EVALUATING HEALTH PROMOTION:

THE STRATEGIC EVALUATION FRAMEWORK

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ABSTRACT

The objective of this study was to produce a framework for evaluating health promotion that is both practical and theoretically defensible. There were six steps in developing this framework. First, the evaluation and health promotion literature was examined for lessons relevant to health promotion evaluation. Second, the author was involved as an evaluation researcher in a series of health promotion projects (five of which are reported here). Third, key practical, methodological, political and theoretical issues arising from these evaluation projects were identified and addressed. Fourth, taking these issues into account, an initial framework for health promotion evaluation was developed. Fifth, the framework was exposed to health promotion practitioners at a series of workshops run by the author and colleagues. Sixth, the strategic evaluation approach was further refined in the light of the author's continuing involvement in health promotion evaluation practice. Six elements make up the resulting Strategic Evaluation Framework for Health Promotion: a checklist for health promotion programme planning and evaluation; a matrix of health promotion strategies; a schema for health promotion programme objective setting; a set of criteria for selecting the type and level of evaluation for different projects within an overall programme; a model of where health promotion strategic evaluation fits within the social problem cycle; and lastly a strategic approach to determining priority health promotion evaluation research methods. Together, these address key issues which need to be dealt with in health promotion evaluation. Based on the belief that evaluation decisions should be strategically driven, this approach is particularly relevant in health promotion areas where issues are strongly contested by powerful stakeholders. This decision as to *what* and *how*

to evaluate comes from examining the strategic priorities of the sector in which the programme is located. This is in contrast to more generalised calls for programme evaluation which demand similar evaluation types for all health promotion programmes regardless of the current strategic needs of the sector.

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CHAPTER ONE

INTRODUCTION

Health promotion, aimed at promoting the health of communities and preventing disease, has emerged as an important area of activity and research in the health sector (Bunton & Macdonald, 1992; Downie, Fyfe & Tannahill, 1990; New Zealand Board of Health, 1988; World Health Organisation, 1982, 1984, 1986a, 1986b). It has generated interest in a number of nations, at least in the industrialised world, for instance, in the United States (U.S. Public Health Service, 1979); Italy (Briziarelli, 1987); Ireland (Crawley, 1987); Sweden (Eklundh & Pettersson, 1987); Australia (Watson & James, 1991) and New Zealand (Board of Health, 1988). Sometimes described under different terms, such as the *new public health* (Martin & McQueen, 1989), it is seen as a "logical framework" for problem prevention efforts (Howat, Binns, Blaze-Temple & Corti, 1987). Some of its more commercial aspects have led to it being seen as an industry (McLeroy, Gottlieb & Burdine, 1987). It weaves together a long tradition of social advocacy for health improvement with the mainstream public health establishment's biomedical concerns and the *new public health's* emphasis on social issues in health and illness (Martin & McQueen, 1989).

As the health promotion movement has developed, the question of how its activities can best be evaluated has grown in importance. While there are particular difficulties in evaluating health promotion and disease prevention programmes (Altman, 1986; Duignan & Casswell, 1989), it is clearly essential that they be evaluated. This is particularly true in a climate in which health promotion is competing for funds against other activities. Health promotion evaluation

encourages the consideration of a range of different methods in health promotion, assists in identifying the effective ingredients in health promotion programmes, monitors implementation, and helps in developing novel health promotion approaches. The World Health Organization (WHO) has noted the particular need to develop methodologies and more appropriate approaches to evaluation in health promotion (World Health Organization, 1986b).

Evaluation as a discipline has accumulated a large body of research findings over the last few decades. A range of different methodologies have been developed and diverse theoretical perspectives currently guide investigations. The evaluation literature has always been widely scattered across publications directed at differing audiences who also have different levels of interest and sophistication in evaluation (Milcarek & Struening, 1975).

Moreover, evaluators come from a wide range of disciplinary backgrounds. Over a ten year period the *Evaluation Studies Review Annual* reprinted journal articles from 110 different journals in 12 substantive areas: economics, education, evaluation, law, management, medicine, psychology, public health, public policy, political science, sociology and statistics (Shadish & Reichardt, 1987, p. 20). As evaluation knowledge advances there has also been a steady accumulation of evaluation experience relating to specific topic areas.

In health promotion, evaluation approaches have until recently drawn largely on models from the biomedical rather than the social sciences. This has resulted in an emphasis on outcome evaluation based on clinical trials in medicine. In addition to the influence of biomedical outcome research, health education has also made a major contribution to health promotion evaluation. In contrast to the biomedical

influence, health education is more oriented towards social science methodologies. However, because health education has generally adopted an individualistic orientation towards health promotion in the past (Brown & Margo, 1978; Naidoo, 1986; Rodmell & Watt, 1986), it has tended to work with a relatively limited range and focus of evaluation models. What is needed for the more broadly focussed health promotion involvement is evaluation models which draw on the broad eclectic foundation of modern evaluation methods (Green & Lewis, 1986). These need to be adapted to the particular evaluation needs of specific issues, institutions, people, communities and politics involved in any health promotion initiative.

Overview of Study

This study's overall objective was to produce a practical, and theoretically defensible framework for the evaluation of health promotion. This has been termed a *strategic evaluation* framework because of the emphasis on where a particular evaluation fits in terms of the strategic issues of the sector in which it is located. Development of the framework proceeded through six steps:

- examining the evaluation and health promotion literature for lessons relevant to health promotion evaluation;
- involvement as a researcher in a series of health promotion projects (five of which are reported here);
- identifying and responding to a series of key practical, methodological, political and theoretical issues which arose for the author as a consequence of being involved in the five evaluations;

- developing an initial approach to health promotion evaluation which took these key issues into account;
- exposing the strategic evaluation framework to health promotion practitioners at a series of health promotion evaluation workshops run by the author and colleagues; and
- ongoing development of the strategic evaluation approach in the light of the author's continuing involvement in health promotion evaluation practice.

The reader will note some differences between this study and an empirical study of a single health promotion project evaluation, case studies of a series of health promotion project evaluations, or purely theoretical pieces. The health promotion project evaluations set out in this study are of interest primarily for the practical, methodological, political and theoretical issues they raised for the author in developing the strategic evaluation framework. The evaluation results of the particular studies are not the central issue in this study, and are published elsewhere.

Outline of Chapter Content

Chapter Two examines ways of defining health promotion. Chapter Three looks at the context in which health promotion has developed and the implications of this for health promotion evaluation. Chapter Four looks at the characteristics of modern health promotion. Chapter Five summarises key concepts in current approaches to evaluation. Chapter Six sets out the five health promotion evaluation projects, in each case describing the project design, the evaluation methodology,

giving a brief summary of results, and indicating the author's involvement. These projects were: Evaluation of the Community Alcohol Health Promotion Organiser Approach; Process Evaluation of the Wanganui Community Alcohol Action Project; Evaluation of Heartbeat New Zealand; evaluation of the Licensing Project; and developing a policy and approaches for evaluation of the Accident Compensation Corporation Accident Prevention Programme. Chapter Seven examines the key issues which arose out of the author's work on these evaluation projects. Chapter Eight looks at three further issues which arose from the author's wider involvement in health promotion evaluation. Chapter Nine sets out the Strategic Evaluation Framework for Health Promotion. The framework consists of the following elements:

- a checklist for health promotion programme planning and evaluation;
- a matrix of health promotion strategies;
- a schema for health promotion programme objective setting;
- criteria for selecting the type and level of evaluation for different projects within an overall programme;
- a model of where health promotion strategic evaluation fits in the social problem cycle; and
- a strategic approach to determining priority health promotion research methods.

Chapter Ten consists of the summary and conclusions from the study.

CHAPTER TWO

DEFINING HEALTH PROMOTION

There is no shortage of definitions of health promotion (De Leeuw, 1988; Downie, Fyfe & Tannahill, 1990; Green, 1984; New Zealand Board of Health, 1988; Nutbeam, 1986; World Health Organization 1984, 1986a). As is the case with any term, various approaches to definition can be taken. Study of the literature reveals four dominant methods of defining health promotion:

- *listing* of content - for instance, activities or topics undertaken in health promotion (e.g. positive health education and health protection);
- *exclusion* - saying what health promotion is not (e.g. not disease prevention);
- *expansion* - defining health promotion as a novel enterprise by virtue of its expansive involvement in domains not traditionally associated with the health sector but all the same intimately involved in the production and maintenance of health (e.g. the economic and political domains); and
- *process* – specifying the nature of the particular process or processes health promotion uses (e.g. empowerment).

Each of these approaches to definition is discussed below.

Definition by Listing Content

In some senses listing the activities or topics which comprise the content of health promotion is the simplest definitional approach. Downie, Fyfe and Tannahill (1990) adopt this method, and identify seven broad types of health promotion

activity: preventive services, preventive health education, preventive health protection, health education for preventive health protection, positive health education, positive health protection, and health education aimed at positive health protection.

The problem with listing in this manner however, is that it fails to give any clear sense of the novelty of the health promotion approach. Also missing is any characterisation of the processes and particular philosophy at the heart of health promotion. It is significant that this definition should be offered by authors who appear to have a health education background. This approach seems to make the point that health promotion should not forget its links with the traditional activities which took place under the headings of health education and health protection. This is a laudable aim, but *on its own* this type of description does not give a clear enough indication of what is new about the health promotion approach in contrast to traditional health education and health protection activities.

The New Zealand Board of Health's (1988) seminal document *Promoting Health in New Zealand* includes aspects of a listing approach, giving a list of topics for health promotion action; these include housing, employment, self-esteem, physical activity, and sound nutrition. Again, *by itself*, this type of listing does not provide enough perspective on the new ways of dealing with these topics which come with a health promotion approach. (It should be noted that the Board of Health document does not just restrict itself to this listing but includes perspectives from the Ottawa Charter (World Health Organization, I986a)).

The advantage of a definition by listing approach to health promotion is that it can provide concrete information on the topics which health promotion addresses. It helps answer the question: "Well, what is it that you actually deal with in health promotion?" The disadvantage is that it does not identify the approach, general

principles or "flavour" which guides health promotion regardless of the topic or activity being undertaken.

Definition by Exclusion

One response to the problem of how to strongly convey the flavour of health promotion is to define by exclusion. This method is illustrated by an exchange at a New Zealand seminar on health promotion which was reported to the author:

> Health Promotion Worker: "I work in the alcohol area on community and policy strategies to reduce alcohol problems. Following this presentation on health promotion, I'm wondering if I'm doing health promotion."
>
> Speaker: "Well, are you trying to *prevent* alcohol problems?"
>
> Health Promotion Worker: "Yes I am. "
>
> Speaker: "Then you are not doing alcohol health *promotion*."

The point being made here is that thinking in terms of *preventing* health problems leaves out some essential aspects of health promotion. It leaves out, for instance, the emphasis within health promotion on positively developing health rather than simply trying to prevent disease and illness. This is rather like Rappaport's (1981) distinction between empowerment and prevention. Such definition by exclusion can be potentially useful for polemic and didactic purposes. It stakes new ground for health promotion and makes the point that health promotion is all about new methods and approaches. This also applies to another distinction, that between health promotion and health education. As Green and Kreuter (1991) point out, health promotion practitioners sometimes "disavow any association with health education in an attempt to distinguish their efforts as more innovative,

modern, technological, behaviouristic, client centred, or scientific than they perceive health education to be" (p. 18).

There is, however, a problem with the definition by exclusion approach. Behind this definition there may be what Ryle (1963) has termed a "category mistake". Category mistakes arise due to confusion about the logical category which a particular term belongs to. In the case of the exclusive definition of health promotion, prevention and promotion are assumed to be on the same logical level and mutually exclusive. However, there are other possibilities; prevention could be nested below a higher level category called health promotion. Equally, health promotion could be a particular style or approach applicable to prevention as well as other work. In either of these views promotion does not have to be set in opposition to prevention.

Definition by Expansion

In contrast to definitions by exclusion, another approach to defining health promotion could be termed "definition by expansion." This approach defines health promotion by the fact that it seeks to move beyond a narrow concern with the health sector and into other social and economic domains. Green, for example, in both his early (Green, 1984), and later (Green & Kreuter 1991), definitions of health promotion includes this idea of including sectors outside of health. As his early definition states, health promotion is "any combination of health education *and* related organisational, economic and environmental supports for individual, group and community behaviour conductive to health" [emphasis added] (p. 219). An early World Health Organization (1984) document also takes, amongst several approaches, an expansionist view by defining health promotion as working on the determinants of health in the whole population in their "everyday life." It further notes that health promotion uses diverse methods such as communication, education,

legislation, fiscal measures, public participation and community development. An expansive definition of health promotion is also reflected in the Ottawa Charter, one of the key documents in health promotion (World Health Organization, 1986a).

Expansive definitions of health promotion make considerable sense if they are directed at getting health onto a range of other social and economic agendas. Such a definition for example may be useful in the context of seeking to have economic policy makers consider the impact of unemployment on health. However, other sectors have to be approached carefully, as this comment to the author from a colleague working in local body community development illustrates:

> The problem with the Healthy Cities' people is that they tend to come along and want to claim credit under the name of health promotion for all sorts of activity that is going on in the community and which we have always seen as community development. This tends to get people's backs up who have been working in the community on these issues for years before health promotion was ever on the scene.

This kind of problem arises when health promoters bring to another sector both a desire for health to be on that sector's agenda and a very wide definition of health. It seems that the World Health Organization's (WHO) approach encourages this because of its particularly expansive definition of health. This point can be illustrated by spelling out the definition of *health* within the World Health Organization description of health promotion. The World Health Organization has previously defined health *as* "a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity" (World Health

Organization, 1946). Substituting this in the World Health Organization definition of health promotion from the Ottawa Charter yields the following:

> Health promotion is the process of enabling people to increase control over, and to improve, their [*complete physical, mental and social well-being*]. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. [*Complete physical, mental and social well-being*] is, therefore, seen as a resource for everyday life, not the objective of living. [*Complete physical, mental and social well-being*] is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the *[complete physical, mental and social well-being*] sector, but goes beyond [*complete physical, mental and social well-being*] lifestyles to well-being. (Modified from World Health Organization, 1986a).

The problem with this description of health promotion is lack of specificity. A wide range of other terms could be put in place of *health promotion* in this definition, and it would still make sense - for instance, *education, social-justice, cultural identity building, empowerment*, *socio-economic development* or *self-esteem building*. This presents a problem for health promotion. Is health promotion just an alternate description for these other terms? Such a wide definition creates particular problems when health promoters approach other sectors seeking to have health issues put on their agendas. To do this while at the same time radically expanding the concept of health, as in the World Health Organization definition, creates some difficulties. It

seems rather as if health promoters are saying *hi, we are here to tell your sector you need to take health into account, yes, and by the way, health is everything anyway, so you therefore need to take everything into account.* Such global approaches to other sectors are likely to be received with a somewhat luke-warm reception in many instances. There may be some recognition by those in other sectors who are also pursuing a holistic programme of global transformation - for instance, some in the environmental sector. However, even in these cases the environmentalists may argue that the language and models they are using are already adequate and that there is little point in viewing everything as a health issue.

In contrast to approaching other sectors with such an expansive view of health, taking a fairly specific set of health concerns to other sectors would seem to be more productive. For instance, asking economic planners to factor in the health effects of employment policies, food regulators the effects of food policy on nutrition, or advertising authorities the effects of advertisements on children's health seem to be eminently reasonable requests. Such approaches at least have the potential for the other sector to act on them, or for health promoters to continue to point to their failure to act. If health promoters lose the specificity of the term health, as Levin (1987) points out, there may be no one to push health issues, in particular:

> This generous definition [of health] can help deepen our understanding of the etiology of health and what it will take to increase and maintain its availability. On the other hand, such an all encompassing definition does little to indicate the unique role of the public health establishment. Indeed it allows the possibility that everybody's business will become nobody's business (p. 92).

Definition by Process

Definition of health promotion by *process* is an approach which stakes out for health promotion a particular kind of process or processes. For instance, looking again at the World Health Organization (1984) definition of health, in addition to an expansionist definition, it also includes the statement that "health promotion aims particularly at effective and concrete public participation" (World Health Organization, 1984). This identifies one particular process as of major importance to health promotion. A similar approach is taken by Beaglehole and Raeburn (1987) when they talk about the "enabling" or "empowering" approach lying at the heart of health promotion. Rootman, Goodstadt, Potvin and Springett (1997) also see empowerment and participation as processes central to health promotion.

The merit of such a definitional move is that it enables a particular process to be identified which can guide work in a variety of settings on a variety of different health promotion topics. The difficulty with such an approach however, is that the particular process may come to be seen as being absolutely essential to anything which is to be called health promotion. This can result in the exclusion of work which does not involve the particular process from the definition of health promotion.

To take an example, at a particular point in time, public opinion may be against increased taxation on cigarettes. However it may be that some health promotion workers could successfully convince the Government that, for revenue reasons, it should increase cigarette taxes. How does this sit with the notion from the World Health Organization (1984) that health promotion aims particularly at public participation? The change may be able to be introduced without significant public participation. In fact encouraging active public participation may put pressure on the policy makers and stop them from increasing the tax and hence the price of

cigarettes. Is the lobby work undertaken by the health promotion practitioners not health promotion just because it does not conform to a process of public participation?

One response to this problem of limiting health promotion to one, or a few, processes is to define health promotion in terms of a whole series of processes. Nutbeam's (1986) definition of health promotion seems to take this tack when it sets out a large number of processes or, as they are termed here, strategies, which characterise health promotion.

> Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. It has come to represent a unifying concept for those who recognise the basic need for change in both the ways and conditions of living to promote health. Health promotion represents a mediating strategy between people and their environments, combining personal choice with social responsibility for health to create a healthier future.
>
> Health promotion as a principle involves the whole population in the context of its everyday life. Central to this is effective public participation in the definition of problems, decision-making, and action taken to change and improve the determinants of health. For this reason health promotion involves close co-operation between all sectors of society, including government, to ensure that the *total environment* is conducive to health.
>
> More specifically, health promotion represents a new strategy within the health and social fields that can be seen on the one hand as a political strategy, directed towards policy and on the other hand as

> an enabling approach to health, directed at lifestyles. Thus health promotion is not only concerned with enabling the development of life skills and individual competence to influence factors determining health. It is also concerned with environmental intervention to reinforce factors supporting healthy lifestyles and to change those factors preventing or prohibiting healthy lifestyles. This strategy has been summarised by the phrase *to make healthy choices the easy choices.*
>
> Health promotion has been summarised through the following general principles of approach: health promotion works *with* people not *on* them; it starts and ends with the local community; it is directed to the underlying as well as immediate causes of health; it balances concern with the individual and the environment; it emphasises the positive dimensions of health; and it concerns and should involve all sectors of society and the environment. [Emphasis in original] (p. 114).

Nutbeam's definitional approach, because it includes so many processes, is able to accommodate the notion of policy making which supports health promotion occurring without full public participation. Such activity could come under the heading of an environmental intervention to "make healthy choices the easy choices."

Definition by process or processes is, then, potentially useful for health promotion. However, if the process is restricted to one, or to a too narrow set of processes, there is the danger that the process based definition will be too restrictive to encompass all of the approaches which characterise modern health promotion practice.

Definition Diversity

The examples given above of defining health promotion by listing of the activities or topics, by exclusion, by expansion, and by way of particular processes, highlight the diversity of approaches which can be taken in describing health promotion. Downie, Fyfe and Tannahill (1990), trying to firm up the definition of health promotion for conceptual purposes, comment on this diversity:

> Although the term [health promotion] has been in existence for many years, it is during the 1980's that it has come to the fore, and it is currently highly fashionable in professional and political circles.
>
> Given this popularity, it is most unfortunate that "health promotion" is used in a number of different ways, even by the same people. The problem is accentuated by the fact that the term tends to be bandied about somewhat glibly, without clarification of underlying meanings. As with health education, therefore, it is perfectly possible--and indeed by no means uncommon--for two people, or even an entire committee or conference, to have a discussion about health promotion and be referring to very different things (p. 55-56).

The above authors express a note of disappointment that the concept has not been clarified better, and there seems a note of censure about the term having been "bandied about somewhat glibly." Others, such as Howat, Binns, Blaze-Temple and Corti (1987), are also concerned by the definitional ambiguity: "unfortunately, there are many conflicting definitions as to what constitutes "health promotion" (p. 90).

Reflection on Definitions

There are two ways of looking at the status of the term health promotion. The first is to see the definitional ambiguity as undesirable, stemming from undisciplined usage by people in the health promotion field. The second is to see the ambiguity around health promotion as simply reflecting the reality that it is a term having a number of different uses. Certainly, one of its uses is as a term in conceptual discussion about health promotion. In this context it is appropriate to grapple with developing concise meanings for the term. However, looking from a practical rather than a purely conceptual pure point of view, health promotion is a term which is often being used for the essentially political purpose of transforming practice in the real world. As Nutbeam (1986) quoted above notes, health promotion can be seen as both a "unifying concept" and a "political strategy."

To give an example, the term health promotion is often used as a rallying cry for particular points of view on health and social issues in highly politicised arenas. In such forums the term is being used as a polemical device to broaden people's perspectives from a simple individualistic notion of disease prevention. This purpose lies behind both the "definition by exclusion" (are you doing business-as-usual prevention or are you stretching your mind around what it might mean to do promotion?) and the "definition by expansion" (have you thought of all the sectors in which you might operate?) discussed above.

It is unsurprising, then, that the definition and colouration of a term used for such diverse purposes is liable to change. Depending on the nature of the forums in which the term health promotion is being used, different definitions will be more or less useful. For instance, in a local health authority where there are existing health education and health protection units, the term "health promotion" will need to be

used in such a way as to incorporate the existing work of these units, while at the same time broadening the horizons of the current staff. In a situation like this definitions of health promotion are likely to be particularly concerned with its relationship to health education and health protection, as in Downie, Fyfe and Tannahill's (1990) or Green's (1984) definitions cited above.

In contrast, at an international conference on health promotion, designed to motivate participants to forge ahead with novel initiatives, the definition of health promotion is less likely to be concerned with its relationship with health education or health protection. Instead it will tend to be pitched at a more general and visionary level in order to capture the imagination of participants. For instance, this is the approach one would expect at a conference such as the World Health Organization's 2nd International Conference on Health Promotion dealing with the issue of healthy public policy (World Health Organization, 1988).

Clearly, there is some merit in each of the approaches to defining health promotion which have been discussed in this section. A comprehensive definition would include facets of each of the four definitional approaches. The description of health promotion set out in the Ottawa Charter (World Health Organization, 1986a) is one such comprehensive definition. The description outlines three generic health promotion methods: enable, mediate and advocate; and is built around five activities or strategies briefly summarised here:

- *building healthy public policy* - putting health on the agenda of policy makers in all sectors and at all levels within society;

- *creating supportive environments* - creating living and working environments that promote health and are ecologically sound;

- *strengthening community action* - making it easier for concrete and effective community action to take place as part of the health promotion process;

- *developing personal skills* - providing information and education for health and enhancing life skills; and

- *reorienting health services* - moving the health sector in a health promotion direction, beyond its responsibility for providing clinical and curative services.

This approach to defining health promotion contains elements of all of the four definitional approaches. It includes listing (the list of five broad activities), definition by exclusion (moving the health sector beyond its current responsibilities), definition by expansion (health on the agenda in all sectors) and definition by process (enable, mediate, advocate).

When thinking about defining health promotion for the purpose of health promotion evaluation it can be argued that it is best to take this type of broad and inclusive approach. In this regard, Rootman et al. (1997) argue that in deciding what is and what is not health promotion one should not be too doctrinaire because:

- this enables inclusion of a "wide range of interventions, some with very modest scope and objectives, which nonetheless make some contribution to promoting health;" and

- "many of the considerations that apply to evaluation in health promotion also apply to evaluation in other domains, especially prevention." (p.9)

However, in spite of this, they do wish to "recognize the importance of the principles of health promotion, especially the cardinal one of "empowerment", as a

means of guiding health promotion activities including those associated with evaluation". (p. 9)

How to marry these two perspectives presents something of a dilemma for the Rootman approach, and they do not provide a solution. The solution which is adopted in this study is to firstly accept a wide interpretation of what health promotion is for evaluation purposes, so as not to eliminate by definition any particular programme types. Secondly, to introduce a tool, as part of the strategic evaluation framework, which can be used in the formative stages of programme development. This is the Matrix of Health Promotion Strategies and it encourages programme planners to consider the traditionally neglected more systemic and structural health promotion strategies. The hope is that this will move new programmes in the directions indicated by the more exclusive and process orientated definitions of health promotion.

CHAPTER THREE

HEALTH PROMOTION CONTEXT: IMPLICATIONS FOR EVALUATION

This chapter looks at the contextual factors that have influenced the nature of health promotion theory and practice, and draws out the implications of these for health promotion evaluation. The factors which underlie the modern health promotion movement, both internationally and in particular countries such as New Zealand, can be divided into three broad areas. Firstly, changes in the political climate coincident with the growth or resurgence of a number of social movements of relevance to health; including, the women's, indigenous peoples', and environmental movements. Secondly, changes in the economics of health; in particular, the potentially limitless demand for services as the range of treatments expands, the pressure to reduce Government social expenditure, and the growth of *managerialism* in the health sector. Third, changes in ideology which have a bearing on the way in which health is viewed; in particular the growth of *new right* ideology, and the narrowing of mainstream economic discourse, the promotion of individualism, the growth of interest in the concept of community, and the development of systems/ecological/holistic thinking. Each of these has implications for health promotion and its evaluation.

Social Movement Politics and Health

One of the noteworthy features of the political landscape in the later part of the Twentieth Century has been the development of a number of *social movements* (Melucci, 1988; Sztompka, 1993). Social movements are differentiated from change

initiated from above and are defined by Sztompka (1993) as having the following characteristics:

1. a collectivity of people acting together;
2. the shared goal of collective action is some change in their society, defined by participants in similar ways;
3. the collectivity is relatively diffuse, with a low level of formal organization; and
4. the actions have a relatively high degree of spontaneity, taking non-institutionalized, unconventional forms (p. 276).

Health promotion has been affected by many new social movements both as a result of their influence on the general socio-political climate and due to formative influences on workers entering health promotion. Some commentators go so far as to claim that health promotion has "appropriated the discourse of new social movements" (Stevenson & Burke, 1991, p. 281).Three of these movements, the women's, indigenous peoples', and environmental movements, will be considered here.

Women's Movement

The women's movement, both internationally and in New Zealand, has been an important part of the social and political context in which health promotion has developed. Even such historic efforts as the Temperance Movement, seen as an important early example of feminist activism (Macdonald, 1993), are now being reinterpreted as health promotion with a policy flavour (Weir, 1984).

Consistent with health promotion perspectives, the feminist movement has focused attention on the systemic rather than individual causes of ill health. A feminist critique of individualism is that it draws attention from the issue of the importance of structural inequalities by treating people as "atomised individuals"

(Young, 1997, p. 6). Health promotion too is not interested in focusing on atomised individuals but on the structural determinants of health (World Health Organization, 1986a).

The women's movement has also drawn attention to the importance of linkages across sectors and movements. The domestic, the workplace, the media, and the policy spheres have all been focused on by feminists. Feminists have also involved themselves with other social movements such as the indigenous people's, peace, environmental and gay movements (Macdonald, 1993). This wide viewpoint has foreshadowed health promotion interest in intersectoral collaboration.

While feminism has emphasised the systemic causes and solutions to problems it has also emphasised the connection between wider political agendas and the personal, summed up in the catch cry "the personal is political" (The Boston Women's Health Collective, 1985, p. 123). This catch cry has two components. Firstly, it forges a bridge between the personal and political. This is consistent with the approach adopted by many in health promotion. For instance, Labonte (1990) wants health promoters who are "comfortable thinking simultaneously in both personal and structural ways" in order to understand the "simultaneous reality of both" (p. 67). Secondly, the feminist call demands personal commitment to political action. This is also picked up in health promotion with, for instance, the Ottawa Charter conference participants making a personal "political commitment to health and equity in all sectors" (World Health Organization, 1986a).

Turning more directly to the women's movement and health; the discourse and practices of medicine have come under particular fire from feminist perspectives. This is because they have both disempowered women when in health care and also, in a wider sense, they have "played a pivotal role in preventing women from entering the public domain." (Lupton, 1993, p. 298). This conflict has come to a

head in the area of the control of childbirth where a tense drama has been played out between doctors and midwives based on their historic and ongoing conflict over childbirth (Brett, 1996; Turnbull et al. 1996). In health care practice generally it is reflected in the struggle between the male dominated medical profession (Allen, 1995) and the largely female nursing profession (Gardner, 1995) with its more holistic theoretical base (George, 1980).

The struggle of the women's movement to reclaim personal control over health from the medical fraternity is reflected in the title of the popular women's health book *Our Bodies Ourselves* (The Boston Women's Health Collective, 1985). In New Zealand an important symbolic focus for the women's movement's struggle to remove control of health from the medical profession was the government-commissioned Cartwright Inquiry into unethical behaviour relating to research on, and treatment of, cervical cancer at the National Women's Hospital (Cartwright, 1988). This is reflected in the following quote from Bunkle (1992), one of the authors of the investigative article which sparked the inquiry:

> The Cartwright Inquiry, which was the first full judicial inquiry chaired by a woman, did not limit itself to investigating the narrow clinical facts, but analysed the institution to explain how this could have happened. The Inquiry made an important shift. Normally the profession defines the reality against which the patient's credibility is judged. At the Inquiry the patients' experiences were at the centre, and the professional performance judged in relation to them. The recommendations of the Inquiry suggested this shift had to happen throughout the health service (p. 59).

