and to ensure they had appropriate evidence to demonstrate compliance. This guideline did not guarantee an automatic "pass" of their audit – rather it aimed to prepare providers to cover all necessary areas.

This was the final activity in KTC's formative support for the providers.

KTC also met with the NSU on:

24th January 2006 to discuss the process for the providers utilising Māori models. The NSU agreed to allow a 'blank sheet' approach for the providers to interpret the models for their plans and that KTC should meet the providers twice before their May 1st presentation to NSU of their plans;

13th April 2006 to discuss the process for the May 1st meeting and the timelines which would follow, to ensure all providers completed their plans by 1st July 2006 for implementation. KTC and NSU also discussed concerns over one provider choosing not to undertake formative support and potential risks of this decision;

18th April 2006 to confirm the guidelines for the health promotion plans and the NSU requirements to ensure the plans would be in a state to be approved. These included ensuring the plans identified the model used, the evidence base used, the proposed health promotion activities, and their proposed reporting and evaluation activities.

KTC used 3 days to complete the reporting requirements of this formative evaluation.

3.2 Establishing the providers

3.2.1 Contracting the providers

All three providers responded to the original RFP from the NSU and presented their proposals to a panel in Wellington in June 2004. This was a positive process for all involved as they were able to receive instant feedback from the panel on their

presentations. Within two weeks all providers were contacted personally and then advised by letter that they were successful. Providers commented that the panel presentation was an excellent process and they appreciated senior management from NSU being on the panel as they felt this demonstrated strong 'high level' commitment toward them.

In July 2004, NSU staff traveled to meet the providers to introduce their team; describe the screening programme and their roles; and to work through a draft Service Specification. The "face to face" meetings were seen by all three formative providers as useful and again demonstrated strong commitment from the NSU through representation from NSU management at these meetings.

The contracts for the 3 new providers officially started on **1 September 2004** and this was the date given to providers during the face-to-face meetings in July 2004. They expected to conclude contract discussions in August 2004 and to then receive their first contract payments in September 2004. Although all providers expected to receive and sign the contract before the start date, this was unfortunately not achieved. Providers were advised by NSU that delays were due to problems with Healthpac[2] completing the contract documentation and that they were continuing to prompt Healthpac to speed up the contracting process for the providers.

Even though they did not have contracts or funding, the three providers started working on their health promotion plans which they knew from reviewing the Service Specification beforehand, would be due shortly after signing the contract(s). As one provider mentioned, they completed their plan '*in the interests of maintaining a positive relationship with the NSU*'.

All three providers attended a meeting with the NSU at Wellington airport in November 2004 at their own cost. Neither Raukura Hauora nor He Waka Tapu had recruited new staff, as they were hesitant to do so without a contract, so this meeting was attended by the Managers only. KTC also attended this meeting as an introduction to the three providers and all three felt the independent evaluation was a positive step in the establishment of their contracts.

Mana Wahine received a draft contract from Healthpac in the last week of October 2004, while He Waka Tapu and Raukura Hauora received theirs in late November 2004. For the latter two providers, they had up till then carried the establishment

[2] Healthpac is the Ministry of Health, NSU and DHB's centralised agency for processing contracts and payments in the health sector.

costs themselves since September, and they eventually received their first payment under the contract in December 2004.

Mana Wahine, however, through miscommunication over the NSU invoicing procedures (which they found varied from other MOH processes that they were familiar with), covered the costs themselves up to March 2005. Absorbing costs for the first 7 months (including attending two meetings during October & November 2004 for training and a new provider meeting) was difficult for them. This would not have been possible for any *new* provider without other accumulated funding to draw from.

As a result of the delays with processing the contracts and then the subsequent payments, providers discussed among themselves the potential to exercise some penalties on the NSU due to the frustration they were experiencing. They noted that the contract had significant clauses relating to NSU's ability to withhold payments if the provider did not meet their deliverables - however there was no penalty on the NSU if they did not deliver on their obligations (i.e. making payments on time). They considered this to be "double standards". While this concern did not go any further, there is a lesson in there that perhaps contracts should be reviewed to be reciprocal in respect of penalties for non-performance. If the delays are caused by Healthpac, the NSU would need to be able to pass this penalty on. It is a matter worth exploring by the NSU.

The providers - in the short period between 1 September 2004 and 31 March 2005 - had also dealt with multiple NSU staff (e.g. contracts staff, health promotion staff, management, clinical experts) which at times became confusing for them as they could not identify a single 'relationship manager'. Sometimes they were receiving different or insufficient information from different NSU staff which added to their frustrations. It was unfortunate that staff changes occurred at NSU during this period, as this only added to provider frustrations following the contract problems with Healthpac. It is clear some goodwill generated by NSU's well received up front work with the selection panel and site visits, was lost in the 6 month period that followed.

The first formative report (Kāhui Tautoko 2005) highlighted these issues including a request from the providers to have an identified relationship manager. The NSU accepted this recommendation and moved quickly to address the concern. Since

then, the providers have had one ISP account manager and this has worked well from the providers' perspectives.

Overall, the less effective features of the establishment phase were:

delays by Healthpac in processing contract documents and payments some 3-4 months after the contract start dates;

providers having to carry establishment and recruitment costs for the first 3-4 months due to the Healthpac processing delays;

some loss of goodwill toward NSU caused by the Healthpac processing delays.

Overall, positive features of the establishment phase where:

senior management involvement in the selection panel;

inviting personal presentations of proposals to a panel;

site visits soon after selection, involving senior management – thereby demonstrating high level commitment;

NSU's quick response to remedy relationship management confusion, with the identification of a single ISP Account Manager for the providers;

the combined early meeting of providers at Wellington and introduction to the formative evaluation contractor.

3.2.2 Recruiting Kaimahi

For all three providers, from the time the contract started (1 September 2004) it took around 5 -6 months to get the health promoters fully oriented into their roles.

For He Waka Tapu, the Clinical Coordinator moved into the role and undertook initial planning. Recruitment of a new Kaimahi to work alongside the Clinical Coordinator began in October 2004 with internal discussion over the expectations of the role and whether it was a strategic and more research role or more front line hands on. Upon receiving the contract, the Job Description for a front line health promoter was finalised and the job was advertised in November 2004. Despite national advertising and high interest, He Waka Tapu received only 6 applications, and from this pool two applicants were interviewed. The successful candidate had previous experience working on a BSA project and had many contacts in the area, and she commenced the position on 7 February 2005.

Raukura Hauora commenced recruitment in December 2004 upon signing their contract at the end of November 2004. Raukura Hauora found it difficult to find qualified staff in a small workforce pool, at the same time absorbing costly advertising expenses to advertise nationally for staff. Their two new health promoters commenced in March 2005, and unfortunately missed the October 2004 NSU new health promoters training.

Mana Wahine finalised their contract with the NSU in December 2004 and were able to allocate service delivery across the 7 providers including targets per provider and funding to be allocated per provider. At the same time, they were in the midst of re-negotiating their subcontract with the Hutt Valley DHB. Rather than recruit NEW health promoters, it was considered that existing health promoters employed under the DHB subcontract on part time hours, could increase their hours with the NSU contract and provide more services.

Key lessons from this process are that providers need up to 6 months to full recruit new health promoters and orient them to their roles, and that deliverables due in the interim (if any) become the responsibility of management instead. This means workers have not been involved in the initial planning and set up of the service, and as a consequence, the opportunity to gain useful knowledge and experience and to take immediate ownership of the service, is lost. Additionally, if recruitment is not well-timed with the NSU's annual Health Promoter training programme, new employees can 'just miss out' and have to wait for up to 11 months to join the next training session.

3.2.3 Relationships

Relationships with other NCSP/BSA Providers

When establishing the contracts of the new providers, there was apparent confusion in all three regions among existing NSU-funded providers, over the role of the new dual-service ISPs. The three new providers understood that the new contracts would be complementary to existing services, and not duplicating them so they did not share any concerns.

While Raukura Hauora noted some "uncertainty" among other providers in the South Auckland region, they were able to mitigate potential issues through making contacts and establishing relationships with others in the community. It should be noted that there were no other providers directly providing services in the region they were funded for.

For He Waka Tapu, having reviewed the process in hindsight, they would have preferred that some form of official notice of their success and new service was advised to the two Lead providers (NCSP and BSA) in Christchurch. While the NSU had communicated individually with the current providers about the new service, and through programme manager meetings, the absence of formal advice appeared to limit the extent to which official shared planning and relationships with the two local providers could take place, and only tentative action could be taken. He Waka Tapu would have preferred that NSU facilitated a meeting of He Waka Tapu, NCSP and BSA in Christchurch to bring the parties together and explain the differences of the new service and how NSU expected the three services to work together down the track.

Mana Wahine was, from their perspective, very clear in their proposal and presentation, that the new service was planned to complement and enhance their existing services that were subcontracted to them by the Hutt DHB. They had been providing their existing breast and cervical screening health promotion services under subcontract for many years, and saw this new service as an opportunity to expand existing services and to undertake new activities that they could not do previously due to lack of resources. There was never a question of the seven individual provider members of Mana Wahine bidding on their own, because the Mana Wahine model - which originated with cervical screening some years ago - had already proven successful as far as they were concerned. They felt that NSU were accepting of the fact that the new service was complementary to their existing services contracted by the Hutt DHB, but unfortunately the Hutt DHB did not share that view. Instead the Hutt DHB saw the new dual-service contract as an opportunity for them to revise the subcontract arrangement completely because they assumed the NSU was now going to fund Mana Wahine health promotion services.

Like He Waka Tapu, Mana Wahine expressed concern that no official notice of the new service (and how it was expected to work with existing services contracted by NSU in the region) had gone to their local Lead Provider / DHB, and that this generated problems for them. As a subcontractor to the DHB for health promotion services, they ran an immediate risk of having their existing subcontract terminated because the DHB assumed this was a duplication of services. In fact, the DHB notified Mana Wahine that they planned to exit their existing subcontract as a result of Mana Wahine receiving the new contract from NSU. Mana Wahine felt very strongly that NSU should have notified the DHB of the contents and intentions of the

new contract as a part of the overall service package for the Hutt Valley, and were disappointed that NSU did not do this.

Relationship with the NSU

During the initial contracting process and the following months, the three providers found the NSU Management supportive of the new contracts and using innovative models to plan, though at times they received less clear signals from operational staff. For example, the NSU Managers agreed that the health promotion planning could and should involve Māori models like Te Pae Mahutonga, yet the health promotion staff who came to assist the providers with planning, brought the Ottawa Charter template to advise them on planning, and strongly encouraged the use of this template.

It was clear that providers enjoyed the leadership demonstrated by NSU Managers in building a relationship with the providers from the outset. While the three providers did not expect constant contact from them, providers would have liked 6 monthly Manager-to-Manager contact to discuss strategic issues - supplemented by the identified ISP Account Manager for day to day issues. These were not such relevant issues for Raukura Hauora as they already had established relationships with the NSU through their existing contract, and were familiar with the processes and NSU staff.

Key lessons in regard to relationships between new providers and the NSU are:

NSU giving consideration to NSU Management having regular (6 monthly) strategic forums with ISP provider managers to cement the relationship initiated at the selection stage;

NSU notifying its' existing NCSP / BSA providers formally, of new services and providers being established in any area – and where possible, facilitating meetings of providers operating in a single region, to ensure everyone understand their roles and service boundaries / parameters.

3.3 Profiles of the providers

One of KTC's deliverables under the formative evaluation was the development of profiles of each of the three providers. The content of this section was gathered during the quarterly meetings, through document reviews and onsite interviews with

key staff held in December 2005. Any changes to these findings were provided through by email or meetings during 2006.

The best practice model used to develop the organisation profile incorporated seven elements:

- Strategy, planning and performance management
- Structure and Human Resources
- Governance
- Financial Management
- Risk Management
- Communications
- Information Systems

3.3.1 Strategy, planning and performance management

KTC's assessment of the strategy, planning and performance management undertaken by both the governance and management of each organisation, focused on the Constitution and Kaupapa, Strategic / Annual and Business Planning, Planning Models and Consultation, and Quality Systems, including documents, management, accreditations and standards.

Constitution and Kaupapa

Mana Wahine is an Incorporated Society with a formal Constitution which describes its' philosophy and purpose. The sole focus of Mana Wahine is on *well women's health*.

Raukura Hauora o Tainui ki Tamaki is incorporated as a Charitable Trust and has been since 1994. Raukura Hauora has a holistic approach to healthcare – "*to provide quality health care services to all people residing within the boundaries of Tainui that embraces the individual's right for integrity and dignity within a culturally appropriate environment*."

He Waka Tapu began as a Trust, and is now a Charitable Company (as of 1 April 2005). This brought about change in the Board from Trustees to Directors however the members remained the same. He Waka Tapu focuses on *working with Māori whanau*. Breast and cervical screening is one of the many kaupapa promoted by He Waka Tapu. Other kaupapa include reducing violence, Alcohol and Drug, mental health/AOD, gambling and addiction services along with a rangatahi service for

young people, and issues relevant to Wahine Māori including screening and individual, relationship and family counselling.

Strategic, Annual and Business Planning

At the time of writing this report, Mana Wahine was in the process of finalising their strategic and annual plans for 2007/08 (developed by utilising the Māori Provider Development Fund). Each member of Mana Wahine have their own plans but there is no combined strategic planning; annual business planning or quality planning processes currently undertaken by Mana Wahine as an entity. Mana Wahine had not produced annual accounts or audits, or Annual reports as at December 2005. The first AGM for the 2004/05 year was held in 2005 - there had otherwise not been any AGM in the past as there was no funding to report on, and members were already meeting frequently anyway.

Raukura Hauora has a Strategic Plan in place for the period 2004 – 2008. There are also Business Plans in place for each core service area. Consideration and approval is sought from the Raukura Hauora Board, for management and preparation of the 3 – 5 year Strategic Plan. Raukura Hauora presents an annual report, annual audited financial accounts at their annual general meetings.

He Waka Tapu did not have a strategic plan at the time of review, however they were provided with a template following an independent assessment by KPMG. Most He Waka Tapu contracts were historically short term and this had impeded their ability to undertake long term planning. They do however have written annual plans and business plans.

Health promotion planning for each of the providers is included in Section 3.3.

Quality Systems

Mana Wahine has formal Policies and Procedures for governance and management practice at member level, and they have recently used the Māori Provider Development Fund to develop specific policies and procedures for Mana Wahine as a separate entity. KTC provided Mana Wahine with a template for Governance and Operational policies and procedures to support this development (and the Table of Contents for the manual is included in Appendix III). While there is no formal internal audit system or internal evaluation process, KTC was involved in the development of the Coordinator role and responsibilities which now includes

quarterly visits to each of the members to ensure the quality of the services and prepare for their NSU audit.

Raukura Hauora has a Quality Assurance manual which contains all organisational and service delivery policies and procedures, including policies on Continuous Quality Improvement. The framework that Raukura Hauora uses to develop their organisational policies and procedures is called *Te Taumata* – an internally developed framework for quality and cultural appropriateness. Raukura Hauora employs a Quality Service Manager, whose responsibilities include quality and clinical assurance, health and safety, infection control, privacy issues and complaints. The Board has overall responsibility for ensuring that the quality management system is continuously monitored for improvement. Raukura Hauora has governance policies in place that are reviewed. These policies cover the following areas:

- Determining the strategic direction and vision
- Policy formulation (the key policy areas are risk management, human resource management, ethical behaviour, public and media relations, legislative compliance)
- CEO selection
- Risk Management and control
- Legislative compliance
- Performance monitoring
- Reporting on stewardship
- Board meeting procedures
- Appointment and role of board members
- Role of Chairperson
- Role of CEO in relation to the Board
- Board committees
- Cultural safety

While individual members have their own quality management systems (QMS) and some are accredited under the Health & Disability Sector Standards, Mana Wahine as an entity does not have a formal QMS or quality plan.

Raukura Hauora has successfully gained the following standards and accreditations:

- July 2003 – 3 year certification against the AS/NZS ISO 9001:2000 Quality Management systems and AS/NZS 4801:2001 Occupational Health and Safety Management systems;

- September 2004 – 3 year certification against the Health and Disability Services (Safety) Act 2001 (HADS).

During 2004, they commenced work towards accreditation against the Royal NZ College of General Practitioners standard for general practice care.

He Waka Tapu had policies and procedures for some services as at December 2005, and were yet to develop policies and procedures for their Family violence, Wahine ora and Whanau ora contracts. He Waka Tapu have been audited twice to receive certification for CYFS and Family Court, however they have not been audited by the DHB.

3.3.2 Structure and Human Resources

KTC's assessment of the organisational structure and human resource management includes composition of staff and communication, human resources policies and procedures, and staff training and development.

Organisation structure

While Mana Wahine is an umbrella entity for the 7 members, this legal entity had not employed any staff since its inception. However, one of the members (Kokiri Seaview) acted as an informal coordinating body and allowed one of its' staff to contribute time to a coordination role. Once the dual contract was taken on board the need to formalise the coordination role became more evident. Throughout the duration of the contract the Coordinator role had continued to expand so the members formally defined the roles and responsibilities of the position during planning sessions with KTC. At that stage funding was ring-fenced from the Mana Wahine budget to pay for a set number of hours for the incumbent to undertake this role.

Raukura Hauora employs 150 FTE staff across two sites (Tamaki and Waikato). The dual breast and cervical screening contract is delivered out of the Whanau and Community Health Services team who are based in the Tamaki office in Manukau. The team leader for health promotion manages both the Tamaki and Waikato services.

He Waka Tapu employs twenty four staff over four teams and each team is supported by the He Waka Tapu administration. The health promoters form the basis of the Wahine Ora team and oversight is provided by a manager who also supervises other teams.

Human Resources Documentation

At Raukura Hauora, Human resource management is the responsibility of the Executive Manager, Business Support. Raukura Hauora has an extensive set of human resource policies and procedures that have been under review since December 2005. There are management policies for the role and function of Management, their responsibilities to the Board and their systems. The policies cover the following areas:

- Recruitment
- Redeployment and reappointment
- Employee entitlements (including leave)
- Staff practice, conduct, complaints, grievances
- Confidentiality and privacy
- Staff development
- Supervision
- Orientation and induction
- Performance management
- Records

He Waka Tapu has their own policy and procedure manuals which include written policies around workforce development.

Due to the fact that Mana Wahine had not formally employed staff in the past there were no human resources policies and procedures. However each member was free to adapt their own human resources policies and procedures for their own situations. Now that Mana Wahine has defined the role of the Coordinator they are reviewing the need to implement human resource policies and procedures and KTC has provided some draft templates to assist in this process.

Staff training and development

The responsibility of staff training and development at Raukura Hauora is that of the Regional Manager/CEO. Staff training, planning and implementation are in accordance with Raukura Hauora's policy for staff development. Both health promoters from Raukura Hauora have attended a number of internal and external training including event management, media, continuous quality improvement and risk management training. They have also participated in all WONS professional health updates (both breast and cervical screening), any local Auckland or Manukau

City Council training offered in the region. While both health promoters are planning on enrolling in the event management diploma through the Auckland Institute of Technology they would both like to do Māori health paper at Auckland school of population health in future.

He Waka Tapu supports staff training by developing training and development plans for each staff member. He Waka Tapu also offers in-house training where available and sessions are provided on issues such as suicide and social work. During the formative evaluation, one health promoter from He Waka Tapu completed a Post-Graduate Diploma in Public Health from Otago University.

Mana Wahine has their own training programmes for health promotion that they have delivered for many years and is advertised on the Kokiri website. Staff from all members are encouraged to attend this training and the current training programme was developed in consultation with the members and health promoters. The Level 1 and 2 course offers an introduction to anatomy and physiology, sexually transmitted diseases, attitudes and contraception choices among other topics, and enables health promoters to deliver well-women education sessions to women and their whanau.

All providers participated in NSU training offered during the period of the formative evaluation, and this included:

Monthly Kaimahi teleconferences

National Kaimahi Hui

NSU Screening for New Health Promoters training

NSU Screening Symposium

Health Promotion Uni-disciplinary Groups (BSA and or NCSP)

3.3.3 Governance

KTC's assessment of the effectiveness of governance was made in relation to the composition and role of the Board and/or Management for each organisation.

The Mana Wahine Board is made up of a 'Management Committee' comprising Managers from each of the seven providers who are members of Mana Wahine. There is a Chairperson who is also the Manager of Kokiri-Hauora (one of the provider members). This Board determines the direction and co-ordination of the seven providers in relation to the service contracts provided.

Raukura Hauora has a Board of six members comprising of five Trustees and a Chief Executive Officer. The key role of the Board is to develop the overall strategy for the organisation. The Management structure for Raukura Hauora consists of a Board, CEO, Executive Managers, Service Managers, Senior Team Leaders, Team Leaders and operations staff. The CEO is responsible to the Board for implementing Board decisions, providing advice to the Board and ensuring all functions, duties and powers delegated by the Board are properly performed. The CEO manages all organisational planning activities maintaining legislative compliance and acts as an interface between the organisation and the public.