The women's movement's challenge to the medical profession's dominance is consistent with the health promotion agenda of de-emphasising medical treatment and looking at health in a much wider context than just the conventional medical one. This de-emphasis is revealed in the Ottawa Charter's call for "re-orienting health services" beyond their "responsibility for providing clinical and curative services" and for a "change of attitude" by health services and a "strengthening [of] public participation and direction of health matters" (World Health Organization, 1986a).

The perspectives of the women's movement have also drawn attention to the importance of listening to women's voices when planning health promotion work, particular at the community level where women undertake much of the grass-roots work. Reflecting this, a World Health Organization conference report notes that, "women are the primary health promoters all over the world, and most of their work is performed without pay or for a minimal wage" (World Health Organization, 1988, p. 28).

Lastly, the women's movement has influenced health promotion methods. Women's networks and organisations have been described as "models for the process of health promotion organization, planning, and implementation" (World Health Organization, 1988, p. 28). The legacy of the women's movement has been offered as a model for health promotion action - "acceptance of different modes of working together, ways that value networking, the sharing of knowledge, building on wisdom, and listening to others" (Galbally, 1997, p. ii). In the research area, feminist perspectives on methodology have encouraged the exploration of a range of research methods which have pushed social science beyond reliance on only a small number of quantitative approaches (Reinharz, 1992).

Indigenous Peoples' Movements

A second social movement of major importance to health promotion is the renewed political activism of indigenous people over the last several decades. Indigenous people's health has been high on the health promotion agenda because of the negative statistics regarding their health status. This is well documented for Maori in New Zealand (Pomare, Keefe-Ormsby, Pearce, Reid, Robson & Watene-Haydon, 1995; North Health, 1995).

Maori bring to the health promotion table a clear call for Maori control of Maori health development. Advances in Maori health have been associated with strong Maori leadership (Durie, 1994a). As noted by an important researcher on Maori health, when talking about Maori leadership of health development, "no amount of expert advice will provide the necessary conviction of ownership which is crucial for developing an approach to health that makes sense to Maori" (Durie, 1994a, p. 1). This is consistent with the empowerment theme in health promotion (Durie, 1994b; Labonte, 1990; Wallerstein, 1992) which is now being recast as a call for *powerment* by some Maori commentators to remove the notion of power having to be given rather than legitimate power being exercised (Barnes & Stanley 1996).

A second contribution from Maori to health promotion has been the reemergence of Maori perspectives on health. In the coexisting Maori and western concepts of health and illness, the Maori perspective has until recently been silent (Pomare, et al. 1995). However, over the last two decades Maori voices have increasingly started to be heard in the mainstream health sector. A number of models of health have been developed from a Maori perspective. Pomare et al. (1995) have summarised the elements of three of these:

- the *Whare Tapa Wha* model which includes the following: *te taha wairua* (spiritual aspects); *te taha hinegaro* (mental and emotional aspects); *te taha*

whanau (family and community aspects); and *te taha tinana* (physical aspects) (Durie, 1994a);

- the *Te Wheke* model which includes the following: *wairuatanga* (spirituality); *hinegaro* (mental); *taha tinana* (physical); *whanaungatanga* (the extended family); *whatumanawa* (emotional); *mauri* (life principle in people and objects); *mana aka* (unique identity), and *ha a koro ma a kui ma* (inherited strengths); and

- the model from the Royal Commission on Social Policy in the late 1980s which includes the following: *whanaungatanga* (family); *taonga tuku iho* (cultural heritage); *te ao tura* (the physical environment), and *turangawaewae* (source of identity) (p. 26).

Consistent with the perspective of health promotion each of these Maori models of health expands the concept of health into a holistic concept which reaches into all areas of life.

Environmental Movement

The environmental movement is the third social movement of importance to health promotion. The environmental movement is now a strong social movement which can be traced back to the impact of the Industrial Revolution and in its modern form covers a wide range of perspectives from the *Deep Ecology Movement's* call for very radical economic and social change to *Environmental Reformism's* desire to mitigate the effects of industrialism and continued growth (Young, 1992). Green ideas (Bnown & Singer, 1996) are now receiving increasingly sympathetic treatment in mainstream media (Time, 1997). The increasing attention being paid to the health implications of environmental breakdown (McMichael, 1993), due at least in part to the work of the environmental movement, is reflected in

health promotion's concern with environmental issues (Catford, 1991; Labonte, 1991a). The Ottawa Charter refers to the importance of "creating supportive environments" which include both the natural and social environment (World Health Organization, 1986a).

The influence of the environmental movement can be see in health promotion under headings such as *primary environmental care* (Catford, 1991), *ecological public health* (Kickbusch, 1989), and *econology (*Labonte, 1991a, 1991b). Indeed, health promotion has moved towards a perspective which is very close to the model of sustainable and environmentally safe economic development which is central to the vision of the environmental movement .

Influence of Social Movements

This section on social movements has discussed three major movements which have been influential in the development and ongoing context of health promotion. These three are not the only social movements which are relevant to health promotion. The peace movement in particular is also of some importance (Middleton, 1988), in developing activist methods some of which are used in health promotion. In additional to these social movements there is a tradition of action reseach and social activism which has influenced health promotion. In particular Lewin (1948), Freire (1968) and Alinsky (1971) are important sources for key figures in health promotion (Labonte, 1997; Green et al., 1995). The consumers' movement, which in some respects can be seen as a social movement particularly in areas such as the health consumers' movement, has also had some influence. Many of the demands which have arisen from the health consumers' movement are similar to those of the women's and indigenous peoples movements, particularly the moving of the balance of power from the professional to the consumer.

To summarise, social movements have impacted on health promotion in the following ways. They have:

- encouraged increased emphasis on the natural environment, and the social, cultural and systemic determinants of health;
- expanded concepts of health to encompass spiritual, psychological, social, cultural, economic and political aspects;
- demanded a power shift from professionals, researchers and bureaucracies to clients and communities;
- reinforced the link between the personal and the political;
- promoted community, grass-roots and *flax-roots* (grass-roots activity in the Maori community) activity;
- pioneered a diverse range of methods and strategies which can be used to promote health (including cross sector networking and collaboration, coalition building, media advocacy, and community development); and
- introduced new research methodologies and perspectives.

Economics and Health

There are three major economic factors that have had an important bearing on the development of health promotion. These are the apparently potentially limitless demand for treatment services as the range of treatments expands; the pressure to reduce government social spending; and the trend towards health managerialism.

Limitless Demand for Health Care

As knowledge increases through health research and as technology advances, the health care delivery system has the potential to spend ever increasing amounts of money treating sicker and sicker, and often previously untreatable, people in increasingly expensive ways. Disease patterns have changed, with a move away from acute and quickly fatal diseases to chronic diseases leading to escalating costs for health care (Neubauer & Pratt, 1981). This mounting demand for ongoing health care, as a US Surgeon General's report on health promotion points out, has been one of the important motivating factors behind the development of health promotion and disease prevention (US Public Health Service, 1979). As Warner (1987) puts it, health promotion has been "molded in important ways by the clash between medical progress and the era of health care limits" (p. 52-53)

Hopes held for health promotion to improve health and reduce, or at least slow the acceleration of, health care costs have led to pressure on health promotion to prove that resources invested in it will pay off in terms of future reductions in health care expenditure. In workshops on health promotion evaluation run by the author and colleagues, health promotion practitioners often said that they were being increasingly challenged by managers to prove through evaluation that their programmes would save money in reduced future health care costs. This pressure influences the way people view health promotion evaluation and has strengthened the push for models of health promotion evaluation based on the clinical outcome trials approach.

Pressure to Reduce Government Social Spending

In addition to the potentially unlimited demand for health care services, pressure on health spending also comes from the push to reduce overall government social expenditure. In fact, as McLeroy, Gottlieb and Burdine (1987)

point out, there is sometimes an implication that health promotion programmes are being established as a sweetener to cutbacks in government services. The push to reduce government social expenditure is one aspect of a shift away from the Welfare State towards a reduced role for the State as a part of a free market new right agenda, both internationally (Taylor, 1990) and in New Zealand (Boston et al. 1991; Jesson, 1987; Kelsey, 1995). The influence on health promotion of the ideological aspects of this shift are discussed later in this Chapter. That such thinking is relevant to the health sector in New Zealand is emphasised by the fact that a New Zealand Minister of Health during the early 1990's round of health reforms was the author of a new right text called *The Withering of the State* (Upton, 1987).

The push to reduce government social expenditure also feeds into the issue of the demand for proof that resources invested in health promotion will have a pay off in terms of reducing the future need for health care expenditure. A second issue results from reduced government social expenditure in New Zealand which has put communities under stress in a number of areas in addition to health, e.g. housing, employment, access to education and, has contributed to a rise in poverty (Kelsey, 1995). This means that health promotion is operating in an environment where there is an increasing range and number of unmet social needs. When this is combined with the fact that many of these needs such as housing and employment can be seen from a health promotion perspective as *prerequisites for health* (New Zealand Board of Health, 1988), a tension arises for health promotion. This is the tension regarding where health promotion should stand in relation to other types of social and community promotion programmes.

In concrete terms this comes down to the issue of the purpose for which resources designated for health promotion should be used. In communities where

numbers of people do not have the prerequisites for health, should health promotion resources be spent on meeting these needs when such resources would be rapidly exhausted by the scale of social need? Or should such resources be used to advocate for the prerequisites for health being met in that community?

For health promotion evaluation the implication of reduced government spending is that it is likely to lead to a reduction in the prerequisites for health. This, in turn, is likely to lead to a reduction in health status for some groups. This means that attempts to assess the outcome of health promotion activity on health status need to be undertaken against a back drop of declining health status for some groups. This has the potential to make such measurement more complex.

Health Managerialism and Funder-Provider Split

A third trend in economics and public administration relevant to health promotion in New Zealand is what has been described as the "Bureaucratic Revolution" in the public sector in New Zealand (Boston et al. 1991). This has included first a greater emphasis on *managerialism* (an approach which puts emphasis on generic management skills rather than a manager's technical or professional skills) in health and other parts of the public sector (Boston et al. 1991, Easton 1997); and second the introduction of a *funder-provider* split (forcing a separation in public sector administration between those who fund services and those who provide them) (The Treasury, 1990). Historically, health services in New Zealand were managed by medical professionals. However with the reform of the health sector in the late 1980s and 1990s, generic managers have moved into positions which were formerly restricted to medically trained personnel. This trend has flowed through to both local health care provision (Crown Health Enterprises), regional purchasing (Regional Health Authorities) and at the national level (Ministry

of Health). It has built on the earlier reforms which led to the establishment of the Area Health Boards in the latter part of the 1980s.

The theory is that generic managers should be more responsive to the management incentives put in place in the new health structures than health care professionals who bring to management positions the assumptions, methods, attitudes and allegiances of their own professional backgrounds. The implications of this for health promotion evaluation are that it is theoretically possible, *given the right incentives*, for generic management to ask questions about how disease and illness can be prevented rather than to simply focus on traditional medical interventions. For instance, Hall, Heller, Dobson, Lloyd, Sanson-Fisher and Leeder (1988) have compared the cost-effectiveness of alternative strategies for the prevention of cardiovascular disease and identified a mass media whole population approach as cheaper than any strategy which involves identification, and medication of high risk individuals. It is possible that, given the right incentives, these findings may be more likely to be acted upon by generic management than by clinicians with an individual treatment orientation. However, while generic management may have the potential for an increased health promotion orientation, the extent to which this will occur relies on incentives put in place to encourage management to take health promotion initiatives.

Impact of Economic and Administrative Changes

The economic and administrative changes relevant to the health area outlined here have created a number of conflicting pressures for health promotion:

- expanding demands on health promotion resources in communities where the prerequisites for health are worsening for a number of groups;
- pressure to justify health promotion spending in economic cost-benefit terms; and

- potential for increased interest in health promotion, if this can be shown to lead to reduction in illness, due to the escalating cost of health care.

Ideologies and Health

In addition to the ideologies of the social movements that have broadened the health agenda, and the impact of the economic and managerial changes just discussed, there have also been important related ideological changes which have impacted on health promotion. Ideologies are sets of ideas about phenomena that provide ways of abstracting, conceptualising and evaluating the social environment (Brown, 1972). Their importance to the way in which health is viewed has been repeatedly referred to in the literature (Bechhofer, 1989; Crawford, 1977; Neubauer & Pratt, 1981; Terris, 1990; Williams, 1989). Five ideological changes will be discussed here in relation to the development of health promotion. They are the closing of mainstream political economic discourse, the growth of individualism, the recognition of the importance of social factors in determining health status, the growth in the concept of community, and the development of systems/ecological and holistic models.

Growth of the New Right: Closing of Mainstream Political Economic Discourse

The last decade has seen the rapid international growth of laissez-faire free market ideology. This ideology has come to be known as *New Right* (Glennerster & Midgley, 1991). The rapid implementation of this ideology in New Zealand (Else, 1992) has led to a radical restructuring of New Zealand's economic and social life (Boston & Dalziel, 1992; Easton, 1989,1997; Jesson, 1987), which has been actively encouraged by influential international bodies such as the Organisation for

Economic Co-operation and Development (OECD, 1991), World Bank and the International Monetary Fund (IMF).

The implementation of this ideology has meant limitations on the range of forums for debating social and economic policy, concisely summarised by a newspaper commentator as, "fashionable causes, traditionally defined by the Left, are now determined by the Right" (Morrison, 1992). Considine (1988) has noted the implications of this type of ideological change for the public sector:

> Economic categories and formulations begin to appear as taken for granted explanations of the work of public organisations so that it becomes extremely difficult to discuss, plan or evaluate public sector action according to any non-economic and non-quantifiable criteria. Similarly, it becomes increasingly more difficult to justify increased levels of public involvement in organisational activities when the community itself has been defined and reduced to the status of consumers (p. 13).

In New Zealand it has been argued that the New Right agenda has made such powerful inroads into public policy setting because a significant portion of the public bureaucracy has a "stake in the reforms and in the [New Right] ideology". This has resulted in the use of economic and financial means for resolving resource allocation and distribution issues being firmly cemented as the "favoured modes of analysis" (Le Heron & Pawson, 1996, p. 394). Le Heron (1996) notes the dominance of one of the New Right ideology proponents, the New Zealand Business Round Table:

> In contrast to other interest groups...[it has] unlimited resources to produce articulate submissions in every major area of public policy, as

> well as promoting its own independent studies....Whatever the subject area, the philosophic approach of the Business Round Table is consistently in favour of much reduced social spending, market liberalisation, private welfare provision and private litigation rather than public regulation (p. 86).

In this New Right ideological climate, there continue to be those who seek broader alternative perspectives than simply those of economic analysis. For instance, Considine (1988), who was quoted criticising the narrow economic perspective above, has called for a wider view of citizenship:

> At the very least a wider view of citizenship which encompassed individuals and groups outside the field of current consumers of existing services might allow evaluations and planning systems to address wider questions such as redistribution, equity or other aspects of systemic change. These social values are diminished by definitions of organisational performance which are cast in a predominantly economic value framework (p.13).

The health promotion arena provides one forum where some of these alternative views can be developed. The health promotion sector has provided a location relatively free from New Right ideological dominance. Health promotion material includes a number of statements which until recently would have been regarded as more appropriately expressed in the realrn of politics rather than of health. For instance, the *Promoting Health in New Zealand* publication (New Zealand Board of Health, 1988), includes calls for the following: safeguarding peace, eliminating fear of war, reduction of social inequalities, full employment,

regional development, removing sexism, removing ageism, and removing racism. The New Right would be unlikely to support putting these items high up on the public policy agenda.

Health promotion has to some extent provided a "safe haven" in which aspects of topics largely excluded from mainstream social policy debates can continue to be discussed. As noted above this is reflected in the way health promotion has grown out of some of the discourse of the new social movements (Stevenson and Burke, 1991). This is not to argue that discussion of such topics has totally disappeared from mainstream non-health social policy and economic forums. In fact, such discussion has continued, but mostly in the form of marginalised critiques of current policies (Boston & Dalziel, 1992; Deeks & Perry, 1992; Easton, 1989, 1997; McKinlay, 1990). Over the last decade health promotion has provided a more sympathetic forum in which discussion of these topics is not only in the form of critiques of current policy direction, but can take a more proactive stance and actually propose policy initiatives.

In a situation of expanding New Right ideological dominance it could be expected that health promotion discourse's relative freedom would come under the New Right spotlight and in time its scope would be brought back in line with that of mainstream political and economic discourse. Such a process would be likely to begin with calls for health promotion to be more "realistic", more "policy relevant", and to "use the current economic jargon". A relative absence of such calls so far may attest more to health promotion discourse's perceived irrelevance or invisibility to the key ideological actors in mainstream political and economic discourse, than to its strength in resisting ideological dominance. While health promotion has provided a haven for the rhetoric of the new social movements, whether or not this is able to

be translated into practice in health promotion is another matter (Grace, 1991; Petersen & Lupton, 1996; Stevenson & Burke, 1991).

Individualism

As argued above, health promotion discourse continues to nurture ideas which are currently eliminated from New Right economic and social discussion. However, it has not gone untouched by major long term ideological currents within capitalist societies, such as the rise of individualism in Western thought (Lukes, 1973). In fact, individualism has played an important role in the development of health promotion. An individualist frame of reference encourages increasing attention to what people can do to improve their own health as an alternative to State-funded health care. The development of lifestyle orientated health promotion in the United States, for example, has been attributed to the consistency of lifestyle health promotion with the "re-emerging American value of individualism" (Runyan, Devellis, Devellis & Hochbaum, 1982).

Individualism as an ideology weaves its way throughout health promotion discourse and affects practice in a range of ways. For instance, individualism, along with the conservative ideology of which it is a part, can be seen to lie behind the popularity of strategies which sensationalise and then victim blame such as *drug wars* (Morgan, Wallack & Buchanan, 1988). Individualism is also responsible for the continuing tension within health promotion between individual and environmental strategies which is taken up later in this study.

Recognition of Social and Environmental Factors Influence on Health Status

Another general ideological shift in recent times has been the increasing recognition that most major improvements in health have come from changes in social conditions rather than from the provision of increased health services (Illich,

1975; McMichael, 1993). For example, researchers have pointed out that most of the decline in mortality in countries such as the United States in the twentieth century has been as a result not of medical intervention but rather of changing social conditions (McKinlay & McKinlay, 1977). Machnes (1990), in a across-country study using multiple regression to estimate the contribution of several factors to life expectancy, found that amount of schooling was the main variable related to increasing life expectancy, although medical services did have an impact. Machnes suggests that "a shift of resources from medicine to education might prolong the life expectancy of the population" (p. 30). The U.S. Surgeon General's Report on Health Promotion and Disease Prevention, concluded in a summary of the research linking people's behaviour to the risk of chronic disease and that 20 percent of all causes of death and disease can be attributed to "environmental hazards" (U.S. Public Health Service, 1979). However, it is ironic, but not unexpected in that individualistic culture, that the major recommendation of the Surgeon General's report was to focus on encouraging individuals to reform their behaviour (Neubauer & Pratt, 1981).

While social factors in health have been noted by commentators for a long time (Bechhofer, 1989), the 1980s and 1990s saw this wider perspective on health highlighted in models of health which pointed to the important role of environmental and life style factors in the causation and prevention of disease. For instance, the Canadian Lalonde model looked at four factors basic to health: environment, life style, human biology and the system of health care organisation; which were then further elaborated in the Dever model (Gunning-Schepers & Hagen, 1987). Such wider perspectives have led to many calls for broadening the focus in prevention of illness from individuals to environmental and social factors (Bechhofer, 1989;

Crawford, 1977; Jackson, 1985; Neubauer & Pratt, 1981; Terris, 1990; Williams, 1989).

Growth of Concept of Community

A further ideological factor in the origin of health promotion and one of those identified by the World Health Organization has been a growing interest among policy makers in community development (Watt, 1986). Community solutions are now routinely proposed for a wide variety of social ills (Willmott, 1984). It is therefore not surprising that community strategies will feature strongly as elements in the health promotion enterprise.

As is fully discussed later, a range of activities can fall under the term community health promotion strategies (Anstis, 1990; Casswell & Stewart, 1989; DeFrank & Levenson, 1987; Mellor, 1987; Green & McAlister, 1984). The concept of community receives support from a variety of different sectors. The reasons for its appeal range from its involvement and empowerment of people (Raeburn, 1992) to its position as a conservative alternative to the welfare state (Willetts, 1992). Because of its usefulness as a concept to a wide range of stakeholders, community features prominently in the modern health promotion movement.

Promotion of Systems/Ecological and Holistic Models

A last major factor associated with the development of health promotion has been the growth of systems/ecological and holistic perspectives in the study of social life (Bateson, 1980). These approaches start by taking broad views of phenomena rather than just looking at individual variables. They are particularly interested in the way in which large numbers of variables interact and feed back to each other rather than only focusing on the interaction between a very small number of isolated variables. Because of the similarity of these views with those of a health

promotion perspective, systems/ecological views have found fertile ground in health promotion.

Links have been drawn between systems theory and the traditional public health concern with the environment, as reflected in the host-agent-environment model. McLeroy, Bibeau, Steckler & Glanz (1988), for example, see the host-agent-environment model as an ecological or systems model. In addition general systems models of health behaviour have been developed (e.g. Kersell & Milsum, 1985).

The emphasis on holism and systems thinking has encouraged the development of a health promotion discipline that can accommodate complex interrelationships between the variables which lie behind health and illness and which can be used to prevent disease and promote health.

Impact of Ideological Changes

Ideological changes spelt out in this section have had the following implications for health promotion:

- emphasis on the social determinants of health;
- looking holistically at systems rather than the traditional attention to only a few variables;
- support for community strategies and perspectives;
- health promotion discourse as a "safe haven" for ideas rejected by the New Right mainstream economic and policy discourse; and
- likelihood of tensions and contradictions within health promotion as it is influenced by ideological currents such as individualism.

Implications for Health Promotion Evaluation

These contextual factors in health promotion's origin and current environment affect importantly health promotion evaluation. These implications are summarised here.

Backdrop of Worsening Social Variables

The pressure to reduce Government social spending has led to a worsening of the social variables which influence health status (Rankin, 1993). This needs to be factored into thinking about health promotion programme evaluation. For instance, a programme may be directed at improving children's health but in a region where poverty is reducing children's' health status. Undertaking outcome evaluations in a context of trends working against the outcome variable has implications for the design and interpretation of any outcome evaluation which is conducted (Campbell & Stanley, 1966).

Demand for Participatory Research Methods

The demand for more community participation in research of all kinds has come from the new social movements. Moreover, the emphasis on aspects of client satisfaction inherent in managerialism has increased the pressure on evaluators to collect data directly from those affected by programmes. The growth of community strategies has also resulted in pressure for a participatory approach to evaluation research in community health promotion programmes (de Koning & Martin, 1996; Green et al., 1997).

Promotion of Multiple Research Methods

Pressure for the use of multiple methods in health promotion evaluation has resulted from several of the trends outlined above. The women's and indigenous people's movements have insisted on widening the range of what can constitute evidence and championed the use of qualitative methods (Laing, 1994; Lennon,

1996). The promotion of systems/ecological and holistic models has meant that a wider range of methodologies has had to be looked at as there is a move away from the earlier more reductionist approach to social and health science (Labonte & Robertson, 1996; Duignan & Casswell, 1988).

Need for Community Programme Evaluation Methods

The growth in community interventions arising out of the popularity of the concept of community, pressure from the new social movements, and government's increasing use of community programmes has meant the need for new evaluation methodologies which can effectively capture information in a community context (Baum, 1992; Duignan & Casswell, 1989).

Demand for Proof of Reduced Clinical Costs

Attempts to control potentially limitless demand for health care services can increase pressure for evaluation evidence that health promotion investment will provide a future return in terms of reduced demand for clinical services.

Wide Range of Evaluation Methods Needed

Evaluators need a wide range of methods which can deal with the broad range of different health promotion strategies currently being used. Managerialism has some theoretical potential to free up management thinking from relying only on medical and health education approaches. The new social movements encourage a range of strategies for social change. The recognition of the influence of social and environmental factors in health status; the growth of the concept of community and the promotion of systems/ecological and holistic models have also all worked to expand the range of possible health promotion strategies.

Resistance to Pressure for Individualistic Approaches

While there has been an expanded range of possible health promotion strategies, the New Right ideological perspectives with their individualistic focus

tend to constantly drag thinking back to individually orientated strategies (Crawford, 1977). Evaluators, particularly when working in the formative stages of a programme, need to have tools which assist in expanding the thinking of health promoters right across the range of available strategies such as the Ottawa Charter or the Matrix of Health Promotion Strategies developed in this study.

Summary

This chapter has looked at a range of political, economic and ideological contextual factors which have influenced health promotion. These factors have contributed both to the existence of health promotion and to its major themes - its community emphasis, concern for empowerment, interest in the variables which affect health, concern with health and not just disease, desire to go beyond a narrow medical focus, and linkages to environmental and other sector concerns. Recognition of these contextual factors have also contributed to the tensions within health promotion - between a systemic and an individual educational focus, and between top-down bureaucratic and bottom-up grass-roots action. These political, economic and ideological factors have important implications for health promotion evaluation and these have been set out here. The strategic evaluation approach to evaluating health promotion developed in Chapter Nine has been designed to be responsive to each of these implications.

CHAPTER FOUR

HEALTH PROMOTION CHARACTERISTICS

This chapter discusses important health promotion characteristics: its multidisciplinary focus, social change orientation and cultural specificity; the Ottawa Charter strategies; and the health promotion processes of advocacy, enablement, mediation and empowerment.

Multidisciplinary Focus

Health promotion is inherently multidisciplinary. The context in which it developed has ensured that it has had to draw on an array of different disciplines both in order to remain credible with its stakeholders in the academic/intellectual and practical worlds, and to cover its wide range of methodologies and social domains. For instance, a single programme can involve health promotion staff undertaking research in their communities; preparing pamphlets, handbooks and other written resources; preparing media plans; writing media releases; preparing media advertisements; making presentations (whether to the community, professionals or policy makers); forming coalitions with like-minded people; and writing submissions on legislation. It is unlikely than any one unidisciplinary staff member would have the experience or skills to be able to work effectively across all of these areas.

Health promotion's need for multidisciplinary knowledges and skills, as well as the novelty of the discipline, has led to a great diversity in health promotion practitioners' backgrounds. These include: health education, community development, social work, nursing, medicine, market research, economics,

sociology, anthropology, political science, and psychology. This means that the usual homogenisation process which occurs in a discipline through professional socialisation during training (Friedson, 1972) has not yet occurred in health promotion. As a consequence there is likely to be more ongoing debate about fundamental issues in health promotion than takes place in more established disciplines.

For those working in health promotion, this can lead to the situation where people *talk past* each other. For instance, a physician's concept of community action could be very different from that of a community worker's. The traditional barriers between disciplines need to be overcome by health promoters if they want to work together. Bice's (1980) summary of the problem for workers in the policy research area also applies equally to health promotion:

> Each discipline rewards its practitioners for their ignorance of theories, methods, and knowledge of the others. One may readily understand how these cleavages have been perpetrated. Each discipline posts limits on the legitimacy of theoretical perspectives in order to advance the accumulation of internally-consistent, albeit partial, knowledge...(p. 192).

Fortunately, the more health promotion practitioners and researchers work together on practical projects, the more they are forced to abandon parochial disciplinary differences and the more they are likely to concentrate on interdisciplinary solutions to health promotion problems. Ideally, such solutions draw whatever they can from the range of disciplines involved in health promotion,

without becoming excessively tied to one particular disciplinary-based theoretical perspective or language.

Therefore, health promotion's multidisciplinary composition makes it:

- demanding for practitioners who have to have a wide range of skills and knowledge bases;
- subject to continuing theoretical debate and questioning because of its varied disciplinary makeup; and
- likely to move gradually towards more developed theories and methods which draw on a wide range of disciplines.

Social Change Orientation

Health promotion is inherently a social change activity. One of the features of the context from which health promotion emerged is a realisation that social and environmental factors powerfully influence health status. Modern health promotion seeks to locate and modify the factors which affect health; factors such as class, gender, ethnic group, housing, and poverty. Commentators such as Martin and McQueen (1989) have seen this as the essence of health promotion:

> Perhaps the essence of a new public health is a healthy scepticism about the role that health professionals, whether biomedically or behaviourally based, can play in the reduction and amelioration of ill-health which is to a large degree a consequence of a modern industrialised world and its social structure (p. 8).

The corollary of recognising the impact of social structure on health is seeking to change that structure. However, this can lead health promoters into hotly contested political debates. Concerns about such political controversy have often led those working in health promotion and related areas, such as preventive medicine, to hold back from advocacy. In particular they have been reticent to advocate changes that, while they might do much for health, are politically difficult and may work against an emerging profession's desire for respectability. For example, historical analysis from England and Wales during the period 1870-1914 shows that many improvements in population health came from local political struggles, rather than through medicine as a prime mover (Blane, 1989).