The Directors of He Waka Tapu are elected at the regular AGM. The executive group for He Waka Tapu is made up of a Managing Director, Manager, Finance Manager and Kaumatua.

3.3.4 Financial management

Our assessment of the financial management of the organisations focused on the policies and procedures for effectively and efficiently managing the finances of the organisation. We did not conduct a financial audit as this was not part of our brief.

Up till December 2006, practice for Mana Wahine had followed the policies of Kokiri-Hauora as a fully audited and viable entity. Kokiri-Hauora provided free financial services under an informal arrangement to Mana Wahine. Financial policies have been included in the new Policy and Procedure Manuals. Mana Wahine operates a separate bank account that is managed by Kokiri-Hauora (via the Chairperson and Coordinator) on behalf of Mana Wahine.

Raukura Hauora has some financial policies and procedures in place and these were under review in December 2005. The financial controller at Raukura Hauora is responsible for the financial management of the organisation. Raukura Hauora accounts are prepared annually and are audited by CST Nexia Audit, Manukau City.

Financial policies and procedures for He Waka Tapu are encompassed in their policies and procedures manual. The organisation uses MYOB for all payroll and accounts. The budget for He Waka Tapu is ratified by the Board at the AGM. All accounts are sent to an independent auditor. He Waka Tapu has produced audited accounts annually.

3.3.5 Risk Management

KTC's assessment of the organisation's risk management focused on identifying potential risk, and identification of any policies or procedures to guide practice around risk management.

Providers of Mana Wahine are required to discuss areas of potential risk at the management committee meeting however there were no documented procedures for risk management. This was being addressed through development of new Policies and Procedures with funding from MPDS.

The development of risk management strategies for Raukura Hauora is a key responsibility of the Board. The identified key risk areas are Financial, political and economic environment, governance, business and strategic issues and operational issues. Risk management objectives have been set for Raukura Hauora, and every manager and employee are responsible for managing risk in their area through:

- Risk identification
- Analysis
- Evaluation
- Treatment
- Communication and consultation with all stakeholders
- Monitoring.

He Waka Tapu has documented policies and procedures for risk management which identify how the organisation manages and mitigates their risks. The teams meet fortnightly and these meetings include identifying risks and strategies to resolve the issues. The wahine ora team manager is responsible for reporting any risks and resulting strategies to the Manager who then reports to the Chief Executive and the Board.

3.3.6 Communications

KTC's assessment of the organisation's communications looked at the effectiveness of internal communication.

The Mana Wahine Management Committee meet bi-monthly and minutes are taken by Kokiri-Hauora and kept in a separate Mana Wahine minutes folder. The Health Promoters from each of the seven member providers of Mana Wahine meet on the alternative months from the bi-monthly meetings, to share experiences and

information from an operational level. Minutes of these meetings are also taken by Kokiri-Hauora.

The Raukura Hauora Board meets every six weeks to review reports from management on the organisations activities. It is up to each team manager to gather information from team members for their board reports and to disseminate information from the Board to their staff.

The He Waka Tapu Board of Directors, chaired by the Chief Executive, meets bi-monthly. The Manager leads the day to day operations and reports to the Chief Executive. Kaumatua support the Board of Directors and also participate in the Kāhui Kaumatua Council which meets monthly to facilitate ideas in the Māori community. The teams from He Waka Tapu meet fortnightly and the meetings are minuted and then provided to the manager.

3.3.7 Information Systems

KTC's evaluation of the Information Systems of each organisation looked at the presence of information and communication tools and policies and procedures to guide use of the system.

Mana Wahine as an entity does not have any electronic information systems (i.e. network, computers or system). Passing of electronic information occurs by email through Kokiri-Hauora. Mana Wahine has its own page on the Kokiri Marae website. This webpage outlines the history, its members and services provided. Mana Wahine does not collect any specific programme or client information on any database as this is done at provider level. Mana Wahine does have some paper-based information systems which are held at Kokiri-Hauora for meeting minutes, health promotion plans and reports and correspondence with NSU.

At Raukura Hauora, information technology is the responsibility of the Executive Manager, Business Support. As a large organisation with many staff and multi-sites, Raukura Hauora is reliant on the networked systems for maintaining communication and storing records. The organisation has information technology policies and procedures that cover security, usage, email and internet use, and computer viruses.

He Waka Tapu spent considerable resources on upgrading their IT system. Due to the multiple locations and various teams located at the various sites from He Waka Tapu, upgrades in the wiring for computers and phone lines were required, as well as re-organisation of the IT systems. He Waka Tapu use File Maker Pro to manage their client data including making appointments, tracking clients, referrals and medical

notes. They can also use this system to locate details of all eligible women with ethnicity and age in order to contact them.

Overall the key lessons gained from the review of infrastructure, highlight the usefulness of the 'audit and standards checklist' – like the example KTC developed for the providers - to identify for providers the key governance and management systems that they would be expected to be in place when delivering services for the NSU.

Additionally, the checklist could be used by the NSU as a tool for assessing proposals so that if the provider is successful, conditions can be included in the contract to ensure the provider meets the requirements within a specified timeframe. This would prevent providers being unclear about expected 'best practice' governance and management systems that are needed to support the delivery of an effective health promotion service, and it would ensure better results during audits.

3.4 Health Promotion Planning

3.4.1 Planning for 2004/05

Planning Processes

In the first year, the contracts were issued and signed between October – December 2004 and the first draft of the health promotion plan was due to the NSU by 1st December 2004. This left little time for the providers to consider, design, plan and consult stakeholders on the delivery of the services using new models. In fact, the initial plan could have been focused on how they intended to plan for the following financial year.

To support the requirement however, the NSU introduced their health promotion plan template to the providers (and the associated reporting requirements) and NSU staff members were made available to support the planning process for providers. The providers, although originally under the assumption they could use Māori models, completed the NSU template as the most expedient method of completing a plan and meeting their contractual requirements.

When completing the first 2004/05 health promotion plan, Mana Wahine and He Waka Tapu both described the process as difficult as they felt the NSU template was not "user friendly". Jargon, language and layout was not seen as appropriate for Māori models of delivery and this made planning difficult. They struggled to fit kaupapa Māori thinking into the Ottawa Charter framework and the NSU's associated template, although they did appreciate the NSU staff's explanation of the template when they visited them.

While He Waka Tapu completed their first plan with support of the NSU staff and other providers in their region, Mana Wahine decided in the end to "slot" what they wanted to do, into the "boxes" required within the template – however some of the components of the plan were not applicable to their desired approach. Despite this, they felt pressured to put information into all the areas of the template to satisfy NSU. Additionally, NSU written feedback was sometimes not clear, and this added to their confusion.

The tight timelines were an issue for Mana Wahine. Their first plan under the contract for the 2004/05 year was submitted in early December (2 weeks overdue) after input from all seven members. They were frustrated by the fact that when putting forward their proposal to deliver the new dual contract, Mana Wahine had

already undertaken considerable planning but this was contingent on their subcontract remaining intact, and the implementation of their new dual-service contract occurring by October 2004. As they had done preliminary planning prior to submitting their proposal, they were able to use this information for their initial plan 2004/05 plan including:

identifying the priority women (where they are located, the access issues they may face i.e. transport and other related issues, cost, DNAs and continuity of services);

the organisations and groups in the region and how they would work with other key stakeholders;

the types of strategies they felt they could implement with the new contract i.e. advocacy, health information sessions, one on one health promotion, special events around the region;

the training available for the Kaimahi and how the new contract can support their current training programme and other new training;

the resources (including their own Mana Wahine resources and those provided by the NSU);

who (between the 7 member organisations) would deliver the activities and how they allocate the funding for health promotion, support to services and smears.

Mana Wahine received feedback on their plan from NSU on 1 February 2005 (one month over the original specified date) and the first plan was finalised at the end of March 2005. Mana Wahine was then concerned their health promotion plan for the next year (2005/06) was due only a month later (1 May 2005).

In contrast, Raukura Hauora, as an existing provider to NSU, had already been in the process of moving their existing services to the new style of NSU planning and reporting template. Therefore they found the template easier the second time around when preparing the plan for the new additional service. At their meeting with NSU staff in mid October they were able to clarify the differences between their existing services and the new services and were happy to complete the template. Although they completed the reporting on the 2004/05 plan, they only commenced activity for the last quarter.

<u>Contract requirements</u>

As mentioned previously, the original timeline was for the contracts to start on 1 September 2004 and for their first draft health promotion plan due for 1 December 2004 allowing providers 3 months to recruit and undertake initial planning. Due to the delays with the contract documentation by Healthpac (some 3 months) the providers felt that having to deliver a draft health promotion plan by 1 December 2004 was an unfair expectation. This was further exacerbated by the fact that no funding had been received by the providers to cover the time and costs of preparing the plan. Providers would have preferred that there was time to recruit first, before embarking on thorough planning, to enable Kaimahi to have input and buy in to the plan they were expected to implement.

Providers also considered that the short timeframe impeded their ability to be creative and to introduce new models through being confined to use the Ottawa Charter planning template, language and format. It was noted as a contradiction that the new contracts were supposed to encourage innovation and new models, but the providers were confined to planning according to the Ottawa Charter and a current template, process and timeline which impeded this freedom to be innovative. Despite this, all providers commented that the assistance and explanations provided by NSU staff at meetings during November were very helpful to clarify what NSU wanted to see in their plans.

Relationships influencing planning

All providers utilised the NSU staff to support their planning process, and Mana Wahine and He Waka Tapu both complimented the NSU assistance in explaining these templates and guidelines allowed them to complete the health promotion plans within the specified timeframes. Despite being concerned about the model and planning approach being implemented by NSU, they complemented NSU health promotion for the explanations and guidance provided to them to meet the requirements.

Raukura Hauora were able to build on the knowledge of their existing team in Waikato who had already been delivering services for NSU for some time to help them with their planning. While Raukura Hauora felt that the other providers in the area were initially hesitant about a new provider and the potential for encroaching on their boundaries, this did not eventuate. Raukura Hauora worked hard to build relationships, share information and reassure others that they were working together for the same purpose.

He Waka Tapu worked with the two local NCSP/BSA Lead Providers in developing their plan, a meeting initiated by He Waka Tapu management. BreastScreen South and Canterbury DHB (NCSP) both noted that He Waka Tapu was proactive in ensuring a positive relationship from the start, however, all parties were receptive to working together to avoid duplication of services or over-servicing of any areas or population groups. He Waka Tapu felt both Lead providers offered responsive, helpful and informative support particularly in sharing plans and ideas.

It is apparent through the success of He Waka Tapu planning, the positive relationship that they had with their Lead Provider obviously benefited the planning process and subsequent coordination of health promotion activities for the region. The formation of a positive relationship from the beginning has immediate results and is beneficial for the start of the service and subsequent planning.

Mana Wahine and the local BSA/NCSP lead provider – Hutt Valley DHB - experienced difficulties in establishing a positive relationship from the outset of this dual contract. As they were unsure about the status of their subcontract with the DHB and were having difficulties renegotiating terms, Mana Wahine were not even at a stage of thinking about collaborating on the plan for the new dual service. In fact, sorting through the subcontract issues almost distracted them completely from establishing the new dual service because of the potential risks involved of losing the subcontract.

Using Māori models

While it was still the intention to use Māori models of health to plan and report on their dual services, this did not occur during the planning for the 2004/05 health promotion plan. The providers felt they were unable to reflect a tikanga Māori model in their planning due to tight timelines and therefore felt it was easier to use the template rather than to do disservice to a Māori model.

He Waka Tapu understood that with a dual service contract, they had room to be more creative and flexible than the Lead Providers who had specific contracts, however the planning template and guideline based on Ottawa Charter was considered to stifle more creative planning. If He Waka Tapu had been able to, their plan would have been based around tikanga principles such as whanaungatanga; whakapapa; role of Wahine Māori; Whanau Ora etc.

Mana Wahine intended to use Te Pae Mahutonga as their model, though they did not believe they could successfully incorporate this model into the current template in the month required to complete the plan. If given more time they would have ensured that all member organisations were involved in planning and some broader community consultation could have occurred.

Similarly, Raukura Hauora was unsure about how best to reflect their own distinct approach to health promotion, within the confines of the planning template provided. They decided to utilise the Ottawa Charter as the basis for their approach, but found the Health Promotion Framework implementation guide "hard going" in terms of comprehending its implications for them. The Raukura Hauora plan was focused strongly on establishment, recruitment, networking and communication and they did not realistically expect too much hands-on service delivery to occur in the 2004/05 period. Their plan and activity had a strong focus on working regionally with local providers to coordinate their efforts (WONS, Te Ha, etc) and they consulted with other providers to inform their plan.

The providers also commented on how having a dual contract and the ability to bring together the two services (breast and cervical screening) into one plan and integrate their ideas works well for Māori women. This holistic approach allowed planning for all women rather than the separating the two parts of the body.

Activities in the first year

In the first year, the Manager for Raukura Hauora identified that the Kaimahi would focus on networking and working alongside the existing providers to ensure they have positive relationships among the community and that they are grounded within the group before trying to do too many activities.

Mana Wahine continued to build on their current activities, however they had already considered a number of different activities they could undertake with the increased funding of the new contract. They had identified the needs in the community, where the priority women are and strategies to reach these women.

He Waka Tapu had started a number of initiatives such as working with Kohanga reo and introducing information packages for the whanau, doing pamper days for through the City Mission, and they had started on the Ngai Tahu project – which involves with the 7 Runaka in the Canterbury DHB region and identifying key women in the community to pass on the key messages of the programmes.

3.4.2 Planning for 2005/06

Planning Processes

Health promotion planning for 2005/06 (draft due by 1 May 2005) was largely undertaken by the new health promoters, some of whom had only recently been hired in their positions. For Raukura Hauora, the new Kaimahi who started in late March 2005 wrote the plan with assistance from the Manager and other health promoter. This process proved difficult for the health promoter as she was attending the NSU new health promoter training and the deadline for the plan was expected at the same time.

The Clinical Coordinator and health promoter at He Waka Tapu wrote their 2005/06 plan within the timeline agreed.

The 2005/06 planning process for Mana Wahine was more extensive than the previous year without the time pressures that had occurred around the 2004/05 plan. Planning began with a management hui to discuss activities for the year and then the Mana Wahine Coordinator drafted the plan. The activities in the plan were selected by Managers of the respective organisations to achieve and report on for the year.

Using Māori models

As the 2004/05 health promotion plans for all three providers were only signed off in March 2005, the three providers did not consider using a different model for 2005/06 as the plan was due 1 May 2005. While all three providers would have preferred to use Te Pae Mahutonga (or another related Māori model) in their service, they were familiar with the Ottawa Charter and felt it was not feasible to draft a whole new plan in the short time frame. Consequently, the Ottawa Charter template was used by all three to complete the plan. Similarly, as they were not able to implement all activities set for the 2004/05 year, these activities were rolled over into the following years plan.

2005/06 Activities

As the majority of the activities included in the 2005/06 plans were rolled over from the previous year, during this period the health promoters from Raukura Hauora and He Waka Tapu were largely working on establishing a presence in their community.

As the Raukura Hauora Manager commented, it was essential to work slowly to build up links and connections in the community, and gain credibility among the networks rather than forcing their message into the South Auckland community.

For these two providers, the activities in the 2005/06 year consisted of:

- establishing relationships with other NCSP or BSA providers to support planning and collaborative events;
- establishing key contacts in the community and with other organisations such as PHO's, GP practices, Cancer Society etc;
- orienting new health promoter to the position (He Waka Tapu);
- commencing education sessions in the community, supporting Marae screening weeks and advertising their services in the community.

For Mana Wahine, as an established sub contracted provider, this period was used to build on their previous activities. These activities were divided among the member organisation and included:

- sharing information with workplaces among the seven members areas;
- exploring opportunities with local kapa haka group leaders;
- exploring joint venture opportunities with community organisations e.g. Māori Women's Welfare League;
- education sessions among the seven members;
- continuing with their own training programme.

Reporting on their activities during this period was difficult for the Mana Wahine Coordinator as all seven members contributed their respective portions to the reports. Through internal breakdowns the final reports were returned in a variety of templates and styles which then had to be incorporated into the final copy to the NSU. This was rectified by the Mana Wahine Coordinator who developed her own template which was distributed to all 7 members.

<u>Resources</u>

Initially, providers found that getting the health promotion resources (particularly the frieze and the flipchart) to deliver their education sessions was difficult. They relied on the goodwill of current providers to lend them resources like the frieze and/or the

flipchart. They felt it would have been beneficial to have a "starting pack" of both breast and cervical screening resources so they did not have to spend time tracking them down. The providers were not even sure what the process was for getting resources and where requests should be directed. The providers also noted that they did not feel comfortable using the Māori Frieze as they were unsure if they were using it correctly. They felt each provider should be encouraged to use the frieze more regularly, even if with the support of Kaumatua, as it is wasted otherwise.

Data

The providers all indicated that they would like more NCSP and BSA data for their region. For both 2004/05 and 2005/06 plans they are using census data and while the Lead Providers are often forthcoming when data is available, they would like more data to target areas of need.

3.4.3 Planning for 2006/07

Planning processes and activities

In December 2005, all three providers were notified by mail from NSU that they were able to adopt a new innovative model for the 2006/07 health promotion plan and that KTC was available to help facilitate this process. This news was welcomed by the providers and NSU was congratulated for allowing this flexibility to occur.

Through the quarterly "face to face" meetings during the period, KTC had already established that He Waka Tapu and Mana Wahine wanted to use Te Pae Mahutonga as their planning model, while Raukura Hauora wanted to use Te Whare Tapa Wha.

During 2005, the NSU had drafted an implementation guide to support the use of Te Pae Mahutonga. The guide included an introduction on Te Pae Mahutonga and provided a background on the model and how to implement it. While the providers had a 'blank sheet', this guide offered suggestions to supplement their planning and ensure it was on track. The guide was seen as a useful resource for them.

All providers were aware that the 2006/07 health promotion plans were due May 1st. In order to provide quick feedback on the draft plans, the NSU convened a panel to allow providers to present their plans personally – and this move was also strongly welcomed. Any requested changes were to be made before 30 June 2006 to allow sign off and implementation on 1 July 2007.

KTC worked with the NSU to establish the guidelines which formed the basis of KTC's support. That is, that while the providers were able to select and interpret their

desired model in a way they saw best fit their organisation and the way they deliver their services, they had to demonstrate:

- Their **model and approach** – and why it was chosen (including extent they have used existing models or a combination of models);
- Their **evidence base** – identifying the community, the differences in the region/community, needs of priority women, how they will work with other stakeholders;
- The **activities or content** of the plan – how the model has been interpreted in practice, what resources are required (human, financial, health promotion), how the plan meets the NCSP and BSA standards;
- **Reporting and Evaluation** – how the health promotion activities would be evaluated, how evaluation is factored into planning, reporting the activities against the plan.

To initiate planning for 2006/07 with **Mana Wahine**, the management committee met to discuss and ratify the potential use of Te Pae Mahutonga. KTC met with Mana Wahine in early February 2006 to discuss planning for 2006/07 with the Coordinator and Chairperson. In March 2006, KTC was invited by the Chairperson to facilitate a hui with all Mana Wahine members to reaffirm their collective commitment to the service delivery model. There was a need by this time for the group to review its invoicing and reporting processes because their review of the previous two years had shown problems in this area.

At this meeting the roles and responsibilities of Mana Wahine, its own members and the Coordinator were discussed. The members indicated that they struggled to complete the planning template, its format and the terminology used. The group discussed possible changes to the way Mana Wahine as a collective runs and dedicating more time for the Coordinator.

A second session was held in March 2006 with all member organisations. This meeting approved all decisions made about the role and responsibilities of the Mana Wahine Coordinator. The meeting then turned to planning which included reviewing the last years plan and activities, building the evidence to inform the 2006/07 plan and brainstorming on innovative activities for this plan. A third session was held with the group in April 2006 to continue working on the plan and activities in preparation for the presentation to NSU on 1 May 2006.

In terms of planning for 2006/07, Mana Wahine was extremely innovative. Rather than selecting one model, such as Te Pae Mahutonga or the Ottawa Charter, Mana Wahine developed a plan that was a combination of many. They felt that some strategies of the Ottawa Charter template worked well, whereas they had difficulties implementing others. In particular they felt the Ottawa Charter was limiting in that they were unable to express and explore cultural strategies, compared with Te Pae Mahutonga which "enables us to explore and express ourselves as Māori and in working with wahine and whanau".