Health promotion's social change orientation is made explicit in the Ottawa Charter Conference's "clear political commitment to health and equity in all sectors"; its highlighting the need for action on society's "rules and practices" which produce health inequalities; its call for international socio-political action in line with the "moral and social values" forming the basis of the Charter (World Health Organization, 1988); and ongoing calls for "political commitment" (Canadian Public Health Association, 1996). These values present a personal and professional challenge for health promoters to be involved in a transformational process which "moves us towards greater equity in power within and between nations" (Labonte, 1990, p. 74). In developing strategies for progressing this social transformation health promoters draw on the experience of other sectors in seeking to research and bring about social change (Green et al., 1995).

In common with other areas of social transformation, health promotion has:

- recognised the need for social change to make significant improvements to health;
- become aware of the political consequences of advocating for changes which threaten powerful stakeholders; and
- explored and developed methods for bringing about social change through political and community organising.

Dependence on Cultural Embeddedness

As with all other social activity, health promotion is embedded within its own particular cultural context. Consistent with this, the health promotion literature contains general calls for recognition of cultural diversity in the planning of health promotion programmes (see Gottlieb & Green, 1987). Specific reports of major health promotion projects also emphasise the importance of cultural context. For example, the North Karelia Project notes the importance of the Finnish culture to the way the programme functioned and raises questions about how successfully it could be transferred to another culture such as that of the United States (McAlister, Puska, Salonen, Tuomilehto & Koskela, 1982).

The very definition of what constitutes health and a health problem is a cultural matter, as has already been noted in regard to Maori concepts of health. The determination of a particular issue as a health promotion problem depends on cultural factors, for example, the degree to which the individual is held responsible for their health, the extent to which formal authorities take responsibility for health and the types of risk that are regarded as significant within a culture at a particular time (McLeroy, Gottlieb & Burdine, 1987). Of course, it must also be remembered

that such cultural views are not static and that over time, the way a culture views health promotion related concepts may change. For example, the way in which a substance such as alcohol is viewed can gradually change and can also vary markedly within groups within a larger culture (Bennett, 1988).

In New Zealand the basis of Maori/Pakeha cultural relations is the Treaty of Waitangi signed between Maori and the Crown. The importance of the Treaty for health promotion is reflected in the fact that important foundation health promotion documents such as *Promoting Health in New Zealand* (New Zealand Board of Health, 1988) note that recognition of the Treaty is a prerequisite for health promotion in New Zealand. It is also reflected in the fact that biculturalism and Treaty relations continue to be such important issues at health promotion conferences. (Health Promotion Forum Conference, Auckland, October 1990; Health Promotion Forum Conference, Auckland, October 1997).

In situations of conflicts between cultures over power and control, such as is happening in New Zealand at the current time, health promotion, as with any issue can become a location for such debates. For instance it has been argued that frameworks such as the Ottawa Charter used in a Maori context could dominate the way in which health promotion issues are conceptualised and fail to put sufficient emphasis on central notions such as the role of the land in health promotion (Paul Stanley, personal communication, 1996). When the discussion moves from conceptual issues to resource allocation for programmes then obviously the wider issues of power and control of resources will also continue to play a role in the way in which the debate is conducted.

In conclusion, in regard to its cultural context, health promotion:

- is always embedded in a particular set of culturally determined perspectives;
- is likely to be different in different cultures because of the variety of ways in which even major concepts such as health are culturally constructed; and
- cannot avoid wider inter-cultural conflicts over power which may spill into conflicts around health promotion concepts and activities.

Ottawa Charter Guidelines

The Ottawa Charter, a centre piece in the modern health promotion movement, was developed at a conference in Ottawa in 1986. The conference was held by the World Health Organization, Health and Welfare Canada, and the Canadian Public Health Association (World Health Organization, 1986a). The Charter sets out principles and strategies for health promotion which are used in this section as headings for discussing the modern health promotion movement's characteristics.

Building Healthy Public Policy

The first Ottawa Charter guideline for health promotion is building healthy public policy. This is a central feature of the modern health promotion movement. The World Health Organization (1988) identifies the thrust of this new concern:

> ...[the] effort to make the effects on health of public policy explicit, and where necessary and possible, to alter policies in the direction of health promotion. Recognition of these health effects will allow health criteria to enter public policy discourse in governments, community groups, and the media and thereby help develop a social climate

> favourable to healthful policy decisions. In effect, this will reduce the costs to political leaders of making healthy public policies (1988, p. 264).

This approach recognises that policies in all sectors, not just those explicitly in the health sector, have health implications and should be monitored at all levels of development to ensure health deleterious effects are reduced. One example is economic policies which cause deprivation and thus can lead to a decline in quality of life and concurrently in health. Another example might be farm policies which set the level of subsidies for food production. Subsidies have implications for nutrition patterns (Milio 1981b) which are in turn likely to affect the incidence of health problems such as heart disease. The centrality of social policy to the task of developing and maintaining health has led some health promoters to conclude that the substantial overlap between the two fields make it "feasible to consider health promotion as social policy", (Bunton, 1992, p. 147). The importance of healthy public policy has been recognised at the international level. The 2nd World Health Organization Conference on Health Promotion in Adelaide in 1988 focused on just this issue (World Health Organization, 1988). Milio (1988) has described public policy in a health promotion context as the "most powerful collective means to shape human living" (1988, p. 264).This perspective of the importance of public policy is consistent with the attention it is paid in evaluation, policy studies, program evaluation, public management science, and policy science (Nagel, 1990; Palumbo, 1987).

A key figure in emphasising the public policy approach to health promotion is Nancy Milio (Draper, 1986). She has written a classic text on the subject (Milio, 1981a) and examined a number of case studies of public policy and its relationship to health promotion, including that of farm policy in Norway (Milio, 1981b) and the role of pressure groups in health policy making in Australia (Milio 1986a). She has identified the key ingredients for healthy public policy:

> ...among the ingredients necessary to develop a policy strategy for health are high-level political leadership, the designation of institutional responsibility, the design of machinery for collaboration within government and between government and outside groups, and material and intangible support for policy development. The resources needed include not only funds, authority, expertise and time but also new types of information and education for new audiences such as policy-makers, community leaders, and journalists (p. 264-265).

In the course of her work, Milio has developed a framework for analysing public policy in health promotion. Described as an ecological framework, it has the following elements:

- *participants* - key interest group stakeholders (e.g. government ministries, commercial enterprises);
- *policy-keeper* - participant who holds and attempts to advance an articulated policy;
- *social climate* - includes current situation (e.g. population demographics), politics (e.g. party alliances), opinion (e.g. public and media opinion) and processes (e.g. ongoing economic reform process);

- *generic policy-making questions* - agenda setting, problem framing, priority setting, option setting, selecting criteria for selecting options, decisions as to who should be responsible for deciding on policy, choice of implementation means, success and evaluation indicators, and determining how and when policy could be reformulated in the future; and
- *the policy process* - each participant's strategic action plan for achieving the policy (Milio, 1988)

Milward (1982), along the same lines, analyses policy development in terms of a *policy system domain,* a *policy community,* a *decision network,* and an *institutionalised thought structure*. The concept of the institutionalised thought structure is used in Chapter Seven.

In spite of the Ottawa Charter's focus on developing healthy public policy, and the availability of frameworks such as Milio's, promoting policy initiatives which support health has proved difficult in the last decade in New Zealand. The ascendancy of the New Right ideology has made it difficult to argue for new public programmes or any additional health promoting interventions that might interfere with the activity of the free market. The current policy mood is to favour self-regulation of industry in many public policy areas. However such self-regulation has been shown to be consistently subverted by the industries involved, for instance in the area of alcohol advertising (Baggott & Harrison, 1986 , Blakeney & Barnes, 1982; Casswell, Stewart & Duignan, 1989).

Even in those instances where there has been a move beyond industry self-regulation to actual implementation of Government policy, a phenomenon which can

be called *pseudo-healthy public policy* can occur. This happens where policies put in place in the name of promoting health are subverted by structures intentionally set up to avoid effective action. In the United States such policy making has been characterised by Christoffel and Christoffel (1989) as follows:

> This more cynical view holds that Congress may at times enact into law social regulatory programs that are not expected to work. This is not a conspiracy view. Some legislators may have fought for an effective bill only to see it whittle down to a hollow shell during the legislative give-and-take. Others may have agreed to support the final bill only because it was a hollow shell, so they could take a public stance supporting the regulatory programme while not significantly alienating the targets of the proposed regulation. Often this is accomplished by creating a regulatory structure so complicated that it assures that regulatory implementation proceeds at a snail's pace (p. 338).

Once set up, government regulatory bodies can become captured by the very industries that they are meant to be protecting the public from. Government agencies, of which the United States Alcohol, Tobacco and Firearms Bureau is one example, can come to operate in favour of the industry rather than in the public interest (Mosher & Wallack, 1981). President Reagan managed to effectively neutralise the work of the Consumer Product Safety Commission in the United States by his selection of industry-sympathetic appointees (Christoffel & Christoffel, 1989). Equally, governments can reverse hard won policies which are supportive of

health. In the early 1990's, New Zealand's National Government removed the ban on direct brand alcohol advertising on television.

In summary, the Ottawa Charter guideline for healthy public policy for health promotion recognises:

- that all policies, regardless of their sector source, can have health implications and need to be examined at all stages of the policy production process to ensure harmful health effects are minimised;
- that health will be promoted by putting in place policies which support health at all levels and in all sectors in society;
- that establishing such policies is a complex process with many potential stakeholders involved; and
- that there will be a tendency for such policies, when politically sensitive, to be undermined by powerful political interests.

Creating Supportive Environments

The Charter describes the process of creating supportive environments as follows:

> Our societies are complex and inter-related. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources

> throughout the world should be emphasised as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organises work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanisation - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy (World Health Organization, 1986a).

As is clear from this quotation, the notion of supportive environments covers a vast territory, from the physical through to the social environment. For the health promotion movement, the major importance of the supportive environments concept is that it encourages the development of holistic and systemic health promotion strategies. Encouraging such strategies is important in the light of the ideological tension between individualism and systemic perspectives highlighted in the last chapter.

In some cultures, such as the United States, the individualistic approach has assumed the status of a paradigm for health promotion (Sloan, 1987; Terris, 1990).This is particularly so for those issues in which powerful commercial groups

have an interest. Such non-environmental perspectives are termed *victim blaming* in the social science literature (Ryan, 1971). This type of thinking has been criticised in health promotion (McLeroy, Gottlieb and Burdine, 1987) and been noted as a general feature of health education (Naidoo, 1986). Victim blaming has also been identified in regard to specific health promotion topics such as drinking and driving (Jernigan & Mosher, 1987), stress management programmes (McLeroy, Green, Mullen and Foshee, 1984), and programmes focusing on the elderly (Minkler, 1984). Langley (1994), in a similar fashion, criticised the "undue focus on the individual" in the area of childhood injury control and points to all of the wider systemic factors which put children at risk. The World Health Organization (1986b) has explicitly noted the inappropriateness of using such non-environmental approaches:

> Health promotion *programmes may be inappropriately directed at individuals at the expense of tackling economic and social problems.* Experience has shown that individuals are often considered by policy makers to be exclusively responsible for their own health. It is often implied that people have the power to completely shape their own lives and those of their families to free themselves from the avoidable burden of disease. Thus, when they are ill, they are blamed for this and discriminated against [emphasis in original] (p. 75).

In line with the World Health Organization perspective on the power of the environment to either support or undermine health, environmental issues are now being recognised as central to health promotion efforts. As Charles and Kerr (1986)

point out, it is the choices available in our environment which are the major drivers of our behaviour:

> If we have a limited amount of money to spend on food, no transport to get to an enlightened supermarket and two or three toddlers to drag around the shops with us, we will continue to buy the foods that are easy to get and bad for us, but in addition to all our other problems we will feel guilty. Clearly, it is not enough simply to persuade individuals that a certain foodstuff is not good for them. If they do not have the power to act on this knowledge, then all that will be achieved is the creation of an enormous burden of guilt and frustration... (p. 57).

From an economic perspective, it is environmental incentives which drive behaviour (Birch & Stoddart, 1989):

> ...we should avoid blaming individuals for behaving in ways which represent rational responses to current incentives as generated by current social forces. The causes of the socially undesirable outcomes, whether it be over utilisation of services or the excessive consumption of tobacco, are the incentives inherent in the system, not the individuals who respond to these incentives (p. 29).

Even where there is a desire to move away from such victim blaming, political climates which contain a strong ideological push for individually-orientated levels of analysis are more likely to support and act upon research that starts from an individualistic rather than a social perspective (Bechhofer, 1989). Chalmers (1980) has gone so far as to compare the individually-orientated approach, as an

impediment to modern scientific inquiry in the human and social sciences, to the mistaken Aristotelian views of the world which led to the persecution of Galileo.

Equally, when attempts are made in health promotion to move away from an individual perspective to approaches which take the environment somewhat more seriously they do not always go far enough. When analysed closely some of these attempts have been shown to be based on a very limited vision of what an environmental and fully contextual approach would entail. To take one example, the models of peer pressure as a factor in adolescent drug use. McLeroy, Bibeau, Steckler and Glanz (1988) argue that even such an apparently socially oriented model still fails to capture the broad social origin of behaviour in networks of interaction which contribute to the peer pressure. Wider levels of analysis are necessary to examine even more environmentally orientated approaches such as changing social norms which are then translated into peer pressure.

One initial useful tool for moving away from individualism towards a more environmental perspective is to take a population perspective on health problems and health promotion. The importance of population perspectives has been a recurrent theme in the epidemiology literature. Rose and Day (1990), for example, call for a population approach rather than a high risk individual strategy in areas like cardiovascular disease because, though there may be little in it for the individual, it is more cost effective for society as a whole. They base their argument on the apparent connection between the population mean on a number of health risk factors and the mean of these variables for the high risk groups. Because of this connection, they argue, reduction of the population mean will also result in reduction of the mean of the groups which are most at risk.

The notion of supportive environments does not refer to just the social environment, but also includes a vision of an integrated social and physical environment that promotes health in all its aspects. In pursuit of this vision, heath promoters have been widening their brief to include areas, such as urban planning, which are important in determining the nature of both the social and physical environment. Morris (1987) calls for the development of cities with "clean air, clean water, peace, quiet, a strong sense of community, and a sense of well-being" and argues that these can be "obtained most effectively and cheaply through a strategy of local self-reliance" (p. 173). This vision is encompassed in the notion of a globe of villages rather than a global village.

Labonte (1991a, 1991b, 1993) with his vision of *econology* and the *holosphere of health* sees an integration of health and sustainable development as central to public health:

> Health promotion and sustainable development policies intersect in many areas. A low meat, low cholesterol, high fibre diet, now recommended as a means of preventing cardiovascular disease and, perhaps, cancer, requires far less land per capita than do current diets in western industrialized countries. Health concerns are also driving increases in more sustainable, organic forms of agriculture that use fewer toxic petrochemical inputs. Decreasing urban car use and fossil fuel consumption by making bicycle commuting easier also promotes personal fitness. Using high density decentralized cores in new town planning and urban redevelopment enhances opportunities for social interaction, allows for more proximate food production, decreased per

> capita energy use and allows for easier access to natural settings (p. 153).

Ideas such as these forge the link between health and environmental concerns. In doing so they raise the exciting possibility for a shared agenda for social change between health promotion and environmental groups.

Lastly, it should be noted, that the notion of supportive environments used in the Ottawa Charter is very broad. Because of this it can be seen as being on a different logical level to the other strands of the Charter. This becomes particularly obvious when one tries to use the Charter to categorise different health promotion activities. For instance, Langford (1990) applying the Charter to the mission statement of a community based health promotion organisation, saw the creation of supportive environments (both social and physical) as the goal of the other four Ottawa Charter strands. Similarly, the Canadian Public Health Association's recent action statement on health promotion identifies three priority areas for action - the advocacy of healthy public policies, the strengthening of communities, and the reform of health systems - but includes within each of these areas the goal of developing physically and socially supportive environments (Canadian Public Health Association, 1996). This makes creating supportive environments something of an overall objective for the other Ottawa Charter guidelines. In summary, the health promotion notion of supportive environments:

- lies at the heart of the modern health promotion movement;
- resists the tendency in capitalist societies to support individually-orientated health promotion strategies;

- encourages health promoters to continually expand their thinking to the wider systemic, environmental and ecological strategies supportive of health; and
- encourages health promoters to forge alliances with other systems-focused groups, particularly the environmental movement.

Strengthening Community Action

Another idea which has come to occupy a central place in the modern health promotion movement is that of community action. From early discussions of the relationship of community development to public health (Morgan & Tyler, 1971), community strategies have been increasingly advocated and used in a variety of health promotion programmes (McAlister & Tuomilento, 1982; Nutbeam & Catford, 1987; Schelp, 1987; Winder, 1985). Community programmes can include grass-roots approaches (Anstis, 1990); bringing together the organisations involved in health promotion in a geographic area (DeFrank & Levenson, 1987); the use of organisers working in the community (Casswell & Stewart, 1989; Mellor, 1987); and large scale media-based programmes (Green & McAlister, 1984).

The initial health promotion forays into community strategies were used in projects such as the North Karelia Project in Finland. In this project "natural community leaders" were trained to detect cardiovascular risk factors in their communities and to advise community members of the desirability of lowering those risk factors (Neittaanmaki, Koskela, Puska & McAlister, 1980). However in the time since such projects as North Karelia, the notion of community action has considerably broadened. This is reflected in the Ottawa Charter's statement on community action:

> Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowering of communities, with the ownership and control of their own endeavors and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support (World Health Organization, 1986a).

The health promotion interest in community is not at all unique. Community interventions have a long history in a variety of different social problem solving areas (Dixon, 1989). A "community" approach is now offered as a panacea for almost every conceivable social problem, unfortunately, usually with no reference to earlier experience with the method in related settings where its use has already been explored. In spite of (or perhaps consistent with) its popularity, community, as a concept, continues to remain tantalisingly vague. One review of the community studies literature identified 90 usages of the word (or term) community, with the only thing they had in common being that they all had something to do with "people" Rose, 1990). "Community" has proliferated into applications ranging from community book shops, community planning, and community broadcasting to

community enterprise. However, according to Willmott (1984) this has not clarified its meaning:

> On the contrary, it seems to be used more loosely than it was, sometimes by politicians or administrators who wish to promote a particular policy or to avoid giving offence, sometimes by local enthusiasts who want to add weight to their campaign or action project. It is applied at a variety of levels from the national to the most local, and in a variety of senses (p. 4).

Any discussion of community approaches to health promotion almost inevitably leads on to the more fundamental question of "what exactly is community?" As the literature shows, attempting to answer such a question is difficult (Lehmann, 1975), or even impossible (Panzetta, 1971). In spite of these difficulties, McLeroy, Bibeau, Steckler and Glanz (1988) offer a framework for viewing community and identify three meanings of community which help to tease out the various meanings of the term *community* used in health promotion:

1. mediating structures (face-to-face primary groups to which individuals belong), e.g., families, personal friendship networks, and neighbourhoods;
2. relationships among organisations and groups within a defined area (local voluntary agencies, local governmental health providers, local schools); and
3. geographic and political relationships, characterised by one or more power structures (city, region).

Looking specifically at community interventions rather than the idea of community, there have been various attempts to develop typologies of community interventions. Rothman's (1979) model, which has been used in health promotion (Wakefield & Wilson, 1986), divides community organisation practice into three approaches: *locality development*, *social planning* and *social action*. This has been further modified by Hall and Shirley (1982) to include a fourth approach, *critical practice* which is directed at transforming the social structure. Hanmer and Rose (1980), in discussing the feminist contribution to community theory propose a distinction between community development, which stresses standing outside of a community, and community action, which involves identification of the community worker with the area in which they are working.

Labonte (1989) has compared major styles of community development such as Alinsky's (1971) approach with that of Freire's (1968). Alinsky defined community largely in geographic terms and focused on single issues, while Freire saw community in terms of an "affinity of interest" and encouraged coalitions and working on a broad range of issues to develop the community's skills and powers of critical analysis (Labonte, 1989). As a consequence of this capacity building, Freire's approach has been seen as less paternalistic than Alinsky's (Minkler & Cox, 1980).

Finally, Rose (1990) also highlights three differing community approaches: *consensual* (consensus between the stakeholders), *conflictual* (utilising conflict between different stakeholders) and *alternative* (opting out of either having to forge a consensus or enter into conflict by setting up alternatives to current institutions and systems). An example of the consensual approach might be the mobilisation of

patients and volunteers around goals set by health professionals, as in many health campaigns such as the North Karelia project. An example of the conflictual approach would be an activist struggle over housing and homelessness. An alternative approach involves setting up alternative services to those which are currently being offered, for example, a Maori-run health programme. Rose argues further that no single one of these methods should be allowed to dominate the definition of community action at one time, and that they should be allowed to "jostle, co-operate and argue with each other" (p. 218).

In summary, community action for health promotion:

- is consistent with the "vogue" status of the concept of community and community programmes in modern social policy discourse;
- is based on the belief that giving communities more control over their own destinies is health promoting in itself;
- encompasses all types of community - personal networks, group relationships, geographical and political; and
- builds on a community development approaches and strategies used on other social issues and adopts a range of:
  - *styles* (from consensus through to conflictual);
  - *methods* (locality development, social planning, or critical analysis and activist social action; and
  - *levels of involvement* by community workers (working outside, alongside, or within a community).

Developing Personal Skills

Developing personal skills is another important strategy for health promotion. It is described in the Ottawa Charter as follows:

> Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injury is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves (World Health Organization, 1986a).

Skills development in this sense has been the primary focus of traditional health education. Health education has its own specialist literature (Dignan, 1986; Draper, Griffiths, Dennis & Popay, 1980; Sutherland, 1979). With the advent of health promotion, health education has concurrently attempted to expand its focus (Green & Lewis, 1986). Skills development is now generally seen as best used as just one element in an integrated approach within a health promotion programme (World Health Organization, 1986a).

Because of its emphasis on individuals developing personal skills the personal skills strand of the Ottawa Charter is usually the one which it is easiest to get

political support for when operating in a New Right individualistic ideological environment. In this sort of climate, health promoters have to be able to resist inappropriate pressure to use the personal skills approach in order to avoid it consuming large quantities of health promotion resources which could be used more effectively through more systemically orientated strategies.

Developing personal skills in health promotion therefore:

- encompasses much of what has historically come under the term health education;
- is now seen as having to be incorporated within a framework of other, more systemically focused, strategies; and
- tends to be disproportionately encouraged over more systemic strategies due to its political acceptability.

Reorienting Health Services

The fifth Ottawa Charter guideline describes the goal of reorienting health services for health promotion as follows:

> The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components (World Health Organization, 1986a).

The way in which health services are structured has an important impact on the extent to which they promote health. For example, in New Zealand the most recent public sector bodies charged with delivering health care have been the Crown Health Enterprises (CHEs) (in existence from 1993 up until the current time). Because of the way the health system was structured during this time, there was a tendency for the CHEs to marginalise public health and health promotion as a low priority. The reasons for this were that public health activity had relatively low revenue potential for the profit-focused CHEs (2-3%), and it was relatively high risk in terms of both unpredictable public health crises, and as a result of potential negative public relations around statutory enforcement (Durham, 1993). In fact, the New Zealand National Party health reforms (1993-97) which set up the CHEs, did not stipulate the delivery of public health and health promotion as a CHE core task. Rather, responsibility for "education, prevention, and public health research" was vested in the Public Health Commission (Blank, 1994). The Public Health Commission was intended to be autonomous and active in promoting a reordering of health priorities (Blank, 1994).

However, the Public Health Commission had little time in which to prove whether it would, from its centralised location, have an impact in terms of reorientating the health system. Reflecting an anti-health promotion political agenda, a National Party Cabinet Minister, Murray McCully, soon called for the abolition of the Public Health Commission on the basis that "providing hospital care for constituents who need it should have priority over such irresponsible projects as research into the damage done by eating meat or dairy products". He also went on

to describe the Public Health Commission as "a bunch of cretins" and "pointy-headed wasters" (Waikato Times, 1994). The Public Health Commission as an independent body was in due course abolished and its functions moved across to the Ministry of Health.

An alternative model to the aborted Public Health Commission approach had been used in the period immediately preceding the National Government's health reforms. This model had been set up under the Labour Government's Minister of Health, Helen Clark. The model had attempted a closer integration between health promotion and health care service delivery. The attempt was made to create incentives for health organisations to reorientate their activities towards health promotion and disease prevention. The contracting arrangements set up between the then Area Health Boards (the health service delivery organisations) and the Labour Government in the late 1980's required that Area Health Boards work towards contracted targets based on a set of New Zealand Health Goals (Minister of Health, 1989). This approach in New Zealand, dismantled by the incoming National Government, was described by one international health promotion commentator as a "particularly innovative approach" towards reorienting health services which "very clearly legitimizes a leadership role for the health services in promoting and protecting health" (Nutbeam, 1991).

The New Zealand health system's changes firstly illustrate how organisational and contractual health service structures can impact on health promotion. Secondly, they highlight the political difficulties faced when trying to reorient health services towards health promotion. In addition to these structural and contractual arrangements which facilitate or hinder a reorientated health service, there are other

possibilities for changing health service behaviour. Other strategies for reorienting the health system include pushing for pro-health promotion community input into local health decision making, ensuring that health professionals are educated about health promotion perspectives, and encouraging multidisciplinary collaboration and alliance building to support health promotion (Canadian Public Health Association, 1996).

In summary, reorientating the health system:

- is a continuing part of health promotion;
- requires structural arrangements to force alignment of health care service goals with health promotion objectives; and
- is likely to run into political opposition particularly at a time of stretched resources for personal health care delivery.

Health Promotion Processes

In addition to the strands of the Ottawa Charter already discussed, the Charter also describes three more aspects of health promotion work - these are to *enable*, to *mediate*, and to *advocate* (World Health Organization, 1986a) Together with the concept of *empowerment*, these point to underlying processes which underpin all health promotion work no matter which strand of the Charter is being used. The section of the Ottawa Charter on enabling talks about equity as a way of enabling all people to "achieve their fullest health potential". Green and Raeburn (1988) pick up on the importance of enabling when they describe it as a key "integrative concept" for health promotion. The section on mediating discusses the importance of co-ordinated action by "governments, by health and other social and economic sectors,

by non-governmental and voluntary organisations, by local authorities, by industry and by media" and the importance of adapting health promotion strategies to the local needs of differing social, cultural and economic systems. The section on advocacy highlights the importance of advocating for changes in the "political, economic, social, cultural, environmental, behavioural and biological factors" which determine health. Advocacy in the social policy arena has drawn considerable attention from health promotors (Chapman & Lupton, 1994; Wallack & Dorfman, 1996) and in related domains such as psychology (Suedfeld & Tetlock, 1992).

In addition to the three elements identified above in the Charter, health promotion discourse uses the term *empowerment* to describe a primary generic process underlying all health promotion activity. This stems from the finding that "powerlessness, or lack of control over destiny, emerges as a broad-based risk factor for disease" and that empowerment is an "important promoter of health" (Wallerstein, 1992, p. 197). Walllerstein (1992) defines empowerment as:

> A social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice (p. 197).

Labonte (1990) has adapted from Kindervatter (1979) a set of criteria for empowerment which spell out the implications of becoming empowered:

- improved status, self-esteem and cultural identity;
- the ability to reflect critically and solve problems;
- the ability to make choices;

- increased access to resources;
- increased collective bargaining power;
- the legitimation of people's demands by officials; and
- self-discipline and the ability to work with others (p. 66).

Labonte(1990) then expands the usage of the term empowerment to set out an "empowerment" continuum which runs as follows: personal empowerment, small group development, community organisation, coalition advocacy, and political action. In doing this he is seeking to broaden the term out so that empowerment is not just seen as something which happens at an individual level.

Health promotion's use of the term empowerment has, however, not gone unchallenged. Grace (1991) in particular has analysed the contradictions and inconsistencies surrounding the notion of empowerment in health promotion discourse. She concludes that:

> The institution of "health promotion" produces an ideology of empowerment that, it can be argued, effectively masks its collusion with the contemporary form of political economy, consumer capitalism. This critique provides an understanding of the process whereby demands made by the health movements for "empowerment" are recaptured and transformed within the health promotion discourse and contribute to the construction of the individual as a "health consumer" (p. 341).

Grace applies her critique of the way empowerment is used to both individually orientated "behaviour-change" and more systemic "social model" approaches to health promotion. The main issue she raises is that in spite of talk of empowerment there is still a sub-text of health promoters having an "a priori agenda". She also regards as problematic the belief among health promoters that "there is a world outside the individual that can be controlled by policy and shaped to create an environment to which people respond with a successful outcome: health" (1991, p. 333).

In the author's view there is no reason why health promoters should be embarrassed about wanting to use policy to shape behaviour, nor about having something of an "a priori agenda" which is based on expert knowledge about the determinants of health and some ideas as to potential solutions to health problems. If health promoters did not have any views on these, then communities would have every reason to ask what it is that health promoters have been doing while they have been studying and researching the determinants of health and possibilities for health promotion action. Widespread and loose use of the term empowerment within health promotion may have contributed to some of the conceptual problems in this area.

Another way for health promoters to look at the *process* of health promotion is to see it in terms of *dialogue*. When working with a community, health promoters should enter into a dialogue with that community. Health promoters bring their resources, knowledge, skills and experiences and respectfully engage with members of the community who in their turn bring their own resources, knowledge, skills and experiences. Labonte (1991) terms this "actively deconstructing the

barriers" between the "them" of the community and the "us" of health promotion professionals (p. 66).

In summary:

- enabling, mediating, advocating and empowerment have been identified as basic processes underlying health promotion practice;
- empowerment is used in a very broad sense in health promotion from personal empowerment through to political action by groups and communities;
- lack of power can be seen as a risk factor for disease and empowerment a promoter of health;
- it is hard to precisely define empowerment due to its breadth, however, at its core is the attempt to ensure that those without power in some sense (either individuals or communities) move to a state of increased control over their own destinies.
- health promotion's use of the term empowerment has been criticised as disguising the fact that health promoters still work to agendas and seek control over what they regard as unhealthy behaviour; and
- thinking in terms of health promoters entering into a respectful dialogue with communities may be another fruitful way of looking at the process underlying health promotion practice.

Summary of the Characteristics of Health Promotion

This chapter has reviewed the current general characteristics of health promotion: its multidisciplinary nature, its social change orientation, and its dependence on its cultural context. The five Ottawa Charter strands have been discussed along with the three process orientated terms - advocate, enable and mediate - plus the popular concept of empowerment.

CHAPTER FIVE

EVALUATION: KEY THEMES

Evaluation practice draws on a wide range of academic disciplines and is undertaken by practitioners from a wide range of backgrounds. This section examines the modern evaluation literature and identifies key themes of relevance to health promotion which will provide a foundation for the Strategic Evaluation Framework.

Evaluation: Cultural and Political Embeddedness

Approaches to evaluation are always embedded in a particular cultural and political context and as such it cannot simply be viewed as a technical exercise separate from that context (Conner, 1988). In New Zealand, Pakeha approaces to evaluation methodology have tended to track North American approaches, with heavy reliance on the work of authors such as Campbell and Stanley (1966) on quasi-experimental design, Lincoln and Guba (1985) on naturalistic inquiry, and Patton (1990) on qualitative approaches to evaluation (see Thomas, 1983).

Because cultural context has so much influence on evaluation approach, the evaluation task becomes particularly difficult when evaluators from one culture are attempting to evaluate programmes directed at, or located in, another culture. This is particularly obvious in a situation such as multi-national evaluation research on international development where evaluators from one culture are involved in evaluating programmes in other cultures (Ginsberg, 1988). However, we also see this difficulty within individual countries such as New Zealand, where similar issues

arise when Pakeha evaluators attempt to evaluate programmes directed at, or run by, Maori.

In the New Zealand context, there is a growing move to respond to these problems by Maori developing research and evaluation methodologies which can be used by Maori for evaluating Maori programmes. A recent hui on strategic directions for Maori health research working from the basis of the Treaty of Waitangi declared the following:

- endorsement of indigenous people's rights over their cultural and intellectual property;
- determination and coordination of Maori research by Maori, working with Maori, for Maori;
- Maori determination of their standards of health and wellbeing;
- Maori control over policies, priorities and funding decisions relevant to Maori research;
- right to use any approach to health research which will benefit Maori;
- promotion and development of Kaupapa Maori methodology and methods;
- commitment to promoting te reo Maori (language) and tikanga Maori (custom) as appropriate for Maori health research;
- need for research to encompass past, present and future;
- recognition of diverse Maori realities;
- accountability to whanau (extended family), hapu (subtribe) and iwi (tribe);

- monitoring, critiquing, discussing in hui and public forums all research impacting on Maori health; and
- commitment to strengthening the community of Maori health researchers and urging supporting organisations to urgently develop the research workforce (Hui Whakapiripiri, 1996).

In regard to health promotion evaluation research specifically, Maori researchers are moving to develop their own Kaupapa Maori approaches (Barnes & Stanley, 1996), and some are intensively involved as evaluators (Moewaka Barnes et al. 1996; Stanley & Casswell, 1995, 1996). Watene-Heydon, Keefe-Ormsby, Reid and Robson (1995) outline issues to be considered in evaluation from a Maori perspective:

- the purpose of the evaluation - testing the effectiveness of a health-orientated programme and as defined by the Maori community and asking why the evaluation is necessary;
- who the evaluation is for - recognising iwi Maori/tangata whenua and acknowledging their status within the community; also recognising needs of funders and key stakeholders (internal and external) closely associated with the work of the community;
- accountability processes - accountability of the evaluators as negotiated in the Maori community and to funders of the evaluation project; and
- level of community involvement - acknowledging and facilitating the role of the Maori community within the evaluation process and ensuring ongoing involvement (p. 494).

One particularly important aspect of evaluation in contexts where different ethnic groups are struggling with issues of power and sovereignty, is the possibility of the use of evaluation in attempts by Pakeha to regain control of resources. For example, evaluation should not be used to impose a set of Pakeha criteria on Maori health promotion programs in an attempt to regain control over the way in which the resources are being used. If there is a genuine intention to pass control over to Maori, the evaluation criteria need to be negotiated at the same time as the resources are handed over.

While evaluation must always be seen in its cultural context, it is also strongly influenced by the political context in which it is operating. Weiss (1975) identifies the following three political factors in evaluation and warns that "the evaluator who fails to recognize their presence is in for a series of shocks and frustrations" (p. 13). These three factors are:

- policies and programmes to be evaluated are the creatures of political processes in both design and implementation;
- evaluation is undertaken *in order to* feed into political decision-making and therefore has to compete against other equally important factors which influence political decision making; and
- evaluation itself has a political stance, making implicit political statements about the problematic nature of some programs and the unassailability of others, the legitimacy of program goals and strategies and the role of the evaluation researcher in the political and policy process (p. 13-14).

Each of these political factors can be seen to be at play in the case of health promotion evaluation. For instance, the direction taken in alcohol health promotion

programmes is a result of the interplay between health, government and industry stakeholders. The conclusions from evaluation reports on health promotion programmes are always weighed against competing imperatives and priorities in health and other social policy areas. Finally carrying out health promotion evaluations often embroils evaluators in controversy.

To summarise, this section argues that evaluation cannot be divorced from its context:

- evaluation is always embedded in a particular cultural context which influences its role, the evaluation criteria and methods used; Maori are moving to develop research and evaluation methodologies for Maori programmes; and
- evaluation is always embedded in a particular political context which influences the type of programmes available for evaluation, the way results are interpreted and the politics of the evaluation itself.

Evaluation: Across Programme Life Cycle

Evaluation approaches have traditionally emphasised measuring programme outcomes (see Campbell and Stanley's (1966) classic text on quasi-experimental designs in programme evaluation). In contrast, the modern evaluation literature sees evaluation input as crucial throughout a programme's life cycle. This change has partially stemmed from examination of the usefulness of various types of evaluation. Patton (1986a), with his concept of *utilization-focused* evaluation, draws attention to the fact that evaluation which takes place during the course of a programme, rather than at the end, is extremely valuable, particularly for those who are running the programme. Rossi and Freeman (1989) and Johnson (1986) also point out that

comprehensive evaluation should run right across a programme's life cycle. Such comprehensive evaluation should include investigation of the conceptualisation and design of interventions, monitoring of programme implementation, and assessment of programme effectiveness and efficiency. In regard to early evaluation input, Fitzpatrick (1988) describes an evaluator's early involvement in programme development:

> Unlike many evaluations, the author was able to be involved in the early stages of program planning and development primarily due to her involvement in the proposal phase. This involvement provided important opportunities for the author to learn of the theoretical foundations or model for the program and to observe the relatively drastic metamorphosis of the program from conception to implementation. However, the author did not play the role of a neutral, detached observer during this stage. Instead, she assumed many, varied roles to assist and advise in the development of a new delivery model for training school administrations in performance appraisal. She became involved in developing the model for the program, identifying and developing objectives, and defining the target population. The time the author spent with program developers at this stage was extensive, but focused little on data and more on identifying the most appropriate strategies for achieving program goals (p. 450).

Such early evaluation input acknowledges the considerable modification that programs will go through, particularly in their early stages, and the constructive role

that evaluation teams can have in influencing programme direction in a desirable direction by giving feedback and information on programme development (Means & Smith, 1988).

In addition to evaluation activities directed at programme development, there has been a call in the literature for evaluation to track programmes' progress in order to help interpret programme outcomes. Flay (1987), for instance, laments the lack of process studies of mass media health promotion programmes to assist in understanding the success or failure of these programs. In regard to school-based programmes, McKinlay, Stone and Zucker (1989) highlight process evaluation as a part of good evaluation design. Indeed Graham and Birchmore-Timney (1989) consider that the absence of process studies is simply "bad science". Wallack (1981) notes the futility of simple outcome studies on health promotion media campaigns which yield no information except that the programme was not successful. Further, he has called for alternative evaluation methods based on a wider range of methods than the experimental-type evaluations which have characterised much health promotion evaluation.

As noted by Wallack, the neglect of early stage evaluation within programmes has been encouraged by the way in which universities have traditionally taught evaluation. Universities world wide have tended to focus on teaching complex outcome evaluation research methodologies which are not only difficult to apply to real world programmes on the scale normally encountered by practitioners, but are also not focused on providing the information stakeholders required.

This tendency has been noted in other applied social science areas (Burck & Peterson, 1975). Over the last decade or so there has been a very significant

movement towards more process orientated evaluation studies in health promotion and other areas (Blake et al., 1987; Dehar, Duignan & Casswell, 1993; Norman et al., 1990; McGraw et al. 1989; Stewart, Casswell & Thompson, 1997; Wendt, 1986). In spite of this, there continues to be ongoing pressure for outcome only studies as funding administrators with little knowledge of modern evaluation approaches call for accountability from providers in areas such as health promotion and pressures for financial accountability mount. It is also likely that the drive towards more evidence-based medicine (Ziglio, 1997) is will to re-kindle the emphasis on outcome evaluation as the only credible type of evaluation for health promotion

In summary, this section suggests:

- evaluation efforts should take place right across a programme's life cycle - to help form a programme, to describe the programme's process and activities and to assess its outcome; and
- the case for spreading evaluation resources across the programme life cycle has to be continually restated in the face of the emphasis on only outcome findings from some funders and administrators.

Evaluation: User Needs Driven

In the past, evaluation has often been undertaken without careful consideration of who the range of potential users of a particular piece of evaluation might be. The assumption has often been made that users are either high level programme funders (in the case of more practical evaluation research) or the social science community (in the case of evaluations which are more orientated towards

social science theory). In many cases evaluations have simply consisted of a ritualised series of steps undertaken by an evaluator, whether they suit the needs of the user or not, because that is the way things have been done in the past. This has been characterised as a "utilization crisis" and Patton (1986a) describes it as follows:

> In the past many researchers took the position that their responsibility was merely to design studies, collect data, publish findings; what decision makers did with those findings was not their problem. This stance removed from the evaluator any responsibility for fostering use and placed all the blame for nonuse or underutilization on decision makers...Technical quality and methodological rigor were the primary concerns of researchers. Use was not an issue (p. 24).

In contrast, modern evaluation thinking regards user needs as the key to good evaluation design. In this view potential users are seen as one of the stakeholders who may have an interest in a programme. Included within this group of stakeholders are those who are running and planning a programme. Patton's (1986a) classic book on utilisation-focused evaluation sets this type of approach to evaluation based on user needs. Morris, Fitz-Gibbon and Freeman (1987) note that the credibility of an evaluation rests on whether or not it has considered users and stresses that without potential or actual users in mind an evaluation should not be carried out. Empirical studies of evaluation utilisation point to the importance of attending to user's needs and of involving users (for instance clients, programme staff, funders) in evaluations in suitable ways (Cousins & Leithwood, 1986). Shadish

(1987) identifies the definition of how evaluation will be put to use as central to any theory of what types of evaluation can be justified;

> ...the decision to evaluate is sometimes justified with simple claims that society requires knowledge about the effectiveness of its programs, or that society must have a means of holding programs accountable. Such statements may be true, but they are not sufficiently developed to justify the practice of evaluation. For example, claims about the need to search for effective programs - if these claims are to be anything more than window dressing-presume some theory of why and how such information might be useful. Such a theory must discuss why and to whom such information might be of interest, the place of such information in improving the functioning of social policy, and the kinds of information that are most likely to result in such improvements (p. 523-524).

Of course, evaluation users include not just those outside programmes, such as funders, but those running and planning a programme as well.

To conclude, the modern evaluation literature has stressed the importance of the user in planning evaluation programmes. Most importantly, it has noted that:

- evaluations should be designed around the needs of users; and
- users can include, programme clients, planners, staff, administrators, management, funders, social scientists, politicians, lobby and advocacy groups, the media and the interested public.

Qualitative and Quantitative

Evaluation in its early stages of development tended to be limited to quantitative techniques because of the "positivist" experimental research basis to most outcome evaluation procedures. However, over the last two decade there has been an explosion of interest in qualitative evaluation techniques as the recognition has grown that much data important to evaluation will be lost if only quantitative methods are used (Guba & Lincoln,1981,1989; Lincoln & Guba, 1985; Patton 1990). The discussion of the choice of evaluation methods has become entangled with an ongoing discussion of the paradigmatic philosophy of science issues which have been associated in various ways with quantitative and qualitative techniques. The fact that the discussion has at times yielded more heat than light is reflected in the comment by Rossi and Freeman (1989) that "a sometimes pointless literature has developed around the controversy of qualitative versus quantitative evaluation methods" (p. 449).

The traditional quantitative approach to evaluation has come up against the problem in the public health area, as in many other areas of social concern, that many real world programmes do not correspond to the types of situations in which classical quantitative evaluation procedures are best suited. This realisation is not new. Bice, Eichhorn and Klein (1975), discussing evaluation of a particular type of community health initiative in the United States (community health decision organisations), comment as follows:

> We contend that this class of interventions [community health decision organizations], as typically structured, confronts the evaluator with rather unique and relatively complex problems that render classical

> evaluation methods unfeasible, if not irrelevant. In such circumstances, evaluators will necessarily find themselves drawing more upon the art rather than the science of evaluation, where breadth of concern and insight rather than experimental design will be the basis of proof (p. 606).

As a consequence of dealing with real world evaluations such as these, the notion that the traditional quantitative approach is all there is to evaluation has been consistently attacked in the evaluation literature (Guba & Lincoln, 1981, 1989; Lincoln & Guba, 1985), in related areas such as policy studies (Kelly, 1987), psychology (Mahoney, 1981; Rappoport, 1986), sociology (Glaser & Strauss, 1967), and in the social sciences in general (Alexander, 1987).

The general response from those disillusioned with the traditional quantitative evaluation approaches has been to explore qualitative methods and approaches. This has led to the current situation in evaluation where the debate between qualitative and quantitative methodologies is almost over. As Patton (1990) comments:

> In the early literature on evaluation methods the debate between qualitative and quantitative methodologists was often strident. In recent years the debate has softened. A consensus has gradually emerged that the important challenge is to appropriately match methods to evaluation questions and issues, and not to universally advocate any single methodological approach for all evaluation situations (1990: 492).

At the level of the practice of evaluation the result has been a general consensus that methods of evaluation should be chosen on the basis of how appropriate they are to the evaluation being undertaken rather than on whether they use qualitative or quantitative methods (Conner, Altman & Jackson, 1984; Reichardt and Cook (1979). The latter put it like this:

> But the lesson that quantitative methods can be overused has already been learned, and it is now time to stop the pendulum from swinging from one extreme to the other. It is time to stop building walls between the methods and start building bridges. Perhaps it is even time to go beyond the dialectic language of qualitative and quantitative methods. The real challenge is to fit the research methods to the evaluation problem without parochialism. This may well call for a combination of qualitative and quantitative methods. To distinguish between the two by using separate labels may serve only to polarize them unnecessarily. Leaving the labels behind, we would have no choice but to go beyond the debate of qualitative versus quantitative methods (1979: p. 27).

Why, when this was written almost two decades ago, is the issue of qualitative and quantitative research methods still a hot topic for health promotion? There are three reasons; firstly because the disciplinary proximity of medicine has imported quantitative experimental outcome studies modeled on clinical trials as the "gold standard" for evaluation. This link continues to be reflected in recent trends such as

the growth of the evidence based medicine movement, which is reviving the focus on quantitative outcome studies (Ziglio, 1997); secondly epidemiology has also influenced health promotion evaluation by bringing in its own intensive use of quantitative analysis; thirdly, in some areas of health promotion which involve conflict with politically powerful stakeholders, quantitative methodologies are less likely to be attacked on methodological grounds.

The lessons of this section for health promotion evaluation are that, while both quantitative and qualitative methodologies can be used as appropriate to the evaluation being conducted, health promotion evaluators are likely to have to continue defending the use of qualitative techniques against continuing pressure to use quantitative methods.

Evaluation Influence on Policy

Initially, the usefulness of evaluations in policy development was assessed in terms of their immediate impact on decisions about programme continuation. However in due course disillusionment set in as evaluators realised that political decision-making was more resistant to evaluations than they had thought. In particular, the fate of the United States social programmes which were subjected to large scale evaluations in the 1960's and 1970s brought this home.

> ...there appears to be little evidence that large-scale experiments (such as on the United States social programmes) can substantially enhance the probability that the tested policies will be implemented - almost regardless of actual experimental outcome. Instead, findings

> from such experiments tend either to be largely ignored or have an inhibiting effect on the policy making process (p. 24).

As a consequence, the initial simplistic view of the relationship between evaluation and policy making gave way to increasing awareness by evaluation researchers that the social and political context of evaluation determines how, and whether, information from evaluations is processed and used (Chronbach, et al. 1985; Weiss, 1970, 1975). The lack of response to evaluation findings was initially seen as a lack of rationality on the part of bureaucrats. However this notion has been well rebutted by Weiss (1975):

> Bureaucrats, or in our terms program administrators and operators, are not irrational; they have a different model of rationality in mind. They are concerned not just with today's progress in achieving program goals, but with building long-term support for the program. This may require attention to factors and to people who can be helpful in later events and future contests. Administrators also must build and maintain the organization, recruit staff with needed qualifications, train them to the appropriate functions, arrange effective inter- staff relations and communications, keep people happy and working enthusiastically, expand the influence and mission of the agency. There are budgetary interests, too, the need to maintain, increase, or maximize appropriations for agency functioning. Clients have to be attracted, a favourable public image developed, and a complex system managed and operated. Accomplishing the goals for which the

> program was set up is not unimportant, but it is not the only, the largest, or usually the most immediate of the concerns on the administrator's docket. (p. 15)

It is now commonplace within the mainstream evaluation literature to point out that research has only a limited place in the policy decision making process (Cook & Shadish, 1986; Weiss, 1975). Rather than looking for immediate implementation of evaluation results, a more sophisticated notion of *enlightenment* has been developed by Weiss (1977). Under this view, evaluation results are seen as filtering through to affect the general way in which social problems are conceptualised, rather than as having an immediate influence on decision making. This notion has now become generally accepted within the evaluation field (Gowler & Legge, 1984).

However, Gowler and Legge (1984) have speculated on why it should be that the concept of enlightenment was so rapidly embraced by the evaluation and policy making community. They point out that the enlightenment view has in a sense let policy makers off the hook. The concept allows the focus of the debate to remain on why evaluators have failed to get their evaluations implemented. Gowler & Legge ask an alternative question: why have policy makers failed to pay attention to evaluation results?

> The redefinition of utilisation [in terms of enlightenment], then, is highly functional for decision makers as well as evaluators, for it provides them with a rhetoric through which to claim that they do utilise evaluation studies, if in ways that are not expressed in immediate action. Because the redefinition of utilisation serves the interests of

> both decision makers and evaluators it is hardly surprising that the redefinition is speedily becoming the new orthodoxy. To echo Voltaire, if it did not exist, it would have to have been invented (p. 11).

Gowler and Legge's caution regarding the enlightenment view of evaluation dissemination is simply further evidence of the subtly of the issues which surround the use of evaluation results in the policy arena.

In summary this section argues that evaluation results:

- are only one input into the policy process; and
- contribute towards general enlightenment in the policy process as much as they impact directly on the survival or otherwise of the programmes being evaluated.

An Evaluation Typology: Formative, Process and Outcome

The evaluation literature uses many categories to divide up the elements of the evaluation task. Many terms such as formative, process, outcome, impact, utilization-focused, stakeholder and summative evaluation are used in varying ways by different authors (Patton, 1986b; Weiss, 1984).

For the purposes of this study an evaluation typology is needed which can accommodate the key points from the evaluation literature which have been examined here. This section looks at the three way distinction between formative, process and outcome evaluation, each of which roughly (although not exclusively) corresponds to a stage in the development of a project - the start, the course of the project and the end of the project, respectively. This particular set of terms for dividing up evaluation has been selected for use in the Health Promotion Strategic

Evaluation Framework because it has the advantage of explicitly legimising early evaluation input into programmes. These advantages are discussed in more detail later in this study. The purpose of the discussion in this section is to outline the ways in which these three terms are used in this study.

Formative evaluation

Formative evaluation is increasingly being used as a part of health promotion evaluation. Examples of this are: school health promotion and drug evaluation (Carruthers & James, 1993); cardiovascular disease prevention (Dehar, Duignan & Casswell, 1992); and alcohol health promotion (Stewart, Casswell & Duignan, 1993).

Formative evaluation seeks to make sure that programmes are well designed and implemented so as to increase the chances that they will achieve their goals. Programmes in their early stages face a number of difficult issues; some of the difficulties faced by emergent programmes are set out by Edwards (1987): undefined client populations, inadequate causal evidence relating programme inputs to outcomes, ambiguous or shifting program objectives, difficulties in standardising treatments, and temporal constraints on program development.

Formative evaluation is designed to provide constructively critical input into the decisions around these issues. McClintock's (1986) notion of formative evaluation highlights such input into programme decision making; he defines formative evaluation as:

> ...the systematic use of empirical procedures for appraisal and analysis of programs as a way of providing ongoing information to

> influence decision making and action on policy, resource allocation, and program operations (p. 205).

While McClintock only talks of *empirical* procedures, the formative evaluator's role does not need to be restricted to just empirical approaches. Formative evaluators can use both empirical data (e.g., a survey as part of needs assessment) and critical analysis (e.g., critiquing proposed programme objectives). As Windsor, Barbanowski, Clark and Cutter, (1984) put it, formative evaluation "produces information used during the developmental stages of a programme to improve it" (p.3). Formative evaluators work alongside programme planners providing independent and constructively critical input into their work. Because of this close working relationship, there are no hard and fast rules about what is programme planning and what is formative evaluation. Important areas where formative evaluators may be involved are*: reviewing previous research and experience* relevant to the programme; programme *infrastructure assessment*, *needs assessment*, *objective setting*, establishing and critiquing *programme logic*, *piloting,* and *process and outcome evaluation design* for the programme. Each is briefly discussed here.

Firstly, good programmes should build on previous research and experience. Formative evaluators will seek to ensure that the relevant research literature has been reviewed and taken into account in programme planning. Equally important is finding out about existing programmes which have not been written up. In a developing field such as health promotion, formative evaluators who have worked in

the health promotion area play a role of carrying with them information from the literature and from other programmes which can be fed into programme planning.

Secondly, programmes need the necessary infrastructure to carry out their work. Formative evaluators will be looking to see that good management structures been set up such as reporting and financial accounting, appropriately trained staff, quality assurance, and routine collection of data for programme implementation monitoring.

Thirdly, there is needs assessment. Siegel, Attkisson and Carson (1978) set out the basic methods of needs assessment. In a community programme context they describe possible needs assessment approaches as: social and health indicator analyses; demands for services; analysis of service providers and resources; citizen surveys; community forums; nominal group techniques; Delphi technique; and the community impressions approach (Rossi & Freeman, 1989). Formative evaluators, along with programme planners, can be involved in designing methods for, or actually, collecting information through any of these methods. The formative evaluators overriding objective is to ensure that adequate needs assessment had been carried out for the programme, whether or not it was done by the formative evaluators themselves.

Fourth, programmes need a systematic approach to objective setting. There are various ways of setting out objectives, the exact way in which objectives are determined is not as important as the fact that programme planners have gone through the discipline of setting objectives for the programme. Formative evaluators may assist with objective setting by providing frameworks for carrying it out (one is

described as part of the Health Promotion Strategic Evaluation Framework); by critiquing a proposed set of objectives; or by being involved in actually facilitating the sessions where programme planners set objectives for the programme. As with needs assessment, the formative evaluator will be seeking to ensure that the programme has undergone a clear objective setting process.

Fifth, there is the specification of programme logic. This consists of the development of a model of how it is believed the programme will work. This process is sometimes called program theory, program modeling, or causal mapping (McClintock, 1986). McClintock has emphasised the value of getting a critical appraisal of programme design in order to reduce uncertainty about likely programme performance and increase uncertainty about programme structure. That is, such appraisal by formative evaluators increases the chances of a programme's effectiveness through encouraging consideration of a variety of ways in which the programme could be undertaken. As noted by Edwards (1987), critical appraisal is improved by inviting external reviewers, not involved in the evaluation design, to examine the objectives of the programme. The way in which the programme logic is set out does not matter, what is important from a formative evaluation point of view is that there is independent critical input into programme planners assumptions and models about the way in which they believe their programme will work.

Sixth, there is the issue of piloting. Formative evaluators can be involved in various aspects of piloting, from emphasising the need for piloting, to assisting in designing pilots, to actually carrying out pilots for a programme. Such piloting can range from testing resource materials to fully blown pilot programme implementations. Again, the formative evaluator's overall goal will be to ensure that

the programme planners are undertaking adequate piloting whether or not the evaluators are involved in the actual piloting themselves.

Lastly, there is the question of process and outcome evaluation design. Formative evaluators can be involved in input into the design of process and outcome evaluation for the programme. Formative evaluators may or may not be involved in the actual process and outcome evaluation studies which are carried out on the programme.

Formative evaluation uses any research methods which can be of assistance in carrying out its task. Different qualitative and quantitative methods will be useful in finding out information for the tasks set out above. In addition, formative evaluation can include methods such as interviewing stakeholders both within and outside a programme in its early stages of development. This then provides feedback to programme planners on stakeholders' perspectives on how the programme is developing. These are the major tasks which formative evaluators are likely to be involved in. The scale of formative evaluation input into a programme can be as simple as an external reviewer critiquing a programme's proposed objectives through to a fully blown formative evaluation with a team of evaluators working on a programme over several years, as was the case with the author's Unit and the Heartbeat New Zealand programme discussed later. Formative evaluation relies on a close working relationship between programme planners and evaluators. Issues in this relationship are taken up later in this study in the discussion of a "lifecycle" for formative evaluation involvement in programmes.

In summary, for the purposes of the Health Promotion Strategic Evaluation Framework formative evaluation is defined as: *evaluating how a programme is being*

planned and implemented and providing constructively critical feedback for programme enhancement. Formative evaluation:

- provides an independent constructively critical perspective on programme planning and implementation;
- ensures that the following tasks have been carried out for a programme: reviewing previous research and experience relevant to the programme; programme infrastructure assessment, needs assessment, objective setting, establishing and critiquing programme logic, piloting, and process and outcome evaluation design; and
- may involve formative evaluators being involved to a greater or lesser extent in actually carrying out any of these tasks.

Process evaluation

Process evaluation is a term which has increasingly come into vogue in health promotion, with an increasing number of process evaluation studies reported in the literature. For example Blake, et al. (1987) provide what they believe is the first example of process evaluation data from a community-based physical activity programme. Norman, et al. (1990) provide a process evaluation of a two-year community cardiovascular risk reduction program. McGraw, et al. (1989) discuss the process evaluation system of the Pawtucket Heart Health Program. Wendt (1986) used process evaluation in an integrated cardiovascular disease prevention programme. The Alcohol and Public Health Research Unit has undertaken a number of process evaluation studies, (Dehar, Duignan & Caswell, 1993; Stewart, Casswell & Thompson, 1997).

Process evaluation tends to have a very wide definition in the evaluation literature. For instance, Owen (1993) sees it as covering studies of programme implementation, guidance for refinement of developing programmes and doing evaluation which is responsive to the needs of practitioners. Sometimes a very wide definition of process evaluation has made it seem as if it is somehow an approach which is opposed to outcome evaluation. Bice, Eichhorn and Klein (1975) point out that process evaluation should not be seen as an easy option when impact or outcome evaluation are too difficult.

For the purposes of the Health Promotion Strategic Evaluation Framework process evaluation is given a relatively specific definition and not set up in opposition to outcome evaluation. Owen's suggested functions of programme refinement and immediate responsiveness to the needs of practitioners are for the purposes of this study put under the heading of formative evaluation rather than process evaluation. The rationale for this is discussed in Chapter Seven. This leaves process evaluation as no more and no less than the study of the *process* of a programme. It will be defined for the purposes of the Health Promotion Strategic Evaluation framework as: *documenting and analysing what happened in the course and context of a programme*.

Process evaluation has two purposes, the first is to let others know what actually happened in a programme. For instance, say it is known from outcome evaluation that Programme X is effective as a health promotion programme, the immediate question which will be asked by other health promoters is "what exactly did Programme X consist of?" As Beurden, Lefebure and James, (1991) note in the absence of process evaluations, transfer of innovative health promotion

programmes "often flounder because published accounts of the strategies themselves usually include only a brief description of the programme itself" (p. 182). The second purpose of process evaluation is to aid in the interpretation of programme outcome evaluation findings. For instance, it may be that a programme failed to achieve its objectives. If the supportive context of the programme changed with a change in Government, the project manager was ill and away most of the time and other programme staff had major personality clashes, this information casts the outcome findings in a different light than the continuing presence of a supportive Government, an efficient and productive programme manager and programme staff functioning as a well oiled team.