The plan included a combination of links to the two models mentioned above as well as the Treaty of Waitangi and He Korowai Oranga. Examples of some of the activities in the 2006/07 plan included:

- **Te Oranga and He Korowai Oranga** – each of the seven members develop a wahine reference group to ensure wahine guide the planning and delivery of services;
- **Mauri Ora and He Korowai Oranga** – Mana Wahine wananga/ noho for wahine Māori which would cover topics like hauora, screening programmes, roles and practices of Kuia to build a secure cultural identity;
- **Waiora** – Journey to a local area with special meaning to Māori to increase access to te Ao Māori and focus on the role of wai in Māori cultural practices;
- **Developing Personal Skills and Toiora** – comprehensive education and promotion activities in line with screening but also include information on sexual and reproductive health to enable wahine Māori make informed decisions on participation in screening programmes;
- **Nga Manukura** – engage community leaders to support the kaupapa. Through building relationships with key community leaders in the community it is envisaged that they will in turn promote the messages to their own community groups.

Mana Wahine presented their draft 2006/07 plan to the NSU panel at the meeting on May 1st 2006. The plan received positive feedback from the NSU and their plan was signed off in June 2006.

For **Raukura Hauora**, the Manager had initial discussions in December 2005 with the management team about integrating all the services in the Whanau and Community Health Services team to be more efficient and effective. While there was support for this suggestion, the Manager went on leave in February 2006 and

throughout the next few months there was a large amount of internal change within management. Although the initial discussions had included using Te Whare Tapa Wha, throughout the changes in management there was discussion over using Te Pae Mahutonga.

In March 2006, KTC met with the health promoters and the Quality Manager and this meeting focused on building the evidence (on priority women and their communities), the activities they would like to use and how they would evaluate and report on their plans. Raukura Hauora indicated they would use their Iwi Advisory to assist them in determining activities for their plan. Following this meeting, Raukura Hauora informed KTC they would complete their 2006/07 plan without any assistance but would keep both KTC and the NSU up to date on their progress and would present their plan on May 1st alongside the other providers.

Raukura Hauora presented their draft plan at the May 1st meeting. The plan was based on the Ottawa Charter template (similar to the previous two years plans) and included activities for mainstream and Māori women. The health promotion team received considerable feedback from the NSU panel. KTC were asked by NSU to visit Raukura Hauora to assist with the plan. One session was held in June 2006; however KTC had no further role in the planning. The previous Manager returned in the latter stages of 2006. KTC is aware that Raukura Hauora's plan was signed off in late 2006.

The plan provided to KTC in December 2006 was based on the Ottawa Charter (Service Description) however the Te Pae Mahutonga components were used as performance indicators.

Examples of some of the activities in the 2006/07 plan included:

- **Mauri ora and Ottawa Charter** – organise and host a Hauora event recognising and supporting Te Ao Wahine Māori, Te Ao Māori and Te Ao Tangata;
- **Toiora** – develop a feasibility study relating to Wahine Māori and whanau social environments to assist in identifying appropriate interventions pertaining to Breast and Cervical screening;
- **Waiora** – develop a Nga Poukai o Tainui education road show that promotes breast and cervical screening to eight Marae, also develop an external organisation database to establish a wider network group;
- **Nga Manukura** – support the establishment of the Raukura Hauora o Tainui Iwi Advisory council to provide leadership in relation to best governance practices for the development of screening guidelines and policy;

- **Mana Whakahaere** – conduct a regional survey that evaluates ethnicity access to breast and cervical screening, clinical history and attitudes including behaviour change.

KTC were unable to meet with **He Waka Tapu** "kanohi ki te kanohi" in December (due to weather conditions). A teleconference was held and noted that the He Waka Tapu team had considered the letter from the NSU indicating the ability to use a new model for the 2006/07 and they had decided on Te Pae Mahutonga. At that time He Waka Tapu indicated to KTC that they would like some assistance around the NCSP and BSA Quality Standards (this was provided through the audit checklist given in December 2006).

When KTC met with He Waka Tapu in March 2006, their health promoters had put a lot of effort into developing their concepts for Te Pae Mahutonga with their Kaumatua. He Waka Tapu included specific needs analysis to inform their health promotion plan. The main goal for He Waka Tapu was that participation rates for eligible Māori wahine would increase by 5-10% in the following 2 years.

Examples of some of the activities in the 2006/07 plan included:

- **Mauri Ora – Access to Te Ao Māori/ Cultural identity** – Wahine Toa programmes to support wahine to participate in kaupapa Māori initiatives such as Waka Ama, Raranga and te reo Māori while promoting positive screening messages;
- **Waiora – Environmental Protection/Physical Environment** – acknowledging the importance of wahine wellness and the wider domains of Ranginui and Papatuanuku. To achieve this He Waka Tapu Kaimahi ensure wahine are able to access Kaumatua guidance and support in relation to self identity;
- **Toi Ora** – **Healthy Lifestyles** – supporting and encouraging whanau involvement in screening initiatives. He Waka Tapu Kaimahi work with kohanga reo and kura kaupapa whanau to promote well women messages and support on whanau days (as appropriate);
- **Nga Manukura – Leadership –** Developing and supporting Kaupapa Māori Research opportunities with regard to screening and Wahine Māori in their region.

All components of the plan had various levels of process, impact and or formative evaluation to ensure He Waka Tapu are meeting the needs of their community and

continually analysing this information for their next plan. He Waka Tapu health promoters presented their plan to the NSU panel on May 1st and the plan was signed off in June 2006.

Following the presentations, the three providers came together to discuss their process and experiences. This was not an open meeting and KTC was not present so their views from this meeting were not documented. Following the meeting KTC assisted the providers where necessary in finalising their plans by 30 June 2006.

It should be noted that KTC identified that the health promotion plans utilising Māori models could not be fully evaluated in terms of effectiveness for Māori women, as KTC completed the contract in December 2006, so therefore has documented the planning process instead.

4. TĀTARITANGĀ – ANALYSIS

The findings from the formative evaluation have been analysed against the objectives of this evaluation.

OBJECTIVE ONE: IDENTIFY AND DESCRIBE HOW, AND IF, THE DIVERSITY OF THE PROVIDERS DELIVERING SCREENING HEALTH PROMOTION SERVICES CONTRIBUTES TO THEIR EFFECTIVENESS

The formative evaluation highlights the various differences between the three providers as being mainly:

one new provider to BSA and NCSP health promotion services (He Waka Tapu)

one experienced provider of breast and cervical screening services under subcontract to a DHB – with 7 providers within its roopu (Mana Wahine)

one branch of an experienced provider of breast and cervical screening promotion services who has experience in contracting with the NSU (Raukura Hauora)

This final report reveals that for **Raukura Hauora,** some of the NSU activity was not new for them, and they were initially able to respond to the templates and processes more easily than the other two providers. This was particularly evident through the first two years of planning with the Ottawa Charter. Further, as the initial Manager of Raukura Hauora ki Tamaki was also the Manager of the branch in Waikato, the new team were able to learn from, and build on the knowledge and experience of the Waikato team. This initially was a positive aspect to having coordination of an experienced team alongside a new team.

The difficulty for this organisation was the changes in management throughout the contract. As each Manager changed, so did the vision for the health promotion team. While it is believed the health promoters had the skill base and enthusiasm to undertake innovative planning, they did not have consistency and/or support from Management during 2006 to allow them to really establish planning using Māori models.

For **Mana Wahine** their effectiveness was initially affected by the issues with their DHB. As they were previously subcontracted by the DHB before winning the dual contract, they were experienced in delivering breast and cervical screening. Rather than this further contract allowing Mana Wahine to build on their services, which was what they anticipated, there was a lot of uncertainty during the first two years over

whether or not the subcontract would be renewed. It was the original intention for Mana Wahine members to be able to divide the new contract between the seven member organisations and add to their funds so that each member would be able to have one FTE. The members believed when tendering for the contract that they were not duplicating the services and therefore through the new contract they would have a health promoter in seven sites around Wellington while at the same time maintaining support and collaboration when required. The splitting of the funds and the workload was meant to allow them to become more effective in the region. However, with the increased contract came increased planning and reporting requirements which in turn required more effort from the Mana Wahine Coordinator than was originally expected.

For **He Waka Tapu** as a completely new provider to breast and cervical screening health promotion, this contract allowed the formation of a Wahine Ora team. This new team complemented their current services well (primarily social services for Men) and allowed a whanau approach. As both health promoters had some experience in breast and cervical screening respectively, they were quick to train in the positions and become operational. The Manager was supportive of being involved in the formative evaluation and this provider took advantage of all opportunities to get advice and support.

While the two Lead providers initially had new concerns over a new ISP in the region, He Waka Tapu was very proactive in managing these and they quickly built a positive working relationship. This relationship has continued and the three providers (He Waka Tapu, BreastScreen South and Canterbury DHB – NCSP) have collaborated on events that build on each of their strengths.

The following table provides an analysis on the success factors and barriers to the effectiveness of delivering a dual breast and cervical screening contract for each of the three providers:

		Success factors to commencing and implementing the dual contracts	**Barriers to commencing and implementing the dual contracts**
Raukura Hauora o Tainui	Structure	• Large organisation with extensive existing infrastructure and quality systems • Built on existing internal knowledge on breast and cervical screening through staff based at other locations	• A multi-site structure which operates across different regions, with a new service that is only confined to one area, experienced difficulties in taking a local approach rather than a regional approach
	Governance and Management	• Experienced board and management • Existing policies and procedures for Management systems • Accredited Quality Systems in place	• Changes in Management throughout the duration of the formative evaluation slowed momentum and direction of service delivery • At one point during the evaluation Management declined any formative support, however the health promoters were keen for any advice and support offered • As a large organisation with many contracts, breast and cervical screening became one of the many contracts. As a smaller service it did not receive consistent attention of management throughout the period of the formative evaluation.
	Human Resources – staffing and training	• The new staff appreciated working within a larger established health promotion team • The organisation had the capacity to supply various training in a number of areas e.g. Te Pae Mahutonga for all community health teams • As they are based in Auckland they were able to utilise the variety of training	• The new staff coming in to contract faced difficulties implementing the contract due to changes in management and working to a different set of instructions.

		Success factors to commencing and implementing the dual contracts	Barriers to commencing and implementing the dual contracts
		resources available • Able to use existing Human Resources to provide 'cover' should additional resources be required	
	Health promotion planning	• The Management was familiar with the NSU planning processes and requirements • Management found the Ottawa Charter easy to use as had supported in other region • The organisation took the opportunity to change models for this contract beyond the formative evaluation and implemented TPM across to all health promotion teams to ensure consistency	• Despite some support being available, the health promoters struggled with the application of the HPF and the template as they were responsible for writing the first two plans (2004/05 and 2005/06) • Initially, the 2006/07 model based on the Ottawa Charter was not signed off as the health promotion plan was too generic and did not focus enough on the needs of priority women. • Further the activities tended towards standard health promotion activities rather than be innovative.
	Relationships	• Recognised the need to establish relationships and networks in the community early on in the contract • Were initially aware of concerns over a new provider in the area and worked hard to mitigate these concerns • Participated in all regional and best practice hui with other BSA and NCSP providers • Work where possible with other providers in the region and support their counterparts in Waikato	• As a result of the timing of the NSU's reconfiguration of the BSA Lead Provider in the region, the development of the relationship between the organisation and the new lead took some time.