Process evaluation usually looks within a programme at such things as the programme structure, what programme staff did, programme materials, and programme activities; it also can collect information on the views of those who participated in the programme. Sometimes it looks outside a programme, for instance undertaking key informant interviews with stakeholders to find out how they viewed a programme. It can go further and analyse the political context in which the programme was initiated, the influences brought to bear on the programme, and describe what was the programme's ultimate fate.

Process evaluation has sometimes been equated with the use of qualitative methods, but this does not have to be the case. Although these are particularly useful in process evaluation, it is by no means limited to one set of methods. As an example, in the process evaluation of the Pawtucket Heart Health Program, McGraw, McKinlay, McClements, Lasater, Assaf & Carleton (1989) used a number of quantitative methods such as quantitative telephone surveys.

Process evaluation can collect information on any of the following:

- programme origin and the chronological sequence of events in programme planning and implementation;
- programme structure, components and delivery system;
- participation rates and characteristics of the people involved;
- resources required for programme operation;
- perceptions of people taking part in the programme;
- the wider social and political context of the programme;
- perceptions of stakeholders about the programme; and
- levels of community awareness.

In summary then, process evaluation:

- for the purposes of the Health Promotion Strategic Evaluation Framework is defined as documenting and analysing what happened in the course and context of a programme; and
- is used to inform other health promoters about what happened in a programme so they can replicate it if they wish, and assists in interpreting a programme's outcome evaluation findings.

Outcome Evaluation

Outcome or impact evaluation, in the narrow experimental and quasi-experimental design sense, dominated the evaluation field for most of its early development; as can be seen from an early 1975 evaluation bibliography which almost exclusively refers to outcome evaluation methods (Milcarek &

Struening,1975). Large scale outcome evaluations of health promotion programmes have been undertaken. For instance Schelp (1987) reports an outcome evaluation of a community intervention programme in Sweden; Shea and Basch (1990) review outcomes of five major cardiovascular disease prevention programmes; Casswell and Gilmore (1989) report on the Community Action Programme; and Kronenfeld, Jackson, Blair, Davis, Gimarc, Salisbury, Maysey & McGee (1987) report on employee health promotion projects.

Over time the design of experimental and quasi-experimental evaluations has become increasingly sophisticated as lessons are learnt from the past. More sophisticated methods have been introduced and refined, including time series designs which track changes in variables at a number of points in time rather than just before and after programmes, and multiple baseline methodologies (Cook & Campbell, 1979; Green & Lewis, 1986; Windsor et al., 1984). The various problems which such experiments can encounter are now well documented (Dunford, 1990). As Dunford points out, there is no excuse for outcome evaluation designers not addressing these problems as part of initial evaluation design rather than attempting to deal with them retrospectively when they predictably enough threaten the validity of their findings (Dunford, 1990). Work is continuing on the use of experiments and quasi-experiments in a range of areas and attempts are being made to develop ways to improve the use of such methods to evaluate social policies (Dennis, 1990).

The traditional emphasis on outcome evaluation has meant that as formative and process evaluation approaches have been promoted more recently they have had to fight against the dominance of the quantitative experimental outcome evaluation paradigm. This seems unfortunate as they evaluate different aspects of

programmes and therefore require different data and methods to answer the different questions they pose. Patton (1990) as quoted earlier in this chapter, sums up the best approach to this issue when he says that the "important challenge is to appropriately match methods to evaluation questions and issues" (p. 492).

Outcome evaluation or impact assessment, as it is sometimes known in the literature, has been defined as: "evaluation of the extent to which a program causes changes in the desired direction in a target population" (Rossi & Freeman, 1985). It presumes that "the project should have its objectives sufficiently well articulated to make it possible to identify measures of goal achievement or the evaluator must be able to establish what reasonable objectives are" (Rossi & Freeman, 1985, p. 187). It can range from the one extreme of randomized experiments through to evaluators just judging whether they believe the objectives have been achieved (Rossi & Freeman, 1985, p. 227). Obviously the less findings just rely on evaluator judgements, the more credible they will be to a wider range of stakeholders.

For the purposes of the Health Promotion Strategic Evaluation Framework, outcome evaluation is defined as: *evaluating the extent to which a programme achieves its objectives or has other positive or negative effects.*

Outcome evaluation includes the following:

- collecting data before the programme starts (baseline data) and during (as part of time-series designs) and after the programme has been implemented, so that changes resulting from the programme can be measured;
- attempting to establish whether measured programme effects resulted from the programme, rather than from other factors (e.g. by use of control groups);
- assessing the extent to which the programme met its objectives;

- assessing other unintended positive or negative effects of the programme.

In summary:

- outcome evaluation continues to be important but is no longer the only type of evaluation in use; and
- for the purposes of the Health Promotion Strategic Evaluation Framework outcome evaluation is defined as evaluation of the extent to which a programme achieves its objectives or has other positive or negative effects.

Summary

This chapter has noted a series of key points from the evaluation literature which will need to be taken into account later in developing the Health Promotion Strategic Evaluation Framework, these are:

- evaluation is always affected by the particular cultural and political context in which it is embedded;
- evaluation effort should be spread right across a programme's life cycle;
- evaluation should be driven by the needs of evaluation users;
- evaluation now includes qualitative as well as the traditional quantitative methods and paradigms;
- evaluators should be realistic about the amount of attention paid to evaluation results in the policy arena; and

- one useful typology of evaluation is to divide it into formative, process and outcome evaluation as they have been defined here.

CHAPTER SIX

THE PROJECTS

This Chapter outlines five health promotion evaluation projects in which the author was involved as an evaluation researcher while working at the Alcohol and Public Health Research Unit (formerly the Alcohol Research Unit), University of Auckland. In the course of this work, a series of key issues and questions arose which became the impetus for the development of a sound framework for health promotion evaluation. These issues will be discussed in Chapter Seven.

The Alcohol and Public Health Research Unit is a multidisciplinary group of social science researchers undertaking research in the health promotion area. The Unit's emphasis is on policy and community strategies for health promotion. The author was Deputy Director of the Unit from October 1988 to June 1991 and, following a move to Wellington for family reasons, a Senior Research Fellow of the Unit from June 1991 to May 1992.

This chapter provides short summary of each of the five projects. Each summary includes a project outline, evaluation methodology, brief summary of findings, and the author's involvement. The specific findings of the individual projects have been reported elsewhere and references to these reports are given in the brief description of findings.

Project One

Evaluation of the Community Alcohol Health Promotion Organiser Approach

Project outline

Since the early 1980s, the Alcohol and Public Health Research Unit has been studying a particular mode of community organisation which involves locating health promotion organisers within particular communities. This method was developed in the course of the Community Action Project (CAP).

The Community Action Project (CAP) was funded by the Alcoholic Liquor Advisory Council and the Medical Research Council and was a large-scale medium-term quasi-experimental demonstration project focused on community attitudes towards alcohol control policies. It ran from October 1982 to February 1985. It compared intervention by means of mass-media campaigns in two cities (media intervention), with the same media campaigns plus community organisation by an alcohol health promotion organiser in each of two other cities (intensive intervention). These four cities were also compared with a further two cities which were not exposed to either intervention (reference cities). The major thrust of the community organisation component of the programme was the attempt to stimulate consideration of alcohol policy issues in the communities in which the organisers were working. Throughout the programme an attempt was made to focus on policy issues, while recognising that the worker's location within the local community meant that her or his activities required the support of community co-workers who in many instances were more inclined towards other approaches.

The initial two workers were fully funded for the duration of CAP by the Alcoholic Liquor Advisory Council (ALAC), as a part of the demonstration project. At the project's conclusion, the contribution from ALAC was reduced. As the number of alcohol health promotion organisers was progressively expanded from the original

two, to a total of at least 18 workers involved either part or full-time in similar roles throughout the country, funding from local health authorities became increasingly important and took over from the original seeding grants from ALAC.

The activity of organisers varied in different regions at different times. Examples of their core activities include:

Public policy: promoting the development of local authority alcohol policies, including guidelines on the use of alcohol at authority functions and the use of alcohol on authority controlled land.

Education: training sessions on responsible server behaviour for catering and hospitality industry course participants at Polytechnics (local tertiary institutions).

Community mobilisation: assisting local residents who were opposed to the introduction of a new alcohol license in an area.

Media advocacy: drawing attention in the local media to hotels which had been the source of many alcohol-related disorderly incidents.

Evaluation Methodology

The formative evaluation of CAP consisted of input into project development; regular meetings (at least bimonthly) between the alcohol health promotion organisers and researchers; and quantitative and qualitative developmental research for the television and radio advertising campaign. Process evaluation consisted of documentation of the project through key informants' interviews, participant observation, reports from those working on the project, and minutes of meetings. A series of street interviews were also carried out and observations made in licensed premises to check on the level of advertising at point of sale.

Outcome evaluation of CAP consisted of general population face-to-face surveys to assess recall of the mass-media programme and relevant attitudes and support for alcohol control policies carried out before and after the programme. Random general population samples of 600 people were contacted in each of the six cities, using a heavily stratified cluster approach, and respondents were interviewed face to face by trained market research interviewers. Identical sampling methodology and an almost identical structured questionnaire were used in additional surveys of independent samples of the general population which were carried out before and after the programme.

Following CAP, some small scale evaluation of the alcohol health promotion workers continued until more intensive evaluation activity started once again with the establishment of the Licensing Project. Over this time there was continuing analysis of the key elements in the community organisation strategy.

Brief Summary of Results

The results of the CAP process evaluation illustrated the difficulties a problem-prevention programme such as this is likely to encounter. Vested interest groups involved in the production, sale and promotion of alcohol had a significant adverse effect on the running of the campaign. (Casswell, Ransom & Gilmore, 1990). The impact evaluation showed that public attitudes towards alcohol use were affected by the mass-media campaign but the combined approach of mass-media and community action showed a slightly greater impact. The mass-media campaign also had an effect on public support for alcohol policies even though this was not the target of the campaign. These results are summarised in papers by papers by Casswell & Gilmore (1989) and Casswell, Gilmore, Maguire & Ransom (1989). The

community organisation aspect of the programme has been summarised in Casswell and Stewart (1989) and the mass-media element in Casswell, Ransom and Gilmore (1990). The aftermath of the project is described in Casswell and Stewart (1990), and the specific elements of the style of community organisation in Duignan, Casswell and Stewart (1993).

Author Involvement

While CAP was undertaken prior to the author's employment at the Alcohol and Public Health Research Unit, the author was involved in the continuing development of evaluation methods for the community alcohol health promotion organiser approach which arose out of CAP. This included involvement in ongoing evaluation of community organiser positions and undertaking analysis of the key elements in the community organisation strategy for presentation at a conference on community intervention strategies at San Diego in 1992 (Duignan, Casswell & Stewart, 1993).

Project Two

Process Evaluation of the Wanganui Community Alcohol Action Project

Project Outline

The Wanganui Community Alcohol Action Programme was a local alcohol-problem prevention project initiated as a national pilot programme. Beginning in May 1987, it ran for three months in the provincial New Zealand town of Wanganui (population approximately 38,000). It cost in excess of $170,000 and involved a number of Government Departments and local organisations such as the Area Health Board.

The project had extremely ambitious objectives for a three month programme. These were set out in Ministry of Transport report on the project:

- Reduce irresponsible drinking and driving;
- Reduce alcohol related casualties;
- Reduce the level of domestic violence;
- Reduce alcohol related work accidents;
- Reduce absenteeism at work due to alcohol related problems;
- Reduce antisocial behaviour on licensed premises;
- Reduce the level of crime related to alcohol;
- Reduce under-age drinking;
- Increase the number of community organisations which have an alcohol management policy;
- Promote public discussion of alcohol issues; and
- Increase availability of low or non-alcoholic drinks at social occasions (Ministry of Transport, 1988).

Activities undertaken as a part of the programme included:

- Regular meetings of a Steering Committee and working party with representatives from local government, police, health, education, licensees and community groups.
- Provision of seven extra traffic officers working on enforcement in the Wanganui area for the duration of the programme.

- Production of an educational kitset on alcohol for a two day workshop for young adults by the Ministry of Transport.
- An educational programme produced by the Department of Education, on trial in some Wanganui schools.
- A Patron Care programme involving police giving lectures on licensing law to staff of licensed premises.
- A regular patrol of licensed premises by Police.
- An "I'm Safe Mate" campaign initiated by the Hotel Workers Union, suggesting one person in a social group should be elected as the non-drinking driver.
- Low alcohol beer made available on some licensed premises.
- Dissemination of information by the local alcohol treatment agency, on alcohol problems and treatment, including a series of short radio broadcasts.
- A poster competition for schools run by the Accident Compensation Corporation.
- T-shirts produced for Students Against Drunk Driving distributed in schools.

Evaluation Methodology

A process evaluation was commissioned from the Alcohol and Public Health Research Unit by the *New Zealand Government Interdepartmental Co-ordinating Committee on Substance Abuse Funding* after the project was already underway. The two researchers (the author and a contract researcher, Mr Robin Ransom) interviewed a total of 29 key informants in Wanganui, where the project had been

running and in Wellington. The interviews were conducted using a semi-structured interview schedule commencing with a list of broad topics. The interview developed around these topics in the direction which the respondent saw fit and the interviewer considered appropriate.

The initial list of topics for the interviews was predefined and used in both the Wellington and Wanganui interviews. The sample of key informants to be interviewed was selected via discussion at the final meeting of the committee overseeing the project and also by perusing the minutes of the meetings from throughout the course of the project. The list was expanded following suggestions from respondents in the course of interviews as to further possible interviewees.

In addition to the interviews written material from the programme was reviewed as were press clippings showing reaction to the programme. In addition, written material from the programme meetings was examined.

This process evaluation was complementary to two outcome evaluation efforts undertaken on the project (de Jongh & Bailey, 1987; Ministry of Transport, 1988). The process evaluation was reported in Duignan and Casswell (1988b), and the project used as a case study in the evaluation of community health promotion projects in Duignan and Casswell (1989).

Brief Summary of Results

The results of the process evaluation showed that the programme was viewed by many in Wanganui as a Wellington initiative imposed on the Wanganui community. There was not sufficient lead time, coordination or resources available for the full involvement of participants in Wanganui. Confusion about the role of enforcement and the community aspects of the campaign caused considerable

difficulties during the campaign. Problems with the design of the programme as implemented meant that from a statistical point of view the outcome was not clear. The evaluation highlighted the complexity of working in the community development area. It also emphasised the importance of integrating any programmes directed at reducing excessive drinking and driving into an overall long-term strategy to put in place mechanisms for reducing this problem (Duignan & Casswell, 1988b).

Author Involvement

The author was responsible for negotiations with the funding body; designing the evaluation framework in consultation with Dr Casswell, Director of the Alcohol and Public Health Research Unit, and the contract interviewer Mr Robin Ransom; conducting semi-structured face-to-face interviews with the 19 key informants in Wellington; analysing transcriptions of these interviews; integrating findings from these with findings and analysis reported on by Mr Ransom from the interviews he conducted in Wanganui; and overall analysis of the findings from the process evaluation.

Project Three

Evaluation of Heartbeat New Zealand

Project Outline

Heartbeat New Zealand was a large-scale cardiovascular disease prevention programme established in New Zealand in 1988. It was funded by the New Zealand Department of Health and coordinated by the Heartbeat New Zealand Committee. This committee was set up by the National Heart Foundation a major non-governmental agency (NGO). It met once every three or four months and the

programme was staffed through a combination of existing National Heart Foundation staff and additional personnel employed specifically for the project. The programme drew its overall inspiration from overseas cardiovascular disease prevention programmes (see McAlistair et al., 1982; Meyer et al., 1980; Mittelmark et al., 1986; and Lefebvre et al., 1987), but was not particularly closely modelled on the specific aspects of any one of these programmes, including its namesake, Heartbeat Wales (Nutbeam & Catford, 1987).

The programme was funded by the New Zealand Department of Health to support a range of different initiatives in the cardiovascular health area, particularly in respect to nutrition and non-smoking. Some Heartbeat-funded projects were initiated by Heartbeat New Zealand itself, while others were developed by other agencies and then adopted and either fully or partially funded by Heartbeat New Zealand. A number of one-off grants were also made to support the work of other organisations in the cardiovascular health area. Specific activities included:

- Heartbeat Awards - encouraging school canteens and workplace cafeterias to provide a health-promoting environment by meeting criteria for health food choices, non-smoking and hygiene;
- funding for non-smoking advocacy groups working for the introduction of smoking control legislation;
- Stop Ourselves Smoking - funding to expand an existing smoking cessation programmes; and
- community grants - a range of community groups and organisations were given funding for local activity in healthy nutrition, non-smoking and exercise.

Evaluation Methodology

Alcohol and Public Health Researchers carried out the evaluation of the Heartbeat project. An evaluation team was established, with one evaluator employed full time on this project. This was Ms Mary Anne Dehar for most of the evaluation, followed by followed by Mr Roger Peach in the latter stages. The author and Dr Sally Casswell made up the rest of the evaluation team. The formative evaluation effort tracked the development of the programme and contributed evaluation input as the programme developed.

The types of evaluation team input included formal reporting and the offering of recommendations on program development at each meeting of the Heartbeat New Zealand Committee.

Brief Summary of Results

There was an ongoing process of the formative evaluators having input into programme development. For example, the evaluators critiqued the mix of strategies being used by the programme in terms of the Ottawa Charter in order to encourage a wider range of strategies, particularly in the areas of building healthy public policy, and strengthening community action. The Ottawa Charter was subsequently adopted by key programme personnel as the framework within which Heartbeat's activities should be considered in future. Other evaluation activities included suggestions in regard to the management structure of Heartbeat New Zealand and formal interviews with programme personal to obtain their views and perceptions about the way the programme was developing. A literature review was undertaken for a specific project of the programme - the Heartbeat Community Project - in order to provide Heartbeat New Zealand with research findings

regarding the approaches which were being considered. In respect of other projects, participant questionnaires and feedback instruments were designed or modified for the Heartbeat Programme. The formative Heartbeat evaluation is reported in Dehar, Duignan and Casswell (1991), Dehar, Duignan and Casswell (1992) and was the subject of a doctoral dissertation by Ms Dehar (Dehar, 1992).

Author Involvement

The author was involved in project planning right from the inception of the project and supervised the full-time Heartbeat evaluator Ms Mary Anne Dehar during work on the project. With Ms Dehar he was involved in developing the evaluation framework, overseeing implementation of the project, and, with Ms Dehar, presenting and discussing with the Heartbeat New Zealand Committee the formative evaluation reports.

Project Four

Evaluation of the Licensing Project

Project Outline

The Licensing Project was aimed at assisting community alcohol health promotion organisers and other public health workers to facilitate public health input into the implementation of the Sale of Liquor Act. The Act was passed in 1989 following a long and protracted debate about alcohol licensing laws, which included an inquiry into licensing laws (Working Party on Liquor, 1986), and parliamentary select committee hearings on the proposed bill. When passed, the Act had as its objective:

> To establish a reasonable system of control over the sale and supply of liquor to the public with the aim of contributing to the reduction of liquor abuse, so far as that can be achieved by legislative means (Sale of Liquor Act, 1989, s. 4).

In spite of the above objective, the actual provisions of the new Act liberalized alcohol availability, enabling 24-hour opening, wine sales in supermarkets and easier access to licenses. As with any new legislation, the initial years of implementation establish the way the new Act functions in practice. The Alcohol and Public Health Research Unit initiated the Licensing Project to maximise the extent to which the structures developed under the new law would provide for public health input into licensing decisions.

The Licensing Project utilised the 18 existing alcohol health promotion organisers employed either full or part-time throughout New Zealand. These positions had developed from the original CAP Project encouraged by the work of the Alcoholic Liquor Advisory Council, and the establishment of Area Health Boards as local health authorities with a legislated responsibility for health promotion.

The project was designed to activate the network of organisers and focus its attention on the implementation of the Sale of Liquor Act. This was based on the assumption that assisting these organisers to network in a synergistic interchange of information would result in a more effective response to the new Act than would have ensued if they worked in isolation.

Five major national meetings of the advisors were held between February 1990 and April 1992 . Organisation of these was carried out by the Health

Promotion Forum of New Zealand and the meetings were facilitated by, Dr Sally Casswell, Ms Liz Stewart and the author from the Alcohol and Public Health Research Unit. The steps to achieving the project's goal were to:

- collaborate with other agencies to ensure an integrated approach to providing public health input into licensing decisions;
- assist community and professional input into the licensing process so as to ensure that public health issues are considered in licensing decisions;
- raise the priority which licensing personnel put on public health input into licensing decisions;
- increase media discussion of licensing issues as an important method for reducing alcohol-related problems;
- promote increased enforcement of licensing laws; and
- develop a positive profile for health promotion adviser activity on licensing issues among key community members, health professionals, and health promotion adviser employers, in order to ensure continued support for work in this area.

Evaluation Methodology

There were two parts to the licensing project evaluation – a formative and a processes evaluation. In terms of formative evaluation, the evaluation team (Dr Sally Casswell, Ms Liz Stewart and the author) took on the following tasks:

- attendance at the national meetings to assist in clarifying the goal, objectives, strategies and targets for the project; kept the focus of the group on its task; and provided research input on questions related to alcohol control policy;

- circulating four questionnaires in the course of the project. In each case a formative evaluation report was prepared summarising the results of the questionnaires in order to facilitate information interchange between advisors and encourage comparisons between them in order to foster increased activity;

- preparation of a newsletter circulated to all organisers to facilitate information flow between them;

The process evaluation, on the other hand, consisted of collection and analysis of :

- a three stage key informant's interview survey conducted by a contracted interviewer, Mr Andrew Thompson, at four case study sites where health promotion organisers were based (Hamilton, Wellington, Nelson and Dunedin). The sites were selected as examples of large and small North and South Island cities. An average of 10 interviews were conducted at each site. A semi-structured interview schedule was used; key informants were identified through the official position they held in the local area. The interviews were audiotaped with the interviewee's consent and transcribed;

- a collection of documents relevant to the project;

- information which came from the formative evaluation, in particular the formative evaluation reports;

- press cuttings of issues relevant to the project; and

- participant observation on the part of the formative evaluators.

Brief Summary Of Results

During formative evaluation, the formative evaluators brought their research-based substantive knowledge of the alcohol problem prevention field to assist the discussion and facilitate a task-orientated process whereby individual health promotion advisors were able to review, amend and plan their activities through discussing and setting objectives and strategies. Detailed information was fed back to health promotion organisers on what the other organisers were doing. Health promotion organisers' needs for specialist information were identified and either circulated in the project newsletter, or by outside speakers included in the six monthly meetings. Details of the formative evaluation are set out in Stewart, Casswell & Duignan (1993). The process evaluation showed that participants in the project found the project helped to foster a more systematic, coherent and cohesive approach to raising the profile of public health issues than was otherwise likely to have occurred. The predominant strategies were in intersectoral collaboration, particularly with licensing liaison committees, and fostering the use of a Last Drinks Survey to collect information about locations of problem drinking. Working on these strategies was supported by local communities and put in place long term mechanisms to deal with alcohol issues as they arose. The outside stakeholders who were interviewed saw considerable value in the independent position of the organisers supporting other who were undertaking pro-health activity. The process evaluation is reported in Stewart, Casswell and Thomson (1997). Conceptual and methodological evaluation issues are dealt with in Duignan, Casswell & Stewart (1993).

Author Involvement

Along with Dr Sally Casswell, Ms Liz Stewart and Mr Andy Thompson, the author was involved in initial discussions regarding this project, with drafting of the grant application, redrafting in response to referee's reports, attendance at all but one of the national meetings, editing of the formative evaluation reports, and conceptualisation of the community organisation approach used in the project. He also supervised staff involved in the project.

Project Five

Accident Compensation Corporation Accident Prevention Programme Evaluation Policy

Project Outline

This project consisted of developing a policy for evaluating the whole of the Accident Compensation Corporation's (ACC) National Accident Prevention Programme. The Accident Compensation Corporation is the state owned accident compensation insurer in New Zealand. Since this project did not consist of undertaking one particular evaluation, there is no specific evaluation methodology section set out here. The objectives of the programme were to:

- examine the available documentation relating to the current Accident Prevention Programmes;
- set out a proposed general framework within which Accident Prevention Programmes could be evaluated which would include examples drawn from the current programmes but not a detailed consideration of the objectives of each programme in terms of their evaluability; and

- develop a proposed mechanism for ensuring that Accident Prevention Programmes were subject to an adequate level of evaluation, including considering the resources needed for this to take place.

Brief Summary of Results

The recommendations which came out of this study were as follows:

- the Accident Compensation Corporation should develop, and review annually, an overall strategic plan for the injury prevention area;
- before embarking on activity in relatively new areas such as community action, there should be a careful examination of the best ways of undertaking such work;
- recruitment and training should be used to ensure that staff within the ACC Accident Prevention Programme have a high level of appropriate project planning skills;
- training programmes in basic evaluation issues are needed for Accident Prevention Programme staff;
- evaluation should be undertaken both by programme staff and an external evaluation team;
- the level of resources needed to effectively evaluate the Accident Prevention Programme is estimated to be ten percent of overall programme spending;
- there should be an external evaluative review of the overall work of the ACC Accident Prevention Programme at least every three years;

- relatively large-scale specific projects run from within the ACC should have an evaluation plan developed for them based on an evaluation checklist (covering similar issues to the checklist in Appendix 3 in this study) and this should include provision for formative evaluation input; an external evaluation team should be involved in both drawing up the evaluation plan and in formative evaluation;
- evaluation of projects involving funding to groups outside ACC undertaking accident prevention work should involve consideration by the Director of Accident Prevention of the evaluation checklist and, in the case of larger projects, an external evaluation programme review.

Author Involvement

The author developed the approach to this project and wrote the report together with Dr Sally Casswell and Ms Mary-Anne Dehar (Duignan, Casswell & Dehar, 1989).

Summary

This chapter has summarised five of the health promotion evaluation projects which the author was involved in while at the Alcohol and Public Health Research Unit. The key issues and questions arising from these projects that provided the impetus for developing a framework for health promotion evaluation are discussed in the next chapter.

CHAPTER SEVEN

DISCUSSION OF QUESTIONS RAISED BY THE PROJECTS

A series of issues arose for the author out of his involvement with the projects previously described. These were: the type of theory needed by health promotion; whether the constructivist paradigm is the paradigm of choice for health promotion; whether there needs to be a dichotomy between community empowerment and government/bureaucratic locations for health promotion work; how to conceptualise the community organisation approach used in the Community Action Project and the Licensing Project; and health promotion input into the policy making process. This chapter examines each of these questions as a preliminary to the development of the Strategic Evaluation approach.

Type of Theory Needed by Health Promotion

The health promotion and related literature contains many calls for the development of theory (Antonovsky, 1996; Dean, 1996; Dean & McQueen, 1996; De Leeuw, 1988; Duignan & Casswell, 1988a; McQueen, 1996; Watt, 1986). The need for theory was emphasised, for example, at a conference organised by the Alcohol and Public Health Research Unit on the topic of research for healthy public policy. A conclusion from the conference was that:

> "[Health promotion] theories should be developed drawing on those in the social sciences. These should be explicit so that they can be compared and their scope, realism, and assumptions clarified" (Duignan & Casswell, 1988a, p. 1).

De Leeuw (1988) describes the development of a theoretical and conceptual framework for health promotion as essential and urgent. A major review of the literature on healthy public policy (Pederson, Edwards, Marshall, Allison & Kellner, 1988) called for increased theorising. Dean (1996) points to problems in lack of theoretical development in health promotion. McQueen (1996) calls for a collective approach to theory building. Antonovsky (1996) puts a strong claim that:

> The concept of health promotion, revolutionary in the best sense when first introduced, is in danger of stagnation. This is the case because thinking and research have not been exploited to formulate a theory to guide the field (p. 11).

Why these repeated calls for theory development within health promotion? Firstly, within science, theory is seen, almost universally, as an unquestioned good. Within a developing discipline such as health promotion, unsure about where it stands vis-à-vis other disciplines, the development of more theory would seem to be an essential prerequisite for disciplinary growth. For example, when the author's medical school department sought support from the Faculty of Medicine for establishing an academic post in health promotion, the departmental representative putting the case was challenged with the question "but what theoretical basis does health promotion have?"

Secondly, pressure for theory comes from health promotion's status as an applied discipline. There is a concern that without theory health promotion may become "limited to action" (Dean & McQueen, 1996). Applied researchers can see theory development as a way of legitimising their activities as science. In this context, Kurt Lewin's widely-quoted aphorism that "there's nothing so useful as a good theory" has been used to highlight the importance of theory in health

promotion as an applied discipline (Kickbusch, 1996; Rootman, Goodstadt, Potvin & Springett, 1997).

Thirdly, as Antonovsky's (1996) above quote reflects, theory is needed to avoid straying from health promotion's original vision. Antonovsky defines this vision as one which puts the emphasis on health rather than disease.

Fourthly, because of its scope, health promotion "borrows" theories from feeder disciplines; this raises the issue of whether these are appropriate for health promotion and whether it might be preferable to develop specific health promotion theories in these areas.

Finally, there is the tendency for those with an expansive definition of health promotion to seek a comprehensive theory for health promotion which covers its whole domain.

For the author, working in the Alcohol and Public Health Research Unit (henceforth, "the Unit"), there were two contrasting aspects to the question of the role of theory. On the one hand, staff of the Unit seemed to have clear "theoretical views" about the way in which health promotion should be approached; particularly, that it should take a systemic rather than an individual approach. This was based on our reading of existing research on the effectiveness of various approaches in promoting health. On the other hand, the Unit was subjected to calls from at least two sources for more "theory" in its work. The first, a reviewer of the Unit's work, raised the issue during a site visit meeting at the Unit (these being the occasions when funders decide whether to continue funding). The second source, a referee's report on the Licensing Project Grant Application, implied that that particular study required more of an hypothesis-testing orientation, presumably implying that this would allow input into theory formulation in the traditional scientific sense. While

these were minority views in terms of comments on the Unit's work, for the author they raised the issue of the nature of theory in the Unit's work.

Clearly, health promotion does need theory of some sort. As Dean and McQueen (1996) state:

> Without engaging in an active process of theory development, research and programs will be carried out on the basis of implicit theory....If research is not guided by some set of theoretical assumptions, the result is analytic chaos. In health promotion this means that the field would become limited to action, devoid of a sound knowledge base, and of reflection and evaluation. A strategy, after all, is a theory of how to achieve a goal based on assumptions about reality relationships. Tactics are practices based on a theory of strategy (p. 9).

However, the key issues is not whether there needs to be theory, which there undoubtedly does, but how finely specified such health promotion theory needs to be to advance health promotion as a discipline. Taking a statement like the Ottawa Charter, it can be seen to be something of a summary encapsulation of a theory of health promotion. Indeed, the role of theory in its origin has been pointed out (Kickbusch, 1996). Consistent with the Ottawa Charter, there are also other high level statements of "theory" from the health promotion advocacy and the new public health movement. In this vein Wallack (1996) sets this out in terms of a contrast between the new and the traditional public health approaches:

"New" Health-Oriented Public Health emphasizes:	**"Traditional" Disease-Oriented Public Health emphazises:**
Social and political issues	Personal and behavioral problems
Role of social conditions	Role of risk factor knowledge
Importance of policy development	Importance of service delivery
Healthy environments	Determinants of disease
Multisectoral planning	Health Sector planning
Broad-based participation in problem definition	Limited participation in problem definition
Social accountability	Individual responsibility
Advocacy and legislation	Education and treatment

(Wallack, 1996, p. 227)

Much of the theoretical basis for the Unit's work is on a similar level to these examples and is reflected in elements of the Health Promotion Strategic Evaluation Framework set out in Chapter Nine of this study. These views can be put in more complex "theoretical" language when necessary, as Stokols' (1992) theoretical formulations illustrate. In advancing his argument that the social and physical environment is important for health promotion for example, Stokols makes, the following theoretical statement which encapsulates notions central to the Charter, Wallack's and the Unit's health promotion approach:

> ...the social-ecological perspective incorporates a variety of concepts derived from systems theory (e.g. interdependence, homeostasis, negative feedback, and deviation amplification...) to understand the dynamic interrelations between people and their environments. Thus,

people-environment transactions are characterized by cycles of mutual influence, whereby the physical and social features of settings directly influence their occupants' health and, concurrently, the participants in settings modify the healthfulness of their surroundings through their individual and collective actions. The various levels of human environments are viewed as complex systems in which local settings and organisations are nested in more complex and remote regions.

e.g. the occupational health and safety of community work settings are directly influenced by state and national ordinances aimed at protecting environmental quality and public health.

The ecological perspective suggests that multifaceted interventions that incorporate complementary environmental and behavioral components and span multiple settings and levels of analysis are more likely to be effective in promoting personal and public health than are those narrower in scope.

e.g. behavior modification programs for smoking cessation may be more effective if they coincide with non-smoking policies at the workplace and municipal ordinances prohibiting smoking in public environment (p. 92).

Whether put simply as in the Charter, Wallack (1996), and this study, or in a more complex fashion as in the case of Stokols' (1992), health promotion work such as that undertaken by the Unit is firmly guided by theory. Obviously there will always be scope for elaboration and more specification of these types of theoretical statements about health promotion. However, such need for elaboration is different from the impression given by much of the health promotion literature that health promotion has a theoretical void at its center. The author did not feel that there was

a major lack of theory holding back the Unit or health promotion in general. Rather than a lack of theory, the problems faced by the Unit were primarily caused by the political forces which resisted effective action on alcohol. These political forces were accompanied by pressure for individualistic strategies to solve social problems arising from the ideology inherent in a market-orientated society.

This view that an acceptable framework for health promotion theory already exists, is in contrast to one which sees the need to construct a new, comprehensive theory of health promotion. The perception that a new exhaustive theory is needed can arise from accepting a very wide definition of what health promotion is; such as "the process of enabling people to increase their control over, and to improve, their complete physical, mental and social well-being" (World Health Organisation, 1946) and then attempting to build a theory which will accommodate the whole range of issues which such a wide definition would raise. This seems to be the approach being taken by Salmond (1989), who argues that health promotion must:

> ...understand the relationships between all of the forces affecting human health...It must explain the political economic, social and cultural conditions affecting health. Moreover, it must reject a simplified view of health, healing and human existence...This requires both quantitative and qualitative research designs and new forms of data. Such an endeavor must grapple with the practical problems of establishing concrete contextual links, distinguishing multiple etiologies, and finding flaws in representations of causal relationships (p. 46).

While work does need to be done on all of these issues, whether health promotion wants or is able to take on such a gargantuan task—a task which could

be construed to encompass much of the biomedical sciences and probably the entirety of the socials sciences as well—is an important question. In the author's view, for health promotion to set itself such a task is both unrealistic and not the highest priority for the use of scarce health promotion resources.

It has been argued so far that firstly, health promotion already does have a relatively clear set of high level theoretical principles to guide it, and secondly, that it should not attempt to develop a "theory of everything" in response to very wide definitions of its domain of action. The issue still remains, however, of health promotion's involvement in a wide number of different areas (policy, community development, media) in which it needs specific guidance from theory of some sort. It is at this point that health promotion turns to other disciplines for their assistance. How does health promotion deal with "borrowed" theories?

Using Borrowed Theory in Health Promotion

The health promotion literature cites a number of social science theories as influential in the design of health promotion programmes. Often cited theories are: diffusion of innovations theory (Alcalay, 1983; Catford & Parish, 1989), systems theory (Stokols, 1992) and social learning theory (Alcalay, 1983 Catford & Parish, 1989; Malfetti, 1985; Parcel, Simons-Morton & Kolbe, 1988). This section will begin by examining one of these theories, Bandura's social learning theory, in order to illustrate the range of ways in which imported theory can be used in health promotion.

Bandura's social learning theory is one of the several social science theories which health promoter Alcalay (1983) regards as having been of "critical import to the field of mass communication as shown by the fact that they have provided the theoretical basis for the design of innumerable campaigns of mass communication

through mass media" (p. 88). Its frequent citation seems to confirm this view (Alcalay, 1983; Catford & Parish, 1989; Malfetti, 1985; Parcel, Simons-Morton & Kolbe, 1988).

Bandura's theory is used in very different ways in health promotion. To give an initial example, Malfetti (1985) uses it to argue *against* the use of an environmental measure - deterrence - to reduce motor vehicle crashes:

> "*As opposed to deterrence*, I seek support for internal or voluntary decision making from the field of learning theory. Social influences can be arranged to create changes in human behaviour. If these changes are to endure, however, people must operate as active agents in their own motivation and behaviour--simply because they preside over their own behaviour and are in the best position to exercise influence over it. To foster such change it is necessary to enlist potential sources of motivation and provide the understanding and skills for effective self-regulation [a reference to Bandura is given here]. These, I maintain, are best provided by education" [emphasis added] (p. 348).

Bandura's theory occupies the dominant position in this passage and is allowed to override empirical considerations. The argument in Malfetti's paper is not based on an analysis of the data concerning deterrence - a strategy which happens to be consistent with the general theoretical orientation of health promotion towards systemic rather than individual interventions. The deterrence strategy is simply ruled out because of the belief that it is inconsistent with Bandura's theory.

A second example comes from Alcalay (1983) in a summary of the Stanford Heart Disease Prevention Program. He seems to indicate that considerable effort is being made to put Bandura's theory to work in the case of this project:

> "The Project [Stanford Heart Disease Prevention Program] is using a communication focus based principally on Bandura's social learning theory to introduce behaviour changes via the mass media, community organizations, and interpersonal relations. The significance of the use of Bandura's model is that in teaching useful skills to the individual for the modification and control of his own behaviour, it has served as a basis for the multimedia and interpersonal strategy approach of the Stanford Project. Bandura's theory allows for the teaching of skills by means of modelling behaviours through auditory systems (like radio and cassettes), visual systems (like slides, pamphlets, highway billboards, posters etc.) and audio-visual systems (like movies and T.V.). For example, a scene that shows a family picnic can suggest through its images the type of foods to be taken in a picnic basket when a family is preparing to go on the picnic.
>
> The applicability of social learning theory to the design of mass communication messages makes possible, at least potentially, the design of behaviour change campaigns at the community level. While it is true that Bandura's approach attains its greatest effectiveness in interpersonal training situations, the cost of such situations is so high that it makes an intervention to change behaviour on the level of entire communities unthinkable" (p. 91).

The tone of this passage clearly portrays the development of the programme as driven by Bandura's theory. The communication focus is "based principally on Bandura's social learning theory". The theory "*allows* for the teaching of skills by means of modeling behaviours through auditory systems." The theory's applicability

"*makes possible* the design of behaviour change campaigns at the community level." This would suggest the theory has a major influence on practice in the programme. However, in spite of this, there is some conflict around the question of the practicality of Bandura's theory. This is put in terms of Bandura's theory attaining its greatest effectiveness in "interpersonal training situations", but the cost of this means that it cannot be used as an intervention at the level of the entire community. So in this second example, rather than allowing Bandura's theory complete dominance in determining the health promotion approach, its applicability is restrained by cost effectiveness considerations. In this regard it should be noted that an important element in the Ottawa Charter type health promotion emphasis on systemic approaches is the belief that these are generally more cost effective than individual approaches.

A third example of the use of Bandura's theory can be seen in Parcel, Simons-Morton and Kolbe (1988). In a school programme attempting to focus on the wider school environment they describe the role of social learning theory:

> Social learning theory (SLT) provided the underlying theoretical framework for the intervention, which focused on the interaction between environmental, cognitive, and behavioral factors...
>
> Although SLT provided a robust framework for defining intervention variables and strategies, a more practical model was needed to plan and organize a coordinated program that would integrate organizational change to modify the environment with instructional change to provide students with new learning opportunities. (p. 440).

In this case Bandura is pushed another step away from dominance by the definition of two realms: that of the "theoretical framework for the intervention" and

that of the "more practical model." This begs the question of what theory, if any, lies behind the "more practical model."

A final example is the Alcohol and Public Health Research Unit's use of Bandura's theory. It was cited by the unit as a general influence on its work in the Community Action Project (CAP), mainly as a justification for looking at social factors rather than individual factors in health promotion. However, in the planning stages of CAP Bandura's theory did not add anything more specific to the design of the programme (Casswell, personal communication, 1991).

These examples show a progressive diminution in the extent to which Bandura's social learning theory influenced the design of programmes. Malfetti shows theory dominating practice; Alcalay shows it playing an important role in programme design but, for cost reasons, not determining the final approach; Parcel, Simons-Morton and Kolbe (1988) relegate it to a realm of theory as contrasted with a realm of practice; and in the case of the Alcohol and Public Health Research Unit's Community Action Project (CAP) it had little influence and was just a general validation for taking an approach which was wider than a strictly individual perspective.

How should such theoretical "borrowing" be managed in health promotion? Wicker (1989) has provided a model of what he calls Substantive Theorising which provides some assistance in this regard. Wicker builds on Brinberg and McGrath's (1985) idea that in research there are three major domains: the *substantive* domain (the area under study), the *conceptual* domain and the *methodological* domain. He sets out an approach called substantive theorising which is based on prioritising the demands of these three domains. In this approach the demands of the substantive domain have the highest priority, setting the terms on which conceptual and methodological decisions are made.

The main features of Wicker's (1989) substantive theorising are:

- selection of substantive domains and conceptual/theoretical developments take priority over methodological issues;
- social significance is a major consideration in choosing substantive domains;
- investigations focus on limited substantive domains;
- psychological and social processes are examined in relation to their social spatial, and temporal contexts;
- substantive domains are explored in depth using multiple methods;
- substantive theorising is a continuous, open process that is grounded in a particular domain;
- knowledge claims are limited to the substantive domains examined; and
- theoretical and empirical contributions can take a variety of forms (p. 534).

Wicker's model provides a framework for the "borrowing" of other theories in health promotion. The key message is that it is the domain and the general theoretical principles of health promotion which should determine the way in which imported elements from other disciplines are used rather than allowing those other theories to drive health promotion approaches. Thus, borrowed theories should not be allowed to work against the major theoretical principles which have been developed in health promotion such as those set out in the Ottawa Charter. In the Malfetti (1985) example above, this is exactly what did occur, as Bandura's theory was used to argue against deterrence even when there was evidence that deterrence worked. Indeed, the research evidence showing systemic strategies to be more effective than individualistic ones is a key foundation for the approach

taken in the Charter and similar systems-orientated health promotion theory behind the Unit's work.

In summary, this section has argued that:

- there is not a major crisis for health promotion due to lack of theory;
- there is a basic theoretical orientation for health promotion set out in the Ottawa Charter, by Wallack (1996), by Stokols (1992), and implicit in the Framework developed in this study, this however needs to continue to be elaborated upon;
- part of the perception of a "theory" problem for health promotion is an unrealistic attempt to develop health promotion theory which adopts a very expansive definition of health, which in turn requires a "theory of everything"; and
- when borrowing theories from other domains they should not be used to override the grounding systemic-orientated theoretical principles of health promotion set out in the Ottawa Charter and similar formulations.

The implications of the theory question for the Health Promotion Strategic Evaluation Framework are that, firstly, a central part of the formative evaluation role in health promotion is to ensure that the general theoretical insights from health promotion (its systemic focus) are introduced into the early stages of programme planning to ensure that systemic rather than politically more acceptable individualistic strategies are adopted. For instance, in the case of the Licensing Project, the Unit encouraged the alcohol health promotion organisers to work on policy areas related to alcohol availability rather than just individual education initiatives. In the case of Heartbeat New Zealand the formative evaluators

encouraged the Heartbeat New Zealand Committee to look at the more systems-orientated strategies rather than just individually orientated ones.

Secondly, when undertaking outcome evaluation, the identification of variables to be measured needs to be informed by health promotion theory. Inappropriate outcome measures which simply focus on individual behavioural change should not be allowed to drive programmes.

The Constructivist Paradigm: Health Promotion Paradigm of Choice?

The methods used in the health promotion evaluations set out in the previous chapter did not seem to exclusively conform to either the positivist or the constructivist paradigm, but contained a mix of elements from both. This raised the issue for the author of which paradigm was the most appropriate for health promotion. This section addresses that question.

Calls for New Paradigms in Health Promotion

The health promotion and related social sciences contain a number of calls for the introduction of a new paradigm (Guba and Lincoln, 1981; Labonte & Robertson, 1996; Salmon, 1989; Susman & Evered, 1978; Walsh, 1987). Phillips (1987), a philosopher of science, defines a paradigm as that which "determines the problems that are regarded as crucial, the ways these problems are to be conceptualized, the appropriate methods of inquiry, [and] the relevant standards of judgment [that researchers use]" (p.205).

In current health promotion there is a strong argument for moving away from the positivist paradigm. Susman and Evered (1978), for example, examining the issue of when to use positivist or other approaches, state that the researcher should be sceptical of using positivist science when the "unit of analysis is, like the researcher, a self-reflecting subject, when relationships between subjects (actors)

are influenced by definitions of the situation, or when the reason for undertaking the research is to solve a problem which the actors have helped to define" (p. 600). All these sound very much like the context in which health promotion operates. Similarly, Guba and Lincoln (1981), in a discussion on the choice between the scientific and the naturalistic/constructivist paradigms, state "it is our judgement that in the field of behavioral science, of which evaluation is surely a part, the naturalistic paradigm should be the paradigm of choice" (p. 77). Focusing on health promotion, Labonte and Robertson (1996), building on Guba and Lincoln's work, concludes that the constructivist paradigm is "more suited to the goals of current health promotion" than the conventional positivist paradigm (p. 431). This call from a major health promotion figure mirrors calls for new paradigms in closely related areas such as community psychology (Walsh, 1987) .

In a health promotion evaluation context, Rootman, Goodstadt, Potvin and Springett (1997) have summarisied three dominant current paradigms:

- the "strong positivist" position - claiming that experimental methodology is the royal path to knowledge; this position is rooted in the view that reality can be assessed objectively by a neutral observer and causality demonstrated if all parameters except the treatment under study are kept constant;

- at the other extreme the "constructivist" position - claiming that all knowledge is local and constructed by the observer; causality and objectivity do not exist and therefore local knowledge constructions reflect the values of the stakeholders including the researcher; and

- the middle position, "critical multiplism" (Cook, 1985) - which claims that methods should be adapted to the question that is being asked and that these methods will draw on various paradigms.

While Rootman et al. do not elaborate on the subtlety of the various positions, they do summarise the common view of these positions in the social science literature. As Rootman et al. note, each view has its problems: the positivist view "has been losing ground" and is a position which they describe as "hardly tenable" any more; the constructivist view makes it difficult to generalise; and critical multiplism is problematic if it is believed that methodologies rooted in different epistemologies cannot be reconciled (p. 13).

A central problem with the paradigms debate is that a number of different, though variously related, issues are bundled together. A different way of looking at the issue is to see if underneath the choice of paradigms is really a whole array of different questions which can be "unpacked". The list of questions includes the following:

- epistemology - on what basis can we make knowledge claims?
- control of the research agenda - who should control the research agenda?
- participation of those who are studied in a research project - to what extent should those involved in a research project be consulted, given control and given feedback about the research?
- methods - when are qualitative and when are quantitative methods best used?
- number of variables - is it possible to isolate one or two variables when studying a phenomena or must they be studied as a total system?
- generalisability of findings - can findings be generalised from one situation to another?

- rationality and society - to what extent are the methods used by science (certain forms of rationality) also implicated in the way in which society has developed?

- values - how do, and how should, researcher's values determine their question framing, methods and interpretation of findings?

- facts/truth and interpretation/meaning - what is the difference between claiming that something is true and talking about its meaning?

- power - who has the resources to purchase and promote research on particular questions which support their world view?

- unified science - to what extent does the subject under study influence the approaches and methods which should be used, i.e. should there be fundamentally different approaches for the physical and social sciences?

- exercise of authority - to what extent are knowledge discourses also mechanisms for exercising power?

- right to represent the world - to what extent do all groups have a right to develop, control and voice their representations of the world?

In the discussion of the paradigm of choice for health promotion (or, for that matter, other areas of social science) it seems that particular sets of answers to this list of questions get assigned to one or the other of the competing paradigms. The stereotyped answers for the positivist and constructivist paradigm are set out in Table 1. The paradigmatic position of the author in regard to the evaluation research set out in this study was that different research projects may well have different answers to a number of these questions. For example, the Licensing Project brought together a group of alcohol health promotion organisers from

Table 1: Stereotyped Answers to the Key "Unpacked" Paradigmatic Questions for the Positivist and the Constructivist Paradigm

Issue	Positivism	Constructivism
Epistemology	We can develop objective knowledge	Knowledge is subjective
Control of research agenda	Bureaucratic/elite control of research agenda	More grass roots involvement in research agenda
Participation of those studied	People studied treated like objects	People studied consulted, given control and given feedback
Methods	Quantitative methods	Qualitative methods
Number of variables	It is possible to study two or so variables in isolation by controlling for other variables	Variables can only be studied as part of a total systems interaction
Generalisability	Findings from one study can be generalised to other situations and general laws developed	Findings are closely tied to particular circumstances, when they are used elsewhere it is always an extrapolation
Rationality and society	Scientific rationality is a major way to move towards a better society	Scientific rationality has caused a divided, polluted, unsustainable and inequitable society
Values	Researchers should not let their values influence their question framing, methods or interpretation	Researchers cannot help their values influencing their question framing, methods and interpretation
Facts/truth and interpretation/ meaning	Researchers should seek facts/truths	Researchers should seek interpretations and meanings
Power	Despite power imbalances truth will out in the end	Science is used by the powerful to support their world views
Unified science	The same underlying approaches can be used for the study of the physical and social worlds	Studying people and society requires a totally different approach from studying objects
Exercise of authority	Scientific discourse is a power neutral description of truth	Scientific discourse in inextricably bound up with the exercise of power
Right to own representation of world	There is only one valid representation of the world	There are many representations of the world and oppressed people have a right to develop, control and voice their own representations

around the country to strategise about how to encourage active implementation of the new Sale of Liquor Act. Table 2 discusses the each key question for the project.

As can be seen from this table the answers to the "unpacked" paradigmatic questions will depend on the evaluation research project being undertaken. The author did not believe that the answers to these questions for an individual project should be proscribed by one paradigmatic position. This position does not seem to be exactly the same as the third paradigmatic alternative Rootman et al. (1997) put forward at the start of this section - Cook's (1985) "postpositivist critical multiplism." Cook's (1985) approach is to endorse multiple approaches, methods, definitions, analyses and interpretations, often also known as triangulation (Hakim, 1987). However, rather than just endorse triangulation, the approach put forward in this study is to accept all methods as potentially useful, but to determine which ones to use based on the position taken in regard to the specific answers to the specific questions underlying the paradigms debate. This approach is much closer to that put forward by Patton (1986a) as the *Paradigm of Choices.* He talks about "matching research methods to the nuances of particular evaluation questions and the idiosyncrasies of specific decision maker needs" (p. 215).

In conclusion:

- different paradigms put forward for health promotion can be "unpacked" into a list of different key questions;
- a paradigm is made up of a set of responses to this list of key questions; and
- accepting only one set of responses to these questions for health promotion does not seem to do justice to the diversity of issues and questions which need to be faced when thinking about carrying out and evaluating specific health promotion projects.

Table 2: Key "Unpacked" Paradigmatic Issues in Regard to the Licensing Project

Issue	Discussion
Epistemology	In the Licensing Project knowledge claims, such as saying that there is evidence that systemic are more effective than individualistic strategies, could not be based on a purely subjective epistemology. There needed to be an epistemological basis which allowed for the formative evaluators to provide a credible basis for their claims about preferred strategies.
Control of the research agenda	The public paid for the Alcohol and Public Health Research Unit to undertake health promotion research on alcohol. The Unit was subject to peer review from other researchers and had developed a research agenda in this context. To what extent might the public have wanted that agenda relitigated and in what forum(s) might such relitigation take place? To what extent did the public just want the Unit to get on with the job which it was set up for and was funded to do?
Participation of those studied	We were working closely with the people involved in the formative and process evaluations so our approach would be modified by what was acceptable to them and results fed back to them.
Methods	Both qualitative and quantitative methods were used but the emphasis was on qualitative.
Number of variables	Multiple variables. Even if we had wanted to it would have been difficult and expensive to have control groups, since we were working on a national project. It might also be unethical, if not impossible, to try to ensure that control/reference regions remained unaffected by policies which the project managed to have introduced at the national level.
Generalisability	Communities differ, however there are some common principles regarding researching and influencing alcohol control policies which can be extrapolated as potentially relevant to most communities.
Rationality and society	While scientific rationality used in certain ways may have been related to a number of today's social problems, in this instance we believed that scientific rationality would lead to a better society. Scientific rationality in the form of research-based interventions was being used to encourage active implementation of the Sale of Liquour Act rather than allowing political expediency let the Act remain unenforced.
Values	Our values influenced our choice of area to work in (alcohol health promotion) and the way in which we actively disseminated and used our research results. Regardless of our values our research methods also needed to be acceptable to the participants and the funders who may have held different value systems to ours - therefore our methods were not only determined by our own values.
Facts/truth and Interpretation/ meaning	We were working with both "facts" (which would not be particularly contested by people with different value positions, e.g. that someone had stated that they had been drinking at a particular hotel) and meanings, the interpretations, the legal, moral and public relations implications of these "facts" for the licensed premises where the person had drunk.
Power	Because of the particular politics of alcohol, specifically its health and social costs, the State was in this instance prepared to fund research which in some cases worked against the interests of a powerful commercial interest (the alcohol industry).
Unified science	We used social science methods which we thought were particularly suited to the study of people and social systems.
Exercise of authority	We were using scientific discourse and in so doing exercising authority. We believed that *in this instance* this use of authoritative discourse did not work against community interests.
Right to own representation of world	By highlighting the problems caused by alcohol in the communities in which we were working we were helping to resist the alcohol industry's attempt to ensure only positive representations of alcohol in these communities.

False Dichotomy: Community Empowerment Versus Government/Bureaucracy

This section discusses another dilemma which the author faced in his work with the Unit. The health promotion literature contains many calls for empowering communities. However, a significant amount of the health promotion activity which took place in the course of the evaluations reported on in this study was located within local and sometimes national government bureaucratic structures. The Licensing Project, for example, sought to ensure the active enforcement of the provisions of the new Sale of Liquor Act. The approach which was adopted included raising awareness and amplifying the voice of community concern about local alcohol problems through local media and other channels. The actual location of much of the activity was however within local bureaucracies, both those concerned with the licensing process and others. It was believed that these structures were where responsibility for the active enforcement of the new legislation should take place.

In another programme - the Wanganui Community Alcohol Action Project - the situation was more complex. Media comment on the Wanganui Community Alcohol Action Programme saw a major contradiction in the programme between the enforcement element in the programme and the community education element. The community element, which was a poor example of a community approach because disengaged from the community, was viewed favorably, riding on the coattails of the positive aura around the idea of community interventions. The enforcement element was viewed negatively as "heavy handed" (Duignan and Casswell, 1988b). Somewhat ironically, it is likely that any good done in terms of reducing alcohol problems in the locality, which was the objective of the programme, was as a result of the "heavy handed" enforcement of alcohol impaired driving laws

by the state, rather than the so called "community" strategy. Was there, then, a contradiction in all this? How did the approach to the health promotion projects reported here relate to the community empowerment calls?

Opposition of Community to Government/Bureaucracy

There is a tendency within health promotion and social programme discourse to oppose community with government/bureaucracy. While community is a term which "seems never to be used unfavourably" (Williams, 1976, p. 66), bureaucracy is a "word with a bad reputation" (Weiss, 1979, p. 7). Unlike community, bureaucracy is seen as potentially disempowering and therefore not health promoting.

The view of community as always positive underpinned much of the discussion at the Second International Research Symposium on Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems (San Diego, 29 January to 2 February 1992). The community organiser approach adopted in the Alcohol and Public Health Research Unit 's Community Action Project and the Licensing Project was one of the approaches examined at this symposium (Duignan, Casswell & Stewart, 1993). It was clear from discussion around the table that there was a conceptual gulf between the European (and Australasian) delegates and those from the United States regarding the notion of community strategies. In the author's view this stemmed from the United States delegates view of community as necessarily in opposition to government, whereas the other delegates tended to see the possibility of a partnership role for some parts of government, particularly local government, in what they still saw as, and called, community interventions.

As an example, in a discussion of a U.S. health promotion programme which included the setting up of a coordinating committee within a geographical

community, a criticism was advanced along the lines that all the members of the committee were still representatives from organisations and hence did not represent the true "community". What is behind such a criticism is a conceptualisation which sees community as "other" than local organisations and local institutions. At the extreme this leads to viewing "true" community as simply an aggregate of isolated individuals. As soon as people coalesce into any form of organisation they become members of "organisations", and hence are no longer authentic grass roots community members.

There are three major sources behind the notion that community is in opposition to government/bureaucracy:

- views of the social movements - the social movements (the women's, indigenous people's and environmental movements) have identified bureaucracy and formal power structures as an important source of oppression; bureaucracy is then contrasted with their own grass-roots movements located in the "community";

- the New Right agenda - seeking to reduce the size of the state the New Right agenda feeds into the identification of the bureaucracy as bad and the non-bureaucracy (read private business and sometimes community) as good; and

- pressures on welfare state funding - pressures on welfare state funding mean that the bureaucracy becomes identified with reviewing, authoritarian control and cost cutting; this further undermines the already low regard in which it is held.

Growing Critique Of The Use Of Term Community

For these three reasons, a conceptualisation of community which sees it as good and opposes it to bureaucracy as bad, is likely to grow up and be fostered

within health promotion by a wide range of groups coming from right across the political spectrum.

The almost totally positive use of the term community in health promotion at present mirrors its use in a related discipline - social work. The current strategic focus on community by health promotion in the 1980s and 1990s is not unique. It echoes similar developments which took place in social work in the 1970s and early 1980s.