		Success factors to commencing and implementing the dual contracts	Barriers to commencing and implementing the dual contracts
	Organisation Experience	• Extensive experience in delivery comprehensive services to whanau including priority women	
He Waka Tapu	Structure	• Smaller provider who were well positioned to start expanding their services • This contracted allowed the establishment of the wahine ora team which complemented current services to provide a comprehensive whanau approach	
	Governance and Management	• Strong commitment from management to support the new contract • Extremely supportive of any help through the formative evaluation • Proactive management in meeting with other providers in the region	
	Human Resources – staffing and training	• They employed staff with good knowledge of health promotion and services • Supported by their Kaumatua	
	Health promotion planning	• Clinical Coordinator had a strong planning focus and ability – very strategic and collaborative • Well thought out model with large focus on basing their strategies on the evidence and continually ensuring they are meeting the needs of the priority women in their region • Strong focus on evaluation of activities	• The current plan was developed according to strengths of the Clinical Coordinator who has since left. There is a risk that it may be difficult for different health promoters with different skill sets to apply in the future.

		Success factors to commencing and implementing the dual contracts	Barriers to commencing and implementing the dual contracts
	Relationships	• Established relationships and a reputation in the community as a sound provider • Proactive in building relationships with other NCSP and BSA providers	
	Organisation Experience	• As this was their first contract with the NSU, the organisation had no preconceived ideas or expectations of NSU	
Mana Wahine	Structure	• The configuration and number of members in Mana Wahine meant a wide coverage across the region	• Initially there was a lack of consistent commitment and understanding of the NCSP and BSA Standards and contract requirements
	Governance and Management	• The Governance and Management formalised their commitment to kaupapa (as a result of the formative evaluation)	• Management commitment across the 7 members of Mana Wahine was not always maintained, while the intention was for bi-monthly meetings alternating with the health promoters this did not always occur.
	Human Resources – staffing and training	• They did not have to hire new staff as the new contract built on existing services so there is also no "lag" in terms of delivery • Have their own training programme which they routinely use to update and train all staff. It has been designed by all 7 member organisations	• Despite the initial intentions to rationalise resources to provide 1 FTE (including subcontract to DHB and whanau ora contracts) this was not carried out by all members. • The skill level and time commitment of staff throughout the members varies– some had not had formal training in planning and evaluation, although they did have training in topics related to BSA and NCSP

		Success factors to commencing and implementing the dual contracts	Barriers to commencing and implementing the dual contracts
	Health promotion planning model	• Innovative model for 2006/07 used as was a combination of TPM, He Korowai Oranga and the Ottawa Charter • Coordinator individually had strong planning skills • Once Coordinator role was sorted, the model and its application were successful	• Mana Wahine had previous had limited planning as an entity before the new contract and they had not previously done a lot of planning under the DHB so the individual members were not aware of the NSU planning process and requirements. Further, Mana Wahine had seen no previous value in strategic planning.
	Relationships	• Each member organisation has their own networks and relationships which can be used to tap into the community. This provides extensive coverage within the region	• Although each of the seven providers have their own networks, it is difficult to ascertain the extent to which each of the providers continue to build and extend on networks to reach priority women • While they initially had a subcontract to the Lead provider in the region. This relationship suffered with the new contract.
	Organisation Experience	• Extensive experience delivering services and all providers have been committed to women's health for a long time • The history of working together as an organisation	• As they were subcontracted by the DHB they were not aware of NSU processes and requirements e.g. the delay in payments because of confusion over invoicing processes.

Based on this analysis, a good model of service delivery for dual contracts would be a provider who:

Delivers whanau services – does not necessarily have to have provided breast and or cervical screening before, or even health services

Has a defined Management commitment to the contract (and to formative support if provided) – this includes a designated Manager responsible for the service who participates actively in NSU-initiated communications (e.g. teleconferences and meetings)

Strong planning skills that can develop an independent service plan while acknowledging the ‘fit’ with organisational plans

Has strong established relationships within the community or has ability to build these very proactively

Has clear policies and procedures of operation particularly for management systems and Health promotion service delivery

Demonstrates mechanisms to meet coverage

Has ability to give effect to strong coordination when multiple parties or multiple sites are involved

Has commitment to professional development of staff and makes it happen!

OBJECTIVE TWO: DEMONSTRATE AND DESCRIBE THE CONTRIBUTION THAT NSU CAN MAKE IN THE DEVELOPMENT OF NEW PROVIDERS (IN THE FUTURE) FROM THE BEGINNING TO ASSIST WITH SERVICE PLANNING, DESIGN AND DELIVERY

There are suggestions for the NSU that would assist with the planning design and delivery of the dual breast and cervical screening contracts and these form the recommendations of this report.

OBJECTIVE THREE: ENSURE THE STAKEHOLDERS' – NSU, KĀHUI TAUTOKO AND THE PROVIDERS THEMSELVES – EXPECTATIONS AND KNOWLEDGE ARE SHARED

Between the providers and Kāhui Tautoko

The three formative reports that precede this final report document the provider's expectations and activities throughout the formative evaluation. The first report highlights the providers' expectations over the establishment of the contracts, while the second report focuses on the activities of the providers in the implementation of their first health promotion plans.

As a third party, KTC believe the providers were able to speak freely to us on their experiences and issues. In particular, at the meeting in July 2005 the providers discussed their concerns over their planning models. As it was our understanding the contracts would allow innovative planning, and this did not occur, KTC advocated the providers' wishes to the NSU.

Further, all three providers and in particular the health promoters from each, built strong relationships with each other through the formative evaluation. As all three commenced at the same time and were sharing similar issues that affect any new providers, these group hui allowed the providers the time to share their experiences, knowledge and progress through the development of the contract.

In terms of knowledge sharing, KTC was able to provide a range of tools to assist providers such as:

NCSP and BSA Standards and audit guideline

Templates for policies and procedures

Self evaluation framework

Literature Review to inform the development of successful health promotion and strategies for improving coverage and participation of Māori and Pacific women in screening services.

From other experiences with health promotion projects, KTC was able to offer some guidance on possible ways of planning effectively and reviewing their own performance. KTC were also available to assist specific activities of the providers where they wanted an independent perspective and two examples are facilitating the Mana Wahine forum in 2006 and being on the interview panel for He Waka Tapu also in 2006.

While the formative evaluation was offered by the NSU to the new providers to support the development and implementation of their programmes, the providers chose the type and level of support they individually required. This support varied between the three providers and during the 2006/07 planning, Raukura Hauora indicated that they did not need support from KTC. While this may appear as non-compliance, and the formative evaluation was included in the provider's contract, the actual type of support in the various areas was optional and not mandatory. In hindsight it is imperative that all parties are fully informed on the expectations and benefits of fully participating in the formative evaluation to ensure maximum buy in and subsequent outcomes.

Between the providers and the NSU

Typically with establishing new and innovative services like this, there are always "teething problems" and issues that arise. A positive feature of this formative process has been that when these issues have been raised with the NSU, they have actively tried to remedy the concerns. For example, when providers were initially confused about whom to liaise with at the NSU, an ISP contracts manager position was established in 2005 as a recommendation in the first formative report. Further, a recommendation in the second formative report was for the NSU to clarify the roles and responsibilities of the NSU staff so that providers could contact them directly on specialist issues. NSU then produced a full schedule of all positions, names, roles and contact details. This was found useful by the providers.

In 2005, when it was determined that Māori models of delivery were not being used the NSU sent a clear and positive signal to providers to encourage them to use Māori models in the 2006/07 year. Furthermore, they had completed the Te Pae Mahutonga guideline which was issued to the providers for use if required.

NSU's convening of a panel on 1 May 2006 to allow the three providers to personally present their plans, was seen as a positive process as it allowed instant feedback. This also enabled the providers to meet the final deadline of 30 June 2006. The NSU staff have also been well received by the providers, where they have come out to explain NSU processes, templates and expectations.

Between the NSU and Kāhui Tautoko

Throughout the evaluation, the NSU and KTC have had a positive relationship and information sharing between the two has been accepted and acted upon. While there was initial miscommunication between the NSU and KTC about roles and responsibilities of health promotion planning support, this was rectified through strong commitment to this evaluation by both parties.

The NSU have been receptive to discussion about many topics raised by the providers through KTC and the NSU were responsive by making changes to planning for 2006/07 using Māori models of health, and stepping back to allow KTC to work with the providers to achieved the desired outcomes of the formative evaluation.

OBJECTIVE FOUR: ADD VALUE TO THE SCREENING PROGRAMME THROUGH AN EFFECTIVE HEALTH PROMOTION FRAMEWORK APPLIED WITH NEW ISPS

According to the NSU, the Health Promotion Framework (HPF) was developed to:

- Ensure a consistent approach to health promotion as part of screening programmes
- Build understanding and knowledge of health promotion and its role in screening programmes
- Facilitate health promotion strategies that create opportunities for informed consent and supportive environments and enable priority groups to participate in screening (NSUc 2004).

The strategic context for the HPF recognises the importance of:

- Treaty of Waitangi – through the three key principles of partnership, participation and protection and their application for Māori in the health and disability sector
- Public Health – the growing emphasis on population health approaches and of which health promotion is one

- Primary Care Strategy – which notes that "Quality primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods" (NSUc 2004)
- Consistency with other strategies – including He Korowai Oranga – as affirming Māori approaches and improving Māori outcomes and using Māori models of health (because these models recognise that good health is dependent on a balance of factors)

On this basis, it is reasonable to expect that the HPF would facilitate health promotion providers to develop strategies that take into consideration the wider determinants of health, and in particular the cultural needs of women. However, the HPF does not provide information on how the Ottawa Charter could be applied within a Māori context. Further, it has not given significance to culture or cultural identity to reflect Māori needs, values and aspirations for health.

The strategic context of the HPF, and other NSU documentation including the BSA and NCSP standards have emphasised the importance of culturally appropriate health promotion in screening. While the HPF has a focus on priority women, of which culture is a factor, the Ottawa Charter does not give the same significance to cultural needs as other determinants of health. While this model does not preclude cultural needs being considered in health promotion and this model could be interpreted in a way that recognises culture as an important determinant of health, culture is not a fundamental component. This is evident through the template that has been developed, as practical interpretation and application of the model has not recognised the importance of culture and cultural needs.