Looking at the social work experience, it is possible to draw parallels with the unfolding development of the concept of community strategies in the health promotion field. Working as a new social worker in the late seventies, as the focus turned towards community strategies, the author recalls the sense of excitement which a more pronounced orientation towards participation in the community seemed to offer for social workers seeking social change. The author sensed the same excitement in the health promotion field in late 1980s and 1990s. However, the exciting 1970s developments in social work were, by the early 1980s, being attacked by commentators who saw in the vogue of community strategies threads of conservative, rather than progressive, political thought. For instance Bryson and Mowbray (1981), writing in the early 1980s, deconstruct the term community:

> Having analysed current usage of the term "community" and alternative approaches, we have demonstrated the way in which it suits conservative interests, particularly through:
>
> 1. facilitation of an `a-political' conception of problems and change;
> 2. emphasis on an essential unity (harmony, cooperation, participation), rather than separation, of interests (as in a class perspective);
> 3. service to the pluralist view that it is possible within capitalism to devolve significant decision making to the local level; and

4. use in characterising a management model geared to minimising government expenditure (p. 265).

Fifteen years later, this time in respect of health promotion/the new public health, Petersen and Lupton (1996) do a similar deconstruction on the term "community participation" disputing the view that it is a "progressive social movement for change" which is in "opposition to dominant relations of power" (p. 172). Grace (1991) similarly argues, in respect of the term empowerment used in a community context, that the "institution of 'health promotion' produces an ideology of empowerment that, it can be argued, effectively masks its collusion with the contemporary form of political economy, consumer capitalism" (p. 341).

Looking more speculatively at the ideological role of the term community, it can be seen to serve an important ideological function in modern societies. Capitalist societies are faced with the ideological difficulty that the personality requirements for people interacting in the free market (self-interest, competition, greed) seem at face value to be the opposite of the nurturing characteristics required for adequate human reproduction and development (love, cooperation, selflessness). As Else (1992) points out, from a social policy point of view a major problem in capitalism is how to encourage both of these contradictory personality styles at the same time. A traditional solution has been to consign the nurturing personality to a realm separate from, but parallel to the market place personality. This realm has in the past been that of the family. The mechanism for doing this has been to assume that there are two different "types" of human personality, corresponding to the two different realms. One of these, the marketplace, is then identified with the male gender and the other, the family, with the female.

However, the widely acknowledged "breakdown" of the traditional family means that the family has become a rather fragile vessel to carry all of the responsibility for the nurturing side of human nature. Consequently, to maintain ideological credibility for capitalism, it is necessary that a substitute for - or at least something to shore up - the family be identified. The community, particularly in a conceptualisation which sets it apart from the more competitive part of society, provides an ideal vehicle.

Hence, community comes to designate a realm which provides a warm nurturing space in which people can practice love, cooperation and selflessness in contrast to the harsh competitive style of the market place. Government bureaucracy becomes the negative term in that it comes to resemble the market place in its methods of organisation and also is seen as responsible for dismantling so many of the former structures of the welfare state. Establishing the term community in opposition to the market place and the bureaucracy enables the idea to be maintained that the capitalist system can adequately meet the needs for human contact and warmth of the people within it. Wilson (1981) makes this point strongly:

> ...`community' is an ideological portmanteau word for a reactionary, conservative ideology that oppresses women by silently confining them to the private sphere without so much as even mentioning them. Moreover it attempts to confine them, or at least implicitly to define them, at the same time as economic policy and social change pushes them into the public sphere of paid work and yet simultaneously removes the last state props that supported them in their work in `the community', that is, in the family. As a first step towards a greater understanding of what women's position in the community actually is, I

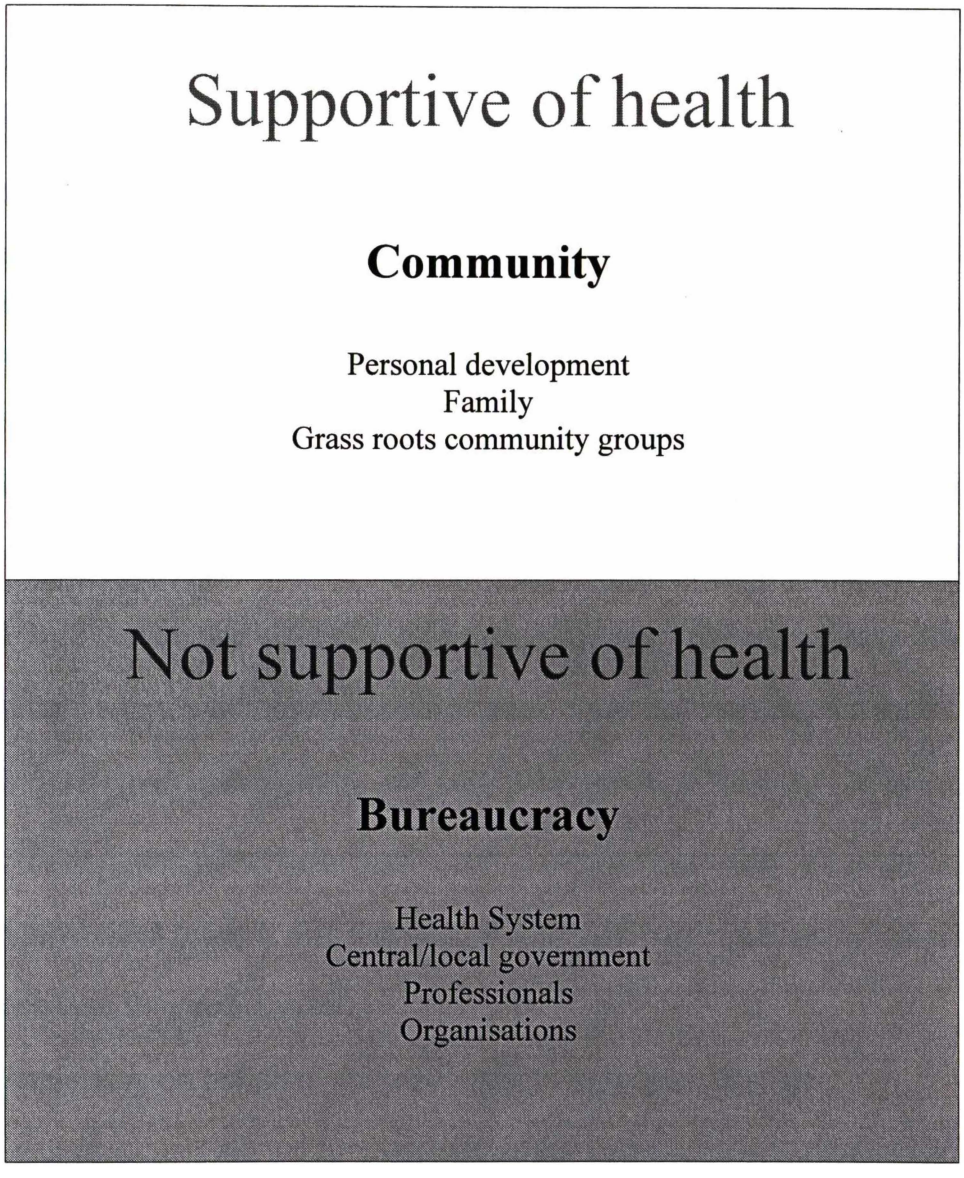
> suggest we abandon the word community altogether--it is only one of the veils of illusion in which we are cocooned" (p. 55).

This analysis of community goes a long way towards explaining first why "community" programmes are so often offered as panaceas to problems from across the political spectrum. Secondly, it also explains why the term is so often set up in opposition to the official structures of government and those of the marketplace. As a consequence of this dichotomy, the "cocoon" of community, as Wilson describes it, becomes associated with all things good and the word bureaucracy with all things bad. This, in the health area, tends to lead to the type of great divide between community as good for health and bureaucracy as bad for health which is set out in Figure 1. Community, personal development, family and grass roots community groups are on the supportive of health side and bureaucracy, the health system, central and local government, professionals and organisations on the other.

Those who have closely examined health promotion rhetoric have identified the tension which arises from this dichotomy running throughout health promotion discourse (Grace, 1991; 1995; Petersen & Lupton, 1996). Baum (1989) talks of the danger of health promotion discourse "hijacking" community development ideas and rhetoric. Grace (1991) muses on the question of why health promotion discourse seems to get "sabotaged and be unable to genuinely reflect its intentions" and why the contradictory position "of being both empowering and controlling infiltrate the health promotion initiative" (p. 333).

Key to these tensions for health promotion is the fact that in its current form it is in large part an activity which is sponsored by the state.

Figure 1: Dichotomy Between Community and Bureaucracy Support for Health



As Petersen and Lupton (1996) argue:

> One central tension emerging from our sociological analysis of the new public health is the relationship between the state and the individual. Although much of the apparatus of the new public health is invested in state-funded and state-run organisations, particularly within local and federal bureaucracies, it is clear that the discourses of the new public health seek constantly to shift the responsibility of the state for protecting the public's health from the state to members of the public themselves. This shift, as we have argued, is supported by the neo-liberal humanist philosophies held by government in contemporary Western societies (p. 175).

This insight needs to be carefully considered by health promoters working in state organisations. Health promotion "community" rhetoric encourages them to move towards community solutions. However, adopted uncritically this can feed into the New Right agenda of forcing communities to take responsibility for social problems rather than making state and collective provision for reducing them. As Minkler (1978) notes, community organisation interventions almost always target poor and powerless groups, and this can be a form of blaming those communities for the problems they experience:

> Intervention on behalf of the powerless to help them change themselves and the larger society must be ethically questioned when concomitant efforts to organize and bring about change in the powerful maintainers of the systems are absent (p. 208).

In order to avoid turning the responsibility for social problem solving entirely onto the community, health promotion needs to ensure that it does not have a

unexamined bias against constructive bureaucratic approaches. Linder and Peters (1990) have described such "actor bias" in the choice of methods for solving social problems. This occurs where there is a bias against one set of actors for policy delivery based on *a priori* preferences for particular ways of going about social problem solving. Referring to the anti-bureaucracy bias, they warn against allowing this to spill over into a bias against particular types of policy instrument, in particular bureaucratic locations and approaches. A good example of this is the community/bureaucratic dichotomy in the public discourse around the Wanganui programme, which did not allow for the view that a strong enforcement element could be one way in which a community could actively use the bureaucracy to respond to its alcohol problems.

Levin (1987) points to the current reality of health promotion which makes the use of bureaucratic locations and approaches as part of the health promotion mix unavoidable:

> However one wishes to characterize the public health establishment, the important fact is that it *is* an established part of governmental responsibility, operating with statutory authority with a well defined organizational structure, distinctive functions, budget, and accountability procedure. While its ideology and experience might not be consistent with the values, goals and strategies of the new public health as envisioned in the Ottawa Charter, the public health establishment as we know it represents the most available and appropriate resource with which to begin the task of building the necessary infrastructure for health promotion (p. 91).

Health promoters need to develop a sophisticated view of the use of community and bureaucratic interventions. When carefully planned to attempt to

avoid the mistakes of the past, there is the possibility for constructive collaboration between community and bureaucratic initiatives and locations.

Clearly, it is not particularly fruitful to simply oppose community health promotion against government/bureaucratic health promotion activity. Figure 2 highlights a view which sees the potential for action supportive of health in both community and bureaucratic approaches and locations.

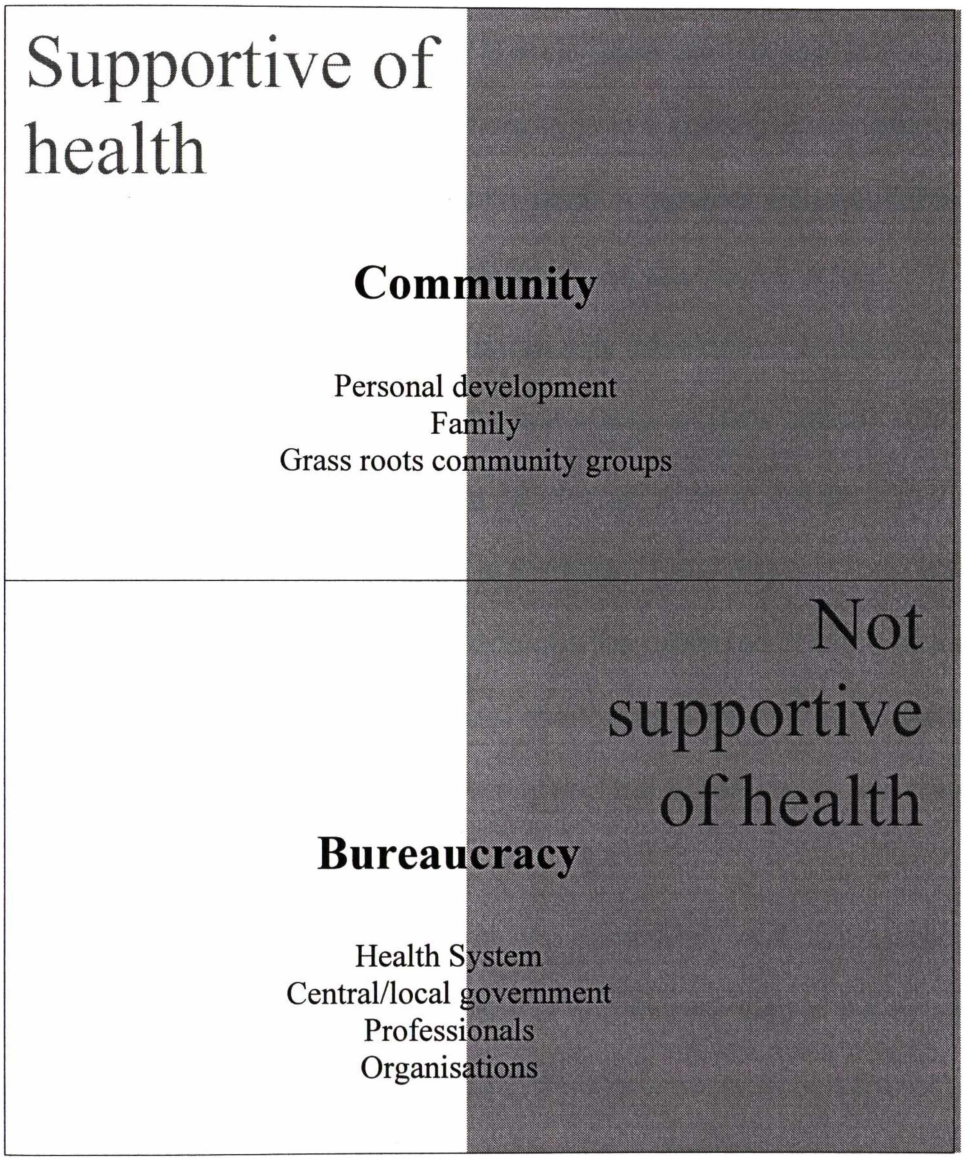
The reasons for not dichotomising community and bureaucracy are summarised here:

- both community and bureaucracy provide locations and approaches which are potentially useful for health promotion;
- a dichotomy feeds into the New Right agenda of removing collective provision for meeting social needs;
- such a dichotomy runs the risk of making the community responsible for the solution of problems which are better addressed within the power and bureaucratic structures; and
- it is simply inconsistent with the current reality of most formal health promotion activity, which is paid for by the state and promoted by bureaucracies.

The Community Organisation Approach Used in the Community Action Project and the Licensing Project

The author was interested in specifying the key elements in the community organisation approach used in the Community Action Project (CAP) and the Licensing Project. This approach was based on the belief discussed in the previous section that health promotion strategies should look to both bureaucratic and

Figure 2: No Dichotomy Between Community and Bureaucracy Support for Health



community settings and approaches. Dixon (1989) has summarised the underlying philosophy in regard to bureaucracy, community and social change which was also behind the alcohol health promotion organiser approach:

> Once community development is put back into perspective, more rational debates can be had regarding the role of citizens in health policy development, and the nexus between health and social change. One scenario under discussion is that citizen involvement in the public policy process is a valuable means to build a constituency committed to social change. Through collective action together with equitable State policies social change may result. An alternative is that community involvement of the community development kind is the precursor to social change. In the first scenario State action, with community support, is the motor for change while in the second the community, with State support, is the motor for change. A long wait lies ahead if this latter course becomes the preferred change strategy. On the other hand, planned social change as a result of a partnership between elements of the community and the bureaucracy can become a reality if history is any guide (p. 90).

This strategy, of a partnership between community and bureaucracy, along with a realistic rather than romantic notion of community, was at the heart of the community organisation approach used in the Community Action Project and the Licensing Project. The seven major characteristics of this community organisation approach (Duignan, Casswell & Stewart, 1993) are discussed in detail below:

1. Based on research findings

The CAP/Licensing Project community organisation approach has as its basis the

research literature addressing alcohol-related problems and the strategies to reduce them. It promotes those strategies which, on the basis of present knowledge and the balance of probabilities, are most likely to be effective in reducing alcohol-related problems. So, for instance, the strategies in CAP were chosen following a careful reading of the research literature over the years preceding CAP. From this reading it was concluded that mass media and other methods of intervention which aim to minimise alcohol-related problems should not focus exclusively on individual behaviour (Wallack, 1980; Holmila et al, 1980). Price, availability and promotion emerged as major areas for activity. Although the emphasis in CAP was more on availability and promotion since the range of community strategies on the issue of price was more limited. In the case of the Licensing Project, the community organisation strategy developed in CAP was further refined and applied to the area of the implementation of alcohol licensing policies. The question of the way in which alcohol licensing policies are actually implemented was emerging at the time of planning the Licensing Project as an important theme in the international alcohol problem prevention literature (Gruenewald & Janes, 1989).

2. Presumes that community attitudes are actively constructed by private interests

The CAP/Licensing Project approach presumes that knowledge and attitudes about alcohol held by members of the community are likely to have been shaped by alcohol advertising, the medical model of alcoholism and media portrayal of alcohol-related problems. The community organisation strategy does not give a privileged epistemological status to unexamined "community" views of alcohol problems or their solutions. Community perceptions on the scale and nature of alcohol

problems, and of potential solutions, is likely to have been distorted by the alcohol industry's positive portrayal of alcohol through advertising and public relations (Casswell, Stewart, & Duignan 1989; Stewart & Casswell, 1990; Wallack, 1983). The community has also inherited the disease model of alcoholism which focuses attention on the individual person with a problem rather than social factors in the wider environment. Mellor (1987) has noted how the feelings of helplessness generated in the community by the way in which the media deals with drug problems give rise to "the formation of community groups reacting to media caricature of drug problems and acting on an uninformed basis on issues of minor concern" (p. 64).

A classic example of this is the concept of a "drug war". Such wars can develop a high level of support because they tap into important veins in community ideology, such as conservative ideology, anti-intellectualism and the desire for simple and clear-cut solutions to problems (Morgan, Wallack & Buchanan, 1988). Hence, while the community organisation approach recognises that such views exist in the community, it does not accept them as a basis for action simply because they are held by a number of people in the community.

3. Enters into a dialogue with relevant members of the community

The findings from the research literature as to the most useful methods of reducing alcohol-related problems act as a starting point for dialogue with a small number of community members who, if convinced of the research conclusions, will support the community organiser in his or her activity in the community.

4. Relies on tacit (not necessarily active) support from the community

Within communities there are various levels of concern about alcohol related problems. This generates at least tacit support at a general level for doing something about the problems alcohol causes. The specifics of what actually needs to be done may initially be different from those strategies supported by the research literature, e.g., sections of the community may want increased penalties rather than increased enforcement and speedier implementation of sanctions; or school-based education rather than licensing changes. However, since the community organisation strategy is clearly attempting to do something about alcohol-related problems and can support its approach with research findings, it tends to get the tacit support of the community for its work. Such tacit support is needed to protect the alcohol health promotion organisers from potential threats from stakeholders who perceive their commercial or other interests threatened.

5. Accepts that few members of the community are likely to have time available to devote to alcohol issues

The CAP/Licensing Project approach does not have as one of its major objectives mobilising large numbers of people around alcohol-related topics. This is because in the settings in which it is being used in New Zealand at the present time those members of the community with skills in community action are already under a great deal of pressure addressing other community issues. In fact, it would seem to be unethical to attempt to draw off the community's own scarce community organisation resources for use on alcohol if they were already being directed in areas such as the prerequisites of health - for instance, housing, employment, and the relief of poverty.

6. Operates in any forum in which it can organise around alcohol issues

The CAP/Licensing Project approach is not limited to operating in any one forum. For instance, in the Licensing Project, one of the regional alcohol workers was able to establish good links with the National Licensing Authority; another forged good links with the Ministry of Transport head office. Both of these are national level bureaucracies. Because the public sector bureaucracy is not seen as in some way inherently opposed to community, the local and national bureaucracy is simply another domain in which to operate.

7. Is directed at putting long term structures in place in the community which will reduce alcohol-related problems

The focus of the CAP/Licensing Project approach is on putting long term community structures in place to reduce alcohol-related problems permanently. For instance, in both CAP and the Licensing Project, considerable effort was put into encouraging local government to adopt policies on alcohol which included their own organisation's use of alcohol, use of alcohol on local government owned land such as sports grounds, and in the case of the Licensing Project a policy on local government's role and perspective on licensing issues. It was hoped that such policies would have an on-going influence on the management of alcohol within communities, in contrast to just running short term alcohol abuse campaigns in the community, such as the Wanganui programme.

These then are the major features of the community organisation approach used in CAP and the Licensing Project. Obviously, it is only one of a number of possible community based approaches. Approaches which are directed at conscientisation and direct empowerment of local communities and groups would involve different methods, styles and locations for action. As already discussed in detail in the section above, the approach set out here is dependent on not

conceptualising community as in opposition to bureaucracy. The major implications for the Health Promotion Strategic Evaluation Framework are as follows:

- in formative evaluation of health promotion programmes, planners should be encouraged to consider a range of both bureaucratic, community and combined approaches; and
- process and outcome evaluation measures of community programmes should be tailored to the particular style of community organisation being employed.

Health Promotion Input into the Policy Making Process

As a result of working on the projects described in this study, the author came to think differently about the relationship between health promotion, evaluation and policy development. Milward's (1982) concept of the *institutionalised thought structure* proved helpful in thinking about this relationship. Milward sees the institutionalised thought structure as the shared conceptualisation of problems and solutions which exists throughout a policy making system. This is the way in which those involved in policy formation and decision making view the key issues, questions and solutions for a policy topic. It is what lies behind the incremental decisions which are made in any policy area. In Milward's view, the concept of the institutionalised thought structure "holds out the hope that social scientists can both understand the system and help to change it" (p. 475).

Input Into the Institutionalised Thought Structure

In one sense the work of the Alcohol and Public Health Research Unit was directed at trying to influence an institutionalised thought structure. Both the Community Action Project and the Licensing Project were attempting to change the institutionalised thought structure on alcohol control policies which lay behind policy makers' actions at both the local and national level. The Unit sought to enter into dialogue with various actors in the policy environment and to bring its research based scientific knowledge to the table. The Unit was interested where ever possible, to enter into dialogue with these groups in order to influence the way ideas are viewed in the policy domain. The Unit has input into the public policy arena through contacts with policy makers, submissions on legislation, comment in the media, dissemination of its reports to policy analysts, and through its work with community health promotion workers and organisations working on health promotion issues.

The ideas the Unit sought to introduce into the institutionalised thought structure about alcohol control policies were not particularly complex in themselves. The core set of ideas around alcohol policy which lay behind CAP and the Licensing Project can be paraphrased as follows:

- in general the more available alcohol is, the more will be consumed;
- in general, the lower the price of alcohol the more is likely to be consumed;
- in general, the more alcohol consumed, the more alcohol-related problems there will be in a given society;
- in general, an industry which is set up to make a profit through the sale of alcohol is likely to take what steps it can to resist attempts to reduce the level of consumption of alcohol, regardless of what it may say its intentions are;

- in general, where laws exist covering the use of alcohol, the enforcement of these laws is likely to reduce the number of alcohol related problems; and

- in general, educational efforts directed at changing an individual's alcohol-related behaviour will be more expensive and less likely to bring about behaviour change than interventions which are aimed at changing relevant aspects of the social structure in which that individual lives.

What is interesting about this set of statements, all of which are based on the research literature (see reviews Ashton & Casswell, 1986; Casswell & Martin, 1986; Casswell & Stewart, 1986) is that they are so apparently simple. Nonetheless, getting these ideas accepted by important stakeholders in the policy domain is a continual challenge. Given their almost self-evident nature, the question needs to be asked of why a research programme should be needed to substantiate such statements and to promote them as input into policy making in the alcohol area. To understand why, it is worthwhile putting in the place of alcohol another drug which is not used so widely, and does not have a legalised industry to support it. This provides the following statements:

- in general the more available heroin is the more will be consumed;

- in general, the lower the price of heroin the more is likely to be consumed;

- in general, the more heroin consumed the more heroin-related problems there will be in a given society;

- in general, an industry which is set up to make a profit through the sale of heroin is likely to take what steps it can to resist attempts to reduce the level of consumption of heroin, regardless of what it may say its intentions are;

- in general, where laws exist covering the use of heroin, the enforcement of these laws is likely to reduce the number of heroin related problems; and

- in general, educational efforts directed at changing an individual's heroin related behaviour will be more expensive and less likely to bring about behaviour change than interventions which are aimed at changing relevant aspects of the social structure in which that individual lives.

These statements about heroin are contested by few in the mainstream policy community. However they are regularly contested in regard to *alcohol*, when in fact there is no logical reason why they do not prima facie apply to alcohol as much as to heroin. The reason for the controversy in the case of alcohol is clearly that accepting these theoretical statements has consequences for social policy; alcohol is a widely used drug, and there is a well organised lobby from the alcohol industry intent on challenging statements such as those set out above. As a result these statements are regularly contested in the public arena. To take one example, the theoretical statement *in general the more available alcohol is, the more will be consumed* was examined in the Laking Report (Working Party on Liquor, 1986), which was produced by a committee set up by the New Zealand Government to investigate licensing laws and which led to the introduction of the Sale of Liquor Act 1989. The Laking report did not accept the connection between alcohol availability and consumption and the new legislation was developed on this basis. A Parliamentary Select Committee investigating the proposed legislation reported criticism of the way in which the Laking Report had dealt with the availability evidence:

> The Department of Health cited the views of Dr J McDonald, Assistant Director of the NZ Council of Educational Research, Dr J V Hodge, Director of the Medical Research Council of New Zealand and

> Professor J S Fraser, Massey University that the credibility of the Laking Report was weakened by its manifestly partisan approach to the question of a possible relationship between availability, consumption and misuse of alcohol. The above accepted the view, based on "international evidence", that a relationship between availability and consumption cannot be excluded and may, indeed, exist (Report of the Committee..., 1989).

However, in spite of reporting this criticism, the Parliamentary Select Committee, as had the Laking Committee, again failed to accept the availability theory. This provides a classic example of how difficult it is to have apparently simply statements incorporated in the institutionalised thought structure where these are contested.

Symbolic Role of Particular Projects in the Policy Making Process

The Wanganui Community Alcohol Action Programme provided a further fascinating insight into the way in which research and evaluation results are dealt with if they do not fit the institutionalised thought structure of the day. As outlined in Chapter Five, the current view in the evaluation literature of how evaluation results from a project are used in policy formulation is much more sophisticated than it was in the early days of evaluation research. The early view was that evaluation research findings would automatically be received with open arms by policy makers and directly applied to decision making on policy issues. The consensus view now is that research findings are only one of many inputs into policy making and form part of the process of "enlightenment" of those in the policy community. What happened in the case of the Wanganui project was that the project assumed symbolic

significance as a positive example of a "community" alcohol programme which was largely unrelated to what had actually happened in the programme or to the evaluation findings.

The Wanganui programme was established as a pilot project. However, there was no clear conception as to what it was actually piloting. Firstly, the project included two different threads: community coordination and increased enforcement. Given that previous research suggests that enforcement campaigns can decrease alcohol related road crashes in at least the short term (Ross, 1988), it is unclear how a pilot which contained both interventions running at the same time could possibly untangle their effects. Therefore, outcome data produced from the programme (de Jongh and Bailey, 1987) could not provide any information on how the community coordination strategy would function *without* heavy enforcement.

Moreover, though the Wanganui programme was ostensibly a pilot, it was unclear whether it could be replicated in the future. The enforcement was undertaken by pulling traffic police into Wanganui from all over the region. But how could this level of resources be made available on a long-term basis to other communities? Graham and Birchmore-Timney (1989) point out that lack of replicability is a major problem in evaluation research. Given this, and the difficulty of untangling the effects of two interventions, it was questionable whether the Wanganui Project would be able to provide useful information for input into the policy debate around dealing with alcohol problems.

The lack of clarity about the exact questions the Wanganui Project was attempting to answer can be traced to its origin. The project stemmed from a meeting between the New Zealand Parliamentary Under-Secretary of Transport and the New Zealand Liquor Industry Council, a trade organisation. This meeting was held in response to a high Christmas period road toll. During the meeting the Under-

Secretary discussed with the industry its statutory obligation to refrain from serving alcohol to intoxicated patrons. Industry representatives suggested that a "community campaign" could be run in a selected small town or country area in which the local community would set up a team to ensure drinking laws were observed. As an outcome of the meeting, the Ministry of Transport was asked to investigate this suggestion and developed a proposal which was accepted by Cabinet.

Each of the groups which had input into the policy-making process behind the Wanganui Project had their own interests to promote, in addition to their concern to do something about the toll of alcohol-related road crashes. The Under-Secretary of Transport, as a national politician reliant on re-election, had an interest in the amount and nature of the publicity such a scheme would generate. The Liquor Industry Council had an interest in broadening the focus away from specific attention on the industry's compliance with the legislative requirements regarding the serving of liquor to intoxicated patrons. The Ministry of Transport had an interest in being seen to be doing something about the road toll. Within the Ministry, researchers had an interest in ensuring a project with a substantial research design. The enforcement branch of the Ministry had an interest in maintaining its prominent profile in the drinking and driving area. And finally, Cabinet had its own political agendas.