In comparison Māori models of health "translate health into terms which are culturally significant and include aspects of Māori identity, knowledge, customs and beliefs" (NSUc 2004). Therefore, by putting Māori cultural needs at the centre, strategies arising from these models ensure that Māori values, needs and aspirations are met first and foremost.

Throughout the planning processes, the providers have struggled with the health Promotion Framework and subsequent template. They felt the framework and template stifled creativity and rather than identifying what will work in their communities through their own comprehensive needs analysis, they felt they were expected to undertake routine strategies and activities that mainstream providers throughout the country already use. While they noted that many of these may be

successful, and work for them too, they felt that some did not apply and therefore they should not have to do them e.g. workplace policies were difficult to implement or communication activities did not work for their population.

In recognition of the desire of health promotion providers to utilise a Māori model of health to develop their health promotion programmes, the NSU developed a Te Pae Mahutonga implementation planning guide to sit alongside the Ottawa Charter template in the HPF. This template was added in 2005 and was well received.

Further, the approach taken by the NSU to the 2006/07 planning was seen as a positive step. The providers felt this planning was empowering as they were able to:

- be creative in ways to meet the needs of the Māori women in their community
- develop their own plans (as long as they met the basic requirements of the contract and framework)
- define and decide how they should deliver health promotion to their community.

It should be acknowledged that the framework came about in 2004 to provide some guidance and support to the development of health promotion plans. There is no doubt that once explained, the HPF has been beneficial to the three providers, and provided a strong guideline to support their planning. However, the opportunity to develop an innovative plan, undertaken in the final year of this formative evaluation, empowered the providers to interpret the HPF to reflect their organisation approach, their own community needs, and the skills of the health promotion team. This process and the resulting health promotion plan is a particularly successful outcome in this formative evaluation. Future evaluation will be able to determine whether utilising Māori models are effective in increasing coverage and participation of Māori women.

The following table gives an analysis based on the providers' views of strengths and weaknesses of the Ottawa Charter and the tikanga based models of health promotion.

	OTTAWA CHARTER PLANNING TEMPLATE		MĀORI MODELS FOR HEALTH PROMOTION	
	Strengths	Weaknesses	Strengths	Weaknesses
Model	• Established international health promotion model • Recognised as the best practice model for health promotion	• While cultural identity and culture could be interpreted under the 5 strands of the Ottawa Charter, cultural needs are not significant component of the model	• These models are underpinned by culture and cultural identity and recognise that these are significant factors in improving health • These models recognise that screening fits within the broader aspirations of Māori rather than being the driving factor.	• Limited knowledge around effectiveness as a model for screening health promotion • Difficulty for some iwi to adopt their own tikanga models when Government may only acknowledge documented pre-existing Māori models • There is a lack of precedents available of robust health promotion plans using Māori models.
Health Promotion Framework (actual template for both	• A national template allows consistency in terms of approach among health promotion providers • Provides a background on health promotion and related screening issues	• The HPF does not provide information on how the Ottawa Charter could be applied within a Māori context. Further, it has not given significance to culture or cultural identity to reflect Māori needs, values and aspirations for	• The TPM template was developed in 2005. This was well received by the providers • Providers were able to use this as a rough guideline if they chose	

	OTTAWA CHARTER PLANNING TEMPLATE		MĀORI MODELS FOR HEALTH PROMOTION	
	Strengths	Weaknesses	Strengths	Weaknesses
Ottawa Charter and Te Pae Mahutonga)	• The Implementation Guide was seen by the providers as practical and easy to use • For new providers, an established template allows them to see what is currently being done, what is effective, and what the NSU supports in terms of health promotion for screening • Guideline offers best practice in terms of screening health promotion	health. • The model did not always fit with the organisation approach (one formative provider felt it was appropriate) • The HPF has limited providers to using the Ottawa Charter model to base health promotion on (rather than selecting a model to suit their organisation and approach) • Complex language used throughout the HPF and implementation guide • Lengthy document was noted as not user friendly • Providers believed the HPF stifled creativity and all regional descriptions had to be met before sign off		
Planning Process	• As providers became more familiar with the requirements of the model and the template	• The planning became a process of trying to fit the activities into the model rather than the model	• Providers could interpret their chosen model in a way that suited their organisation e.g.	• Translation of Māori models into documented plans can be challenging for

	OTTAWA CHARTER PLANNING TEMPLATE		MĀORI MODELS FOR HEALTH PROMOTION	
	Strengths	Weaknesses	Strengths	Weaknesses
	(from 2004/05 through to 2005/06 years) it was easier	and the evidence determining the activities • Providers felt they had to develop activities in each of the 5 strands of the Ottawa Charter rather than recognising that some of these may not fit or suit their communities • Activities specified in template do not always suit community. e.g. developing a media strategy for priority women may not suit a small community with limited media	providers were able to select a model or a combination of models	those who have a strong understanding of models but are unfamiliar with writing health promotion plans
Activity and content of plan	• A strong guideline of successful strategies	• The specificity of the activities limits innovation • The template does not allow discretion of the provider to tailor the template to the specific characteristics of the population of women being served in that community. • The evidence base may	• Allowed for development of innovative health promotion strategies, particularly those recognising cultural needs	• There is little evidence of the effectiveness of practical activities that have been implemented under Māori models, and even less for screening screening health promotion

	OTTAWA CHARTER PLANNING TEMPLATE		MĀORI MODELS FOR HEALTH PROMOTION	
	Strengths	Weaknesses	Strengths	Weaknesses
		not support some of the activities for the individual communities • Best practice for screening health promotion may not sit		

OBJECTIVE FIVE: DEMONSTRATE AND DESCRIBE HOW OTHER STRATEGIES ARE INTEGRATED WITH THE PROVISION OF SCREENING HEALTH PROMOTION SERVICES – IN PARTICULAR THE PRIMARY HEALTH STRATEGY; MĀORI HEALTH STRATEGY HE KOROWAI ORANGA, THE NZ HEALTH STRATEGY AND THE NSU STRATEGIC PLAN

As discussed in the previous section, the NSU's Health Promotion Framework acknowledges the importance of other key strategies in developing screening health promotion.

The NSU directly supports the New Zealand Health Strategy through encouraging providers to adopt a population health based approach. This approach recognises the determinants of health and the NSU supports the providers to plan and implement activities aiming to reach the wider population in order to increase coverage and participation. Similarly, the NSU has a strong reducing inequalities focus, and all activities undertaken by the providers must focus on improving health outcomes for Māori women.

The dual contracts and the use of Māori models of health to plan health promotion directly align to He Korowai Oranga. These dual contracts directly implement the key purpose of this strategy – that is affirming Māori approaches. This is a positive step forward for breast and cervical screening health promotion, and improving coverage and participation rates among Māori women.

As He Korowai Oranga states "using models that operate within and through te ao Māori can be a very effective means of reaching Māori whanau" and further that the unobservable (spiritual, mental and emotional) elements are just as relevant as the observable or physical elements" (2002). The use of Māori models to plan and deliver health promotion is supported by the providers who noted that the Ottawa Charter planning template did not allow them to recognise and affirm their cultural identity.

The NSU Te Pae Mahutonga Toolkit document acknowledges that using Te Pae Mahutonga as a planning model is a specific way to achieve Whanau Ora. Further, existing whanau ora service specifications encourage providers to operate holistically and integrate their services and programmes to provide a total approach to delivering services to whanau.

The NSU have met this challenge by contracting the three new providers on dual services, (as opposed to the separate breast or cervical contracts that the majority of

the current ISPs hold). The dual contracts allow and encourage providers to operate holistically in delivering services to women. The dual delivery of breast and cervical screening sits appropriately within a Māori health context and allows the health promotion teams to plan and deliver their services for all women, rather than separating out the parts of the body. It is appropriate for these providers to deliver an inclusive service for all women, rather than exclusive health promotion only for women of certain ages (as specified by the programmes).

While the development of health promotion plans utilising Māori models has occurred during this formative evaluation, we are unable to ascertain the effectiveness of health promotion in improving coverage and participation. While this formative evaluation concluded midway through implementation of the 2006/07 plans, it would be fair to say that the process in itself of using Māori models has been effective for the health promotion providers.

Objective Six: Identify Those Areas That Isps Need Or Desire Support In (From Nsu), When Commencing Delivery Of Health Promotion Services In Screening, And During The Delivery Period – To Enhance Their Effectiveness

When a provider commences a new dual service, it would be beneficial that they met each of the areas noted as ideal for service delivery in Objective 1. Further to this however, is the ability for the provider to:

- have robust well managed systems – *while the NSU may not be involved in developing the systems, if these are required by the provider then formative support would be of use*;
- ensure planning is evidence based in particular identifying the qualitative and quantitative needs of the community, and linking the needs of priority women into health promotion activities;
- ensuring the providers are able to evaluate and report on their health promotion service delivery.

The NSU contracted KTC to provide formative support to the ISPs to implement their services, and simultaneously had a clause in the ISP contracts that they would participate in this formative evaluation. Despite this, it was evident that the providers were at times confused about KTC's role, and didn't always maximise the use of the available support to benefit their new service. Subsequently, KTC was concerned its own deliverables were placing undue pressure on the providers. For instance, KTC was attempting to deliver its first milestone yet the providers indicated they could not participate in formative activity until they received their contracts.

While the outcomes of this formative evaluation have been positive, suggestions the NSU could implement to improve effectiveness include:

- Arranging for the provider to undertake a self-assessment of the formative support they think they need, for presentation to the NSU for approval (the provider needs assessment tool in the appendix could be used as a guide);
- Using the self-assessment tool to help the NSU define the contract deliverables for the consultant providing the formative support;
- Clarifying the formative evaluation objectives for both the provider and the consultant in both their contracts, helps both parties work to achieve the objectives of the formative evaluation and contribute accordingly;

- Allowing the provider to have a 6 month establishment period would allow the self-assessment to be completed and be established with the consulting providing the formative support.

5. TŌTOHUTANGĀ - RECOMMENDATIONS

A number of recommendations have been made to the NSU and these have been included in the Executive Summary.

Key points for providers

While this report has been written for the NSU, there are some suggested points for new providers. KTC suggest that providers:

- CONSIDER developing formal policies and procedures for health promotion and support to services;
- CONTINUE management support for the contracts (this includes health promotion planning and communications with the NSU);
- CONTINUE to build and maintain positive relationships with other BSA and NCSP services in the region. Collaborative planning, delivery and evaluation of services fosters positive gains and also avoids duplication and any potential over laps in service delivery;
- CONSIDER commencing planning for the upcoming year in the 3 months leading up to the 1 May deadline. This would allow sufficient time to consult with the community, undertake relevant needs analysis and gather any other qualitative and quantitative data. This consultation time should be included in the plan for the following year;
- CONTINUE the collaborative approach to planning where Kaimahi, management and kaumatua work together to complete the health promotion plan. Kaimahi involvement from the outset ensures appreciation and understanding of the health promotion plan, however the plan should not be completed by Kaimahi only. Kaumatua and Management can provide vital support and guidance;
- CONTINUE to undertake robust needs analysis including setting targets (using NSU data among other forms) for increasing coverage and participation rates within the regions;
- CONTINUE to build and develop innovative activities to reach Māori women based on the above needs analysis. These activities may change each year depending on the evaluations.

- CONTINUE to build and develop evaluation of activities to measure effectiveness. This should be built into the health promotion plan and constant review of activities will assist in determining whether or not these activities are helping to reach the overall targets of the programmes;

- CONTINUE to use the support of kaumatua to deliver health promotion if the Kaimahi do not feel comfortable or competent (e.g. with the Māori frieze)

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TĀPIRITANGA – APPENDICES

APPENDIX I – PROVIDER NEEDS ASSESSMENT TOOL

APPENDIX II – SELF EVALUATION PLANNING TOOLS (health promotion cycle, project & evaluation plans, education session summary)

APPENDIX III – TABLE OF CONTENTS FOR GENERAL POLICY AND PROCEDURE MANUAL

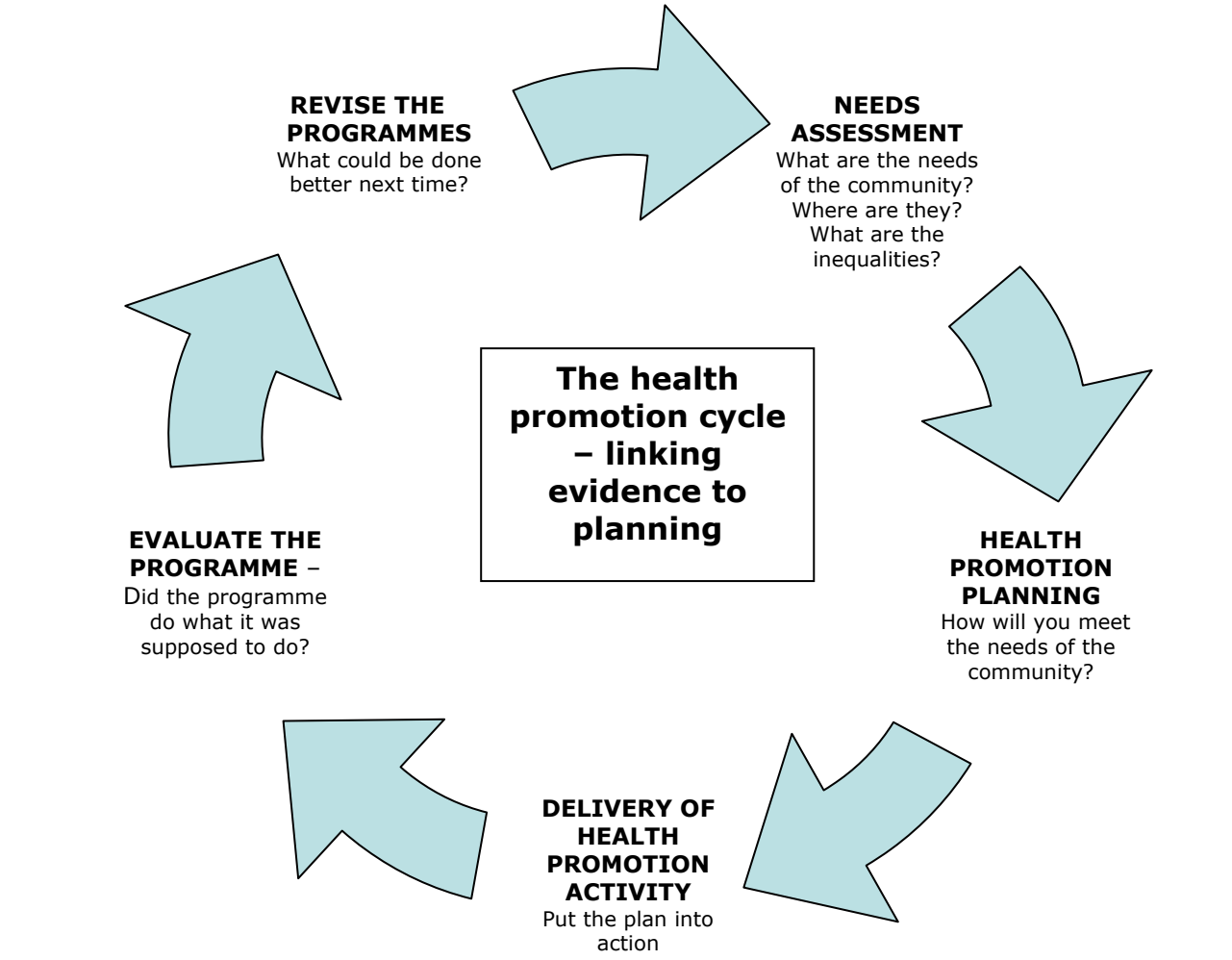
Appendix I – Provider Needs Assessment Tool

The following table outlines the Provider Needs Assessment (PNA) tool used to assess each of the providers in terms of strengths, weaknesses, gaps and opportunities.

Area of Support and Items	**Types of Evidence**	**Assessment**
Infrastructure		
1. Governance practice	Governance kaupapa Governance structure Governance policies and procedures Minutes of recent Board meetings Governing documents – constitution/trust deed	
2. Management practice	Organisational structure description Management reports to governance Organisational policies and procedures Service delivery policies and procedures Information on management systems Job descriptions for key roles	
3. Financial stability and viability	Audit reports Financial reports over last 12 months	
4. Quality management systems (audits, evaluations, processes, certifications)	Quality Manual Extent to which QMS in place	
5. Planning methods used (for organisation)	Strategic/long-term plans Business Planning Planning processes – who drives it, who is involved, role of governance, outputs	
6. Information Systems – service and management reporting	Policies and procedures Types of reports and frequency	
7. Human Resources – staff practices & processes, recruitment, employment, performance management and disciplinary processes	Policies and procedures Performance management system Key documentation – job descriptions, employment agreements, personnel files, performance management and training plans	
8. Risk management practices	Policies and procedures Governance and management roles Evidence of application	

Appendix II – Self Evaluation Tools

This following model of health promotion[3] was given to the providers to ensure that all five phases are considered in the delivery of the dual health promotion contracts. The self planning and evaluation tools were given to the providers to assist in the planning and evaluation of health promotion activities.



[3] This cycle has been adapted from Health Canada in A Guide for First Nations on Evaluating Health Programmes (1999)

PART A: PLAN FOR HEALTH PROMOTION ACTIVITIES

Activity: _____ **Date:** _____
Where does this fit in HPP: _____

Rationale - Why are you doing the activity? What evidence do you have e.g. BSA/NCSP data, your own needs analysis or evaluations, community consultation? *(Attach evidence as appendix)*

How will this activity reduce inequalities and increase coverage and participation? _____

Target Population - Who is your target group (age, ethnicity, location) and how will they participate (e.g. attend education session; participate in a focus group etc)?

Goal of Activity – what do you want to achieve with this activity and the timeframe (e.g. increase coverage of women in a region/area etc.)

Objectives - identify measurable outcomes which will help you meet the goal e.g. conduct an education session

1.
2.
3.

Strategy – how will you meet these goals?

1.
2.
3.

Performance indicators – how will you know you have been successful? These should fit with your health promotion plan and must be measurable so you know if you have met the goals

1.
2.
3.

Health Promotion Activity

Describe the planned initiative – include the setting, method, available resources (staff, equipment, funding if required)

Are you collaborating with other organisations? If so, who and what are their expected roles: _____

Data Collection and Reporting

Determine what information will be collected. If an education session is held will participants be given a feedback sheet to complete, if an advertisement is placed on the radio how will you determine its effectiveness?

How will you collect feedback/data? *E.g. education session feedback, own evaluation etc*

How will the results of your activity be reported and by whom: _____

Expected timeframe of the activity:
Expected completion date:

PART B: EVALUATION OF HEALTH PROMOTION ACTIVITIES

Activity: _____
Where does this fit in HPP: _____

Rationale – What evidence informed the health promotion activity? *Tick those that apply*

NCSP or BSA data ☐ Other data e.g. census ☐ Needs Analysis ☐
Community consultation External research ☐ Other, please describe ☐

_____

Target Population - Did you reach your target population? If not, why?

_____

_____

Did you meet their expectations? (based on feedback forms etc) If not, what could you improve?

_____

_____

Did you unintentionally reach other groups/providers? If yes, what were the outcomes? – can this lead to further health promotion activity or into areas you may not have considered?

_____

_____

Health Promotion Activity
Was the activity implemented as planned? If not, why?

_____

_____

Were the resources/venue successful? If not, what could be improved?

_____

_____

If you collaborated with other organisations/providers, was this successful? Would you collaborate again? If not, why?

_____

_____

Goal of Activity – Did you reach your goal? If not, why?

_____

_____

Making a difference – Did you meet your targets? Yes/No which ones and why
1. _____
2. _____
3. _____

Will you do this activity again? **Yes** **No**
Would you do anything different next time?

_____

_____

Reporting
Have you collected the results? Participant feedback forms ☐ Session Evaluation ☐
Have you input your results into your report? Yes No
Was the activity completed within the desired timeframe? Yes No

PART C: EDUCATION SESSION SUMMARY SHEET

Health Promoter/s: _____ Date _____
Group _____ Venue: _____

1. Total number of women attending: ……

2. Ethnicity of women: *note number of each*
   Māori ……. Pacific Island …… European ……. Other ……

3. Ages of women (as completed in education session feedback form)
   Under 20 ……. 20 – 30 ……. 31 – 40 ……..
   41 – 50 ……. 51 – 60 ……. 61 – 69 ……..

4. Number of women intending to have a smear following the session: …….

5. Numbers of women intending to have a mammogram following a session: ……

6. Numbers of women who need transport to either a smear or mammogram: ……

7. What were the positive outcomes from this session? *Any relationships or contacts or potential areas to go into, positive feedback from participants?*

8. Was there anything that could have been improved? *Preparation, time, venue, resources?*

9. Are there any other comments or issues raised by this group that could reduce barriers for Māori women to breast and cervical screening?

Appendix III – Table of Contents for General Policy and Procedure Manual

The following is the table of contents for the general policy and procedure manual given to Mana Wahine.