The decision which finally emerged met a number of the hypothesised interests of the groups involved. The Under-Secretary had a highly visible project which would attract publicity. The Liquor Industry Council had the emphasis moved off the industry and onto the community. The research section of the Ministry of Transport had a research project they could evaluate and the enforcement section had the opportunity to make their presence felt.

Hence, in the case of the Wanganui Project, the question being asked by the pilot was not linked in any systematic way to priority questions in the area of reducing alcohol-related problems in New Zealand. However, this did not seem to detract in any way from the project continuing to play a symbolic role in policy related discussions around prevention of alcohol problems in New Zealand.

The most important symbolic feature of the Wanganui Project rapidly came to be its "community" focus. The background to the programme and the reasons that a community approach was adopted were set out by the Ministry of Transport (1988):

> It [the program] arose out of a concern about the serious role of alcohol in road accidents and a desire to attack the problem in a different way. In developing a new approach it was recognised that road accidents are just one consequence of alcohol misuse. Violence, ill health, unemployment, absenteeism, crime and vandalism are other social problems often associated with alcohol. It was eventually decided to plan a community-based program in an attempt to mobilise local resources to raise the level of awareness of alcohol misuse and its consequences not only in respect to road trauma but also across the other problem areas mentioned above. The community would, thereby, be challenged to join forces in promoting a more responsible attitude to alcohol drinking. It was designed as a pilot study which, if successful, could be used as a model for other parts of the country (p.1).

The project, then, was established because "something had to be done" in response to the problem of the Christmas road toll. This "something" became a "community" initiative. Therefore Wanganui came to symbolise community initiative

in response to alcohol problems. In fact it was far from many conceptualisations of a community programme and did not appear to draw on any modern health promotion approaches to community development. A measure of this lack of genuine "community" focus in the programme was the way its planning proceeded in isolation from the local community. During the Christmas immediately before the May in which the programme started, another community alcohol campaign had been run in the same town. This was the Drink, Drive, Die campaign organised by the Wanganui Area Health Board. At the time the decision was made in Wellington to run the Wanganui project, the programme organisers in Wellington (where the Ministry of Transport Head Office was based) did not know that the Drink, Drive, Die campaign would be taking place. The fact that Wellington was unaware of the Wanganui Drink, Drive, Die campaign is a measure of the program organisers lack of involvement with the community in which they were hoping their programme would run. This lack of contact did not bode well for the success of the Wanganui campaign as a community programme.

It was argued earlier in this chapter that certain types of bureaucratic action can be effective for health promotion when not opposed to community action. However this is not an excuse for believing that bureaucrats can just wander into communities and announce that a community campaign is going to take place there. Community programmes need to be integrated with the approaches, frameworks and initiatives of the local community. This was the approach which was used, for instance, in the Community Action Project and the Licensing Project. In contrast, the Wanganui Project was very much something thrust into the community without allowing time for the developmental work to be done to identify whether there was a place for it in the Wanganui community itself.

The evaluation findings from the Wanganui project were largely negative. The de Jongh and Bailey (1987) outcome evaluation report attributed the main observed effect to the earlier Drink, Drive, Die programme run by the Area Health Board. In addition, the Duignan and Casswell (1988b) process evaluation raised serious questions about the project as a community strategy, as set out in this section. However, in spite of these findings, the project came to be viewed as a considerable success. It developed a momentum of its own within the institutionalised thought structure and became a significant example of what "should" occur. This is without particular attention to what actually happened at Wanganui or to the reported evaluation findings.

Indeed, the Ministry of Transport (1989) used the example of Wanganui in a strategy document on increasing road safety in the future strategies section discussed community interventions and noted:

> This is an area in which integrated programmes can be most effective. The 1987 Community Alcohol Action Programme in Wanganui...demonstrated the value of local organisations working together to attack a specific problem. Much was learnt from this programme and the results were sufficiently encouraging to justify further efforts along similar lines. (p. 25).

In actual fact there had been a number of other community drink drive programmes in New Zealand at that time, most of which had been initiated in association with local health authorities and were much more integrated, localised and sustainable initiatives than the Wanganui Project. The reasons why Wanganui continued on as a symbol of a successful community programme, when in fact it could be argued that it was far from this, lie in the policy making process itself. Firstly, the political forces which originally gave rise to the pilot programme did not

go away simply because of the negative evaluation results of one project. As Suedfeld and Tetlock (1992) note, "policy abhors a vacuum". Given that the social, economic and political problem of alcohol-related road crashes still existed and the make up of the Wanganui programme met so many of the stakeholders' interests, it was much more likely that Wanganui would be promoted as an ideal than that it would be declared a wrongheaded adventure.

Secondly, within the policy making process, because of the range of issues to be dealt with, there is a tendency to adopt simple approaches to solving social problems. The Wanganui Project provides an ideal example. Instead of grappling with all the issues involved in community development, alcohol impaired driving and other alcohol problems, the push was for the much easier option, of high visibility and a contemporary community label.

Thirdly, pilot programmes within communities should not be conceived as simply experimental-type exercises where an intervention can be introduced from outside the community, trialled and then continued or removed depending on the results of the trial. Clearly within the institutionalised thought structure there was the idea of being able to go into a community and within a couple of months run an "experimental" community programme. Work with communities must be based on building long term relationships and over time embedding changed ways of doing things which are more supportive of health. Whatever happens in terms of a trial in a community needs to be framed as a part of an ongoing process rather than a one-off experiment. This leads to a somewhat different perspective on what it is that pilot programmes in communities should be trying to achieve. The role of many such programmes is more one of boosting moral, giving a sense that something can be done, and sparking other initiatives, than it is about trialling a particular intervention. This view does not sit easily with the idea of pilots and their evaluations leading to

go/no-go decision points. Once one starts working with a community there needs to be a commitment that, regardless of the continuing vicissitudes of funding and other factors, those sponsoring the programme will have designed and implemented it in a way which maximises its ongoing usefulness to the community. The Wanganui project was not set up with this sort of approach in mind.

For these reasons, then, the Wanganui project continued to be prominent in policy discussions about drinking and driving. Because the Unit had undertaken the process evaluation of the Wanganui project, it had a voice in the ongoing debate about community programmes and alcohol control policy measures which followed Wanganui. For instance, following the Wanganui Programme, the Alcoholic Liquor Advisory Council (ALAC) encouraged the undertaking of more such projects in the future. Staff and council members from ALAC visited the Alcohol and Public Health Research Unit to discuss this issue. At this meeting ALAC representatives raised the idea of repeating the Wanganui Project somewhere else in the country.

The author, Dr Sally Casswell, and other representatives from the Alcohol and Public Health Research Unit argued that, instead of a repetition of the Wanganui project, what was needed at this stage was coordination at the national level of the various initiatives being undertaken in the alcohol impaired driving area. The best way of doing this was to hold a national policy meeting whereby coordination could take place. Following this ALAC held a national summit on alcohol impaired driving and the emphasis moved more towards national strategy coordination rather than community programmes along the lines of the Wanganui Project.

Following this broadening of the agenda, individual community projects were established such as the CARS project (Slack, 1991), which ostensibly used Wanganui as a model, but which were influenced to a large extent by the broader agenda of the approach which ALAC was taking at the time.

In the discussions with ALAC and in other policy forums at the time there was little point in directly critiquing the Wanganui Project. It had gained such a symbolic hold in the institutionalised thought structure that it had to be worked with rather than taken off the agenda. The suggestion that the discussion be moved up to a consideration of wider issues enabled Wanganui to continue in the policy debate as an example of a community programme. Because later community programmes were influenced by the wider agenda they no longer had to mimic the problematic elements in the Wanganui programme.

This section has looked at the relationship between policy formation and health promotion evaluation and research. It has highlighted the following points:

- where ideas, such as those on alcohol control policies, are strongly contested by powerful stakeholders it will be difficult to have them accepted in the institutionalised thought structure which lies behind the way issues, questions and solutions are viewed by policy makers;
- one of the roles of evaluation projects such as CAP and the Licensing Project is to feed research based information into the policy making process; and
- within the policy debate, health promoters have to work with the symbolic status of some programmes even though this status may have little resemblance to either the actual nature or evaluated results of such projects.

This section has the following implications for developing the Health Promotion Strategic Evaluation Framework:

- health promoters should be strategic about their evaluations and when designing them have an eye to their impact on the institutionalised thought structures around health promotion topics;

- piloting a programme in a community should be part of an ongoing relationship with that community and is not a matter of going in, running a program and then being able to continue or withdraw it simply on the evaluation results;

- decisions about which programmes to evaluate at a particular point in time should be made on a strategic basis depending on what are the current issues in the institutionalised thought structure. For instance in the case of the Wanganui Project, the Alcohol and Public Health Research Unit undertook a process evaluation because it enabled the Unit to be involved in the ongoing policy debate about alcohol health promotion. It was clear that the Wanganui project was going to play an important role in the institutionalised thought structure because it had a group of important stakeholders involved in its establishment.

Summary

This chapter has looked at a number of questions which were raised for the author as a consequence of being involved in a series of health promotion evaluation projects. The conclusions from each section have been considered in the development of the Health Promotion Strategic Evaluation Framework along with the issues examined in the next chapter.

CHAPTER EIGHT

FURTHER QUESTIONS RAISED BY HEALTH PROMOTION EVALUATION INVOLVEMENT

This chapter considers three further issues in health promotion evaluation. The impetus for thinking through these three issues arose as much from the author's wider involvement in health promotion evaluation as from the specifics of the five projects outlined in this study. In particular this was his involvement in running a series of workshops on health promotion evaluation for health promotion practitioners. This chapter looks at the impact of changing health administration systems and structures on demands for health promotion evaluation; the rationale for using the three way distinction between formative, process, and outcome evaluation in health promotion evaluation; and issues in distinguishing between formative evaluation and programme planning and implementation.

Changing Health Administration Systems and Structures

The introduction of managerialism in the New Zealand health sector has spanned the period in which the author has been working in health promotion evaluation. This section looks at the impacts of changing health administration systems and structures on the nature of demands for evaluation.

The decade of restructuring of the New Zealand health system which began in the mid 1980's has seen a range of different incentive structures for health promotion evaluation as waves of reform, introduced by successive Governments, have swept thorough the health sector. These changes have been reflected in the

comments of health promotion practitioners in the course of the workshops on health promotion evaluation run by the author and his colleagues. The types of issues about evaluation raised in the workshops have corresponded to the successive phases of managerial incentives sweeping through the system.

A first set of issues arose during the early phase of restructuring which established the Area Health Boards (Minister of Health, 1989). Health promotion became the responsibility of these Boards, which were also responsible for most clinical services in their districts. Prior to this, much health promotion activity had taken place from district offices of the Department of Health, which were separate from the Hospital Boards responsible for local clinical services. This first phase led to comments by health promotion practitioners at evaluation workshops that they were being pressured by management to produce proof that funds spend on health promotion evaluation would produce savings. The managers were responding to the need to make funding allocation decisions between clinical services and health promotion activities. The typical observation made in the workshops at the time was that managers were being forced to decide between things like more children's medical beds or health promotion programmes which might not have any return for a number of years. Clearly health promotion was likely to lose out if returns could not be documented through evaluation.

The second phase was the introduction of a set of national goals for health. These included the reduction of alcohol consumption. The author, in conjunction with Associate Professor Sally Casswell and via Professor Robert Beaglehole of the Auckland Medical School, had some input in developing this goal. The establishment of these goals was followed by an attempt to earmark funding for Area Health Boards for specific national health goal topics. In this phase, there was

an attempt to tie overall Area Health Board contracting to improvements in the priority health goal areas which had been established. Area Health Board contracts with the government required the setting of targets, expressed in "specific terms, defining what is to be achieved (in quantifiable terms) and when this is to be achieved by" in respect of a set of New Zealand Health Goals (Minister of Health, 1989). In this phase, discussion among health promotion practitioners in the evaluation workshops turned to the evaluation issue of whether it is wise for an organisation to contract for the achievement of targets which are not entirely within that organisation's ability to achieve. For instance, in the case of the alcohol consumption goal, overall economic factors could affect the levels of consumption throughout the country, including within a particular Area Health Board district. No matter how well alcohol health promotion programmes had been conducted in that district, consumption could still rise and in terms of the Area Health Board's contract it would then have failed to meet its contractual obligations.

A third phase occurred during the restructuring of the health sector into Regional Health Authorities (RHA) responsible for purchasing health, Crown Health Enterprises (CHE) which delivered services, and a Public Health Commission (PHC) nationally responsible for the public health and health promotion areas (Ashton et al. 1993). In the initial stages of this restructuring there was general dissipation of effort regarding evaluation issues as health promotion units sought to fit within restructured Crown Health Enterprises. As a general reflection of the amount of change in the health sector during this period, it was reported to the author by one participant at a health promotion evaluation workshop that they had worked under nine different management structures in the course of the past seven years.

A fourth phase took place when health promotion practitioners started to settle into the new environment and come to terms with the role of the Public Health Commission. The Public Health Commission was responsible for ensuring that public health services were purchased from providers and for providing advice to the Minister of Health on public health issues. The first implication for evaluation was that it was now structurally clear that health promotion services could be purchased in their own right. This took some of the heat out of the notion of evaluating health promotion in terms of a direct comparison with funding for clinical beds.

The second implication, in relation to reporting procedures introduced by the Public Health Commission, was complaints from the health promotion practitioners that the Public Health Commission was only interested in "number crunching" in terms of evaluation. This issue arose from the fact that the Public Health Commission (PHC) asked only for such relatively trivial output data as the number of meetings health promotion practitioners had attended in the course of running a health promotion programme or the number of pamphlets produced. The practitioners believed that the outcomes of a programme were much more important than figures about the number of meetings or pamphlets.

The PHC request for only this type of output monitoring information was however consistent with the logic of the State Sector Act (1988) and the Public Finance Act (1989), which were the corner stones of New Zealand public sector financial management reforms (The Treasury, 1990). These reforms were based on the notion that it was the responsibility of Ministers and Ministries to deal with the link between outcomes and outputs (the evaluation question) and that service providers were simply being contracted to provide certain outputs, not to deal with the question of outcomes. This issue was extensively discussed at health

promotion evaluation workshops at the time with two viewpoints being aired. One view was that providers should simply do the "number crunching" and get on with programmes since that was all that was being statutorily required of them at the time. The other view was that, regardless of the prevailing statutory requirements, from a professional and public accountability point of view they had to continue to seriously grapple with the issue of the effect of their programmes on outcomes.

The controversy in this phase reflects a central evaluation problem in the whole outcomes/output aspect of the public sector reforms in New Zealand. The problem is that leaving the responsibility for linking outcomes to outputs just at the Ministerial and Ministry level assumes that it is possible for this task to be undertaken at a centralised policy analytical level. In other words it assumes that there are effective evaluation methods, and sufficient resources, available to policy analysts in the Ministries to enable them to get a grip on the link between outcomes and all of the different outputs which are being purchased. In fact, it can be strongly argued that evaluation of the link between outputs and outcomes must involve itself extensively at the level of those who are providing the outputs because they are the ones closest to the ground in terms of the actual effects that programmes are having.

It can be expected that a new set of issues will arise now that we are into yet another period of health sector reform, with the Public Health Commission having been disestablished and moved into the Ministry of Health, the amalgamation of RHA's and the restructuring of the Crown Health Enterprises as set out in the coalition agreement of the new 1997 government (New Zealand First & New Zealand National Party, 1997). The implications of this most recent round of restructuring in terms of the managerial incentives which will affect health promotion

evaluation are hard to determine. However, the announced policy of the new Government involves "greater emphasis to health gain" and the maintenance of the separation between funder and provider in the health sector (The Evening Post, 1997).

How can the uncertainty in health promotion evaluation demands generated by the waves of structural change be reduced? Several steps are possible:

- health promotion practitioners should "take the debate back to its source". The author has seen many instances where practitioners have quietly accepted totally unrealistic demands for evaluation. They should be encouraged to go back to the programme funders who are making such demands and put to them the issue of the difficulty and cost of measuring health promotion outcomes, rather than mutely accepting demands and then being unable to deliver credible evaluations; and

- There may be some merit in a sector conference on health promotion evaluation which would include funders and providers from across the sector. Firstly, such a conference would discuss basic principles in evaluating health promotion programmes, including the difficulty of measuring outcomes when these are long term and are only one part of a number of strands of health promotion activity; the issues in evaluating community programmes; and new paradigms and models for evaluation. Secondly, it could look at the current key issues for evaluation right across the sector. This could then give guidance in decision making about the level and type of evaluation for specific projects.

This section has tracked changing demands for different types of health promotion evaluation which have accompanied waves of structural reform in the

New Zealand health system. In conclusion, the implications for the Health Promotion Strategic Evaluation Framework are:

- regardless of the evaluation demands produced by the particular health sector managerial incentive structures at a particular point in time, health promoters should continue to attempt to undertake strategic evaluation projects;
- health promotion practitioners should be willing to enter into dialogue with those who are demanding evaluation; and
- the type of evaluation which should be used on a particular programme needs to be looked at in terms of what the evaluation issues for the sector are rather than exclusively focusing just on the one programme which is being considered for evaluation.

Advantages of Three Way Formative, Process, and Outcome Split

In Chapter Five a typology for evaluation was offered which divided it into formative, process and outcome evaluation. This section provides a justification for the use of this typology in looking at health promotion evaluation. As has already been indicated, the evaluation literature contains a range of terms, including formative, process, outcome, impact, utilization-focused, stakeholder and summative (Patton, 1986a; Shadish, Cook & Leviton, 1991; Weiss 1984). The health promotion literature also reflects a range of evaluation terms. For example, Bank (1987) describes using utilisation focused evaluation. Altman (1986) sets out a framework for evaluating community-based heart disease programmes based on a three-way division: evaluation of process, including longitudinal assessment and

untangling the effects of the intervention from other influences and qualitative analysis; evaluation of psychological and social effects which includes conceptualising a broad range of outcomes and assessing the independent effects of specific interventions; and evaluation of social relevance which includes cost-effectiveness, utilisation of findings and generalisability. Nutbeam, Smith and Catford's (1990) model for evaluation in health education makes a distinction between outcome and process evaluation, where outcome evaluation shows whether the intervention has achieved its goals and process evaluation assesses how a programme is implemented and the who, what and where of intervention activities in addition to assisting in attributing causality to the programme intervention.

The particular three way typology of formative, process and outcome evaluation was used because it because it provided a way of thinking about evaluation which could deal with the needs of health promotion as it was developing in New Zealand at that time. There was an unexamined demand for outcome evaluations based on medical and health education models of evaluation. The Unit used to be approached by health promotion managers with requests that the Unit undertake outcome evaluations, usually with funding already available. Typically, the projects had been going on for some time and it was usually clear that they had not been designed with modern health promotion's systemic focus. There seemed little point in undertaking outcome studies when such programmes seemed to be clearly heading in the wrong direction.

The concept of formative evaluation which was emerging in the evaluation literature at that time provided a useful way of justifying the use of evaluation resources at the earlier rather than the later stages of a programme's life cycle. To

the author and the Unit this was a more fruitful use of evaluation resources than to undertake outcome evaluations of programmes which we knew to be ill-formed. This view was further reinforced by the difficulties of undertaking outcome evaluations of programmes which were embedded in communities and were only one thread in a mix of different strategies leading to a set of outcomes.

The term process evaluation could have been used and interpreted widely to include formative type activity as it is by some in the literature (Hale, Arnold, & Travis, 1994). However, the advantage of pulling out the specific term formative from within process evaluation is that its name clearly reflects its intention - to ensure that programmes are well formed. In the early health promotion environment, where hands-off outcome evaluation was the expected norm, the name formative evaluation legitimised the evaluators close involvement in programme formation in a way that the term process evaluation did not.

Another approach could have been to use the term *evaluability assessment* (Wholey, 1977). This is the assessment of a programme to see if it is worthwhile undertaking an outcome evaluation. This term was not used for two reasons. Firstly elements of it can be subsumed within the wider term formative evaluation. Secondly, it seemed to imply a go/no-go type of situation involving a decision as to whether *any* evaluation resources should be spent on a programme. The author's perspective was that the decision as to whether to spend evaluation resources on a programme should not be dependent on whether or not an outcome evaluation was able to be carried out. Regardless of whether an outcome evaluation could be justified, a case can be made for using evaluation resources on formative evaluation if there was a good chance of influencing programme planning in the direction of systemic health promotion strategies.

A further, broader, term which included some of the elements of formative evaluation is *action research* in the tradition of Lewin (1948). However there were three reasons for not using this term: firstly, formative evaluation work is a part of evaluation, labeling it clearly as evaluation legitimises its right to draw on resources earmarked for evaluation; secondly, regardless of what actually happened under the term action research, its name put the emphasis on *research* while the term formative evaluation's implication is that the focus is on the programmes which is being evaluated; and thirdly, the term action research is more politicised than formative evaluation. In a New Right environment dealing with politicised health promotion subjects such as alcohol, formative evaluation activity seems much less likely to be attacked by those antagonistic to health promotion than formative evaluation which clearly labels its intention as being to ensure well formed programmes.

The use of the term *process evaluation* needs less justification because it is in wider currency than formative evaluation. In the way it was used in the chosen typology it did not include the formative evaluation aspects but was concerned with providing a detailed description of a programme.

Lastly, *outcome evaluation* was used to describe looking at whether a programme had met its objectives. This term was used because it enabled a clear juxtaposition with formative and process evaluation. An alternate term which could have been used was *impact evaluation* which incorporates a recognition of the difficulty in many instances of measuring final outcomes. However, it seemed useful to use outcome evaluation (which could include intermediate impact type outcomes) in order to use a terminology medical, managerial and other colleagues could recognise. Making a clear distinction between formative, process and outcome

evaluation facilitated frank debate taking place around the relative priority of the three different types of evaluation for different types of programmes at different points in time.

Other important terms from the evaluation literature which were not used in the typology were: summative evaluation, utilization focused evaluation and stakeholder evaluation (Patton, 1986a; Shadish, Cook & Leviton, 1991; Weiss 1984). Summative evaluation, designing and using evaluation to judge merit (Shadish et al. 1991), was not used explicitly since it was too global a term, even though it is basic to all levels and types of evaluation. Utilization focused (Patton, 1986a) and stakeholder evaluation (Weiss,1984) are prescriptions for approaching evaluation which argue for a focus on determining evaluation questions and methods on the basis of the needs of stakeholder users, including programme planners. This approach generally informed the way in which evaluation was conceptualised in the Strategic Evaluation Framework but, as with the term summative evaluation, they were global statements rather than at the specific level of formative, process and outcome evaluation.

As discussed here, the formative, process and outcome typology was used for very specific reasons in the Health Promotion Strategic Evaluation Framework. It has continued to prove to be a workable typology.

Distinguishing Between Formative Evaluation and Programme Planning and Implementation

The last question raised for the author by his experience in the projects described in this study is how evaluation research can be distinguished from programme implementation. In particular, how can this be done in the case of formative evaluation? Within health promotion there are calls for increased

cooperation between researchers and practitioners (Kok & Green, 1990) and formative evaluation allows the possibility for such close cooperation. From this point of view there is no particular need to draw a distinction between research and practice. Many of the things that formative evaluators may participate in (needs assessment, objective setting, pretesting) are also the central tasks which programme planners have to undertake. However, it is important to look at the relationship between formative evaluation and programme planning in order to assist formative evaluators to be more effective in handling the issues and conflicts which are likely to arise. In addition, research funders are keen to understand the distinction between formative evaluation and programme planning so that they can determine which are the legitimate calls on public research funding, and which should rather be the responsibility of normal health promotion programme funding.

The close relationship between formative evaluation and programme implementation is seen in the fact that formative evaluation is often seen as a process carried out by internal evaluators. For instance, McClintock (1986), in his outline of formative evaluation looks at it from the point of view of internal evaluators. Given that by its nature formative evaluation work attempts to ensure that a programme is well formed, it is clear that there is not going to be a clear line between the activities of research and project staff. This is in contrast to the traditional model of evaluation where the evaluators were often brought in from outside and maintained a rigorous separation from programme staff on the basis that to not do so would compromise their scientific integrity.

Morris and Fitz-Gibbon (1978) outline the situation where there is a merging of the formative evaluator with the staff:

> In many cases the formative evaluator is practically a program staff member, gathering opinions about preferred or more effective ways of installing the program; perhaps conducting short experiments to answer controversies that arise among the staff; and holding discussions to help the program planners achieve a comprehensive and rational statement of what the program is supposed to be doing (p. 11).

In a later discussion, in terms of the development of formative evaluation, Means and Smith (1988) can be seen to be struggling with maintaining the line between the formative evaluation and the project staff role:

> Certainly, in the early stages of the evaluation it would have been easy to allow a complete blurring to occur between the evaluation team and the programme, a situation made a real possibility by programme staff resignations that, at one stage, made the evaluation team the main constant in the history of the programme. The evaluation team played a more visible and a more interventionist role on many occasions in this period than it would have liked...However, the evaluation literature does give numerous warnings on this point and this has helped evaluation team members to resist the temptation to act on behalf of the programme. Agreement to perform a task has always been questioned in relation to overall research priorities and in relation to appropriateness (p. 26).

Fitzpatrick (1988) raises a question which is particularly relevant to formative evaluation - personal identification by the evaluators with the design or method of delivery of the programme. Such personal identification can jeopardise evaluator's ability to carry out outcome evaluation. Fitzpatrick encourages evaluators to adopt the attitude recommended by Campbell (1975), which consists of viewing programmes as experiments and so not being attached to the particular outcome of any one particular programme but moving forward through a series of social experiments. She believes that such an approach permits a more objective examination of outcomes. In an example of the formative evaluation of a nutrition education programme, Edwards (1987) also talks about her impression that the evaluation input was "biasing" the formation of objectives. She used outside experts in the field to provide critical feedback on the initial objectives.

In the projects examined in this study, similar issues arose. Firstly, there was the effect of health promotion's relative newness as an area of endeavour. This meant that evaluators, tended to carry with them knowledge about health promotion methods which had, in a number of instances, not yet reached health promotion staff. A good example of this is the area of community action. The knowledge gained by Unit evaluators through involvement in the Community Action Project and the consequent work of the alcohol health promotion organisers was essential to the evaluators in grappling with the problems raised by the question of community development and action in the Wanganui, Heartbeat and the Licensing Project evaluations.

As evaluators are involved in more projects they obviously become something of subject specialists in addition to evaluators. This means that they then become actively involved in discussions around the choice of health promotion strategies for

particular projects and, naturally enough, they push for methods which fit with modern health promotion practice. However it remains the role of the formative evaluator to constructively critique and that of the project planner and manager to finally decide on what strategies the programme is going to use.

Team Approach to Evaluation

The method of working which evolved in the course of the projects described in this study was a team approach to evaluation. In all of the projects reported here involving formative evaluation a team approach, rather than an individual evaluator, was used. In the case of the Licensing Project, three evaluators worked as a team, in addition to a contract interviewer. This was also the case in the Heartbeat evaluation. In each of these evaluations the relationship between team members and project staff varied.

The closer an evaluator is to project staff the more they are likely to become an advocate for the particular programme they are evaluating. On the other hand, the more distant evaluators are from a programme, the more they are likely to fail to understand the details and dynamics of the programme being evaluated. In the team approach used in the evaluations reported here, the perceptions of each of the evaluators were combined. This has the benefit that some of the team could become close to the programme and programme staff perspectives. On the other hand, other members of the formative evaluation team were able to take a more detached and constructively critical perspective. The weaving together of these two streams, in the author's view, enabled the programmes which were being evaluated to benefit from both perspectives. The proposals put forward for programme improvement hopefully took into account both the on-the-ground reality of the project and also a more independent overview.

The Formative Evaluation Lifecycle

One of the interesting findings to arise out of the Heartbeat Project is the notion of a formative evaluation lifecycle. This is not simply the notion that at different stages in a project different types of evaluation input are more appropriate, e.g., formative at the start, outcome near the end. The lifecycle referred to here is in terms of the relationship between the formative evaluators and project staff and management. As a programme develops this relationship changes.

Such a lifecyle could be characterised as follows:

Initial Acceptance

Initial nominal acceptance of the concept of evaluation by project staff. Enthusiasm on part of evaluators to be involved in a new project.

Suspicion

Project staff suspicion about what the evaluators will do. Evaluators' concerns about how they will win the trust and co-operation of project staff.

Working Together

Overcoming suspicion and working together. Project staff realisation of the value of formative evaluation. Evaluators realising the skills that project staff have.

Involvement

Increasing involvement of the evaluators to the stage where they are closely involved in programme planning and design. Lots of positive feedback and mutual support.

Concerns at Over-Involvement

Concerns by project management and staff that evaluators are playing a too dominant role in the planning and running of the programme. Concerns by evaluators that they may be losing their ability to provide an outside perspective on what is happening in the project. Fears by evaluators that they are turning into programme planners rather than evaluators.

Separation

The possibilities at this stage are for a fresh evaluation team with new staff; less involvement of the formative evaluators in the programme; a cessation of the formative evaluation.

Seeing formative evaluation in terms of a lifecycle such as this enables both evaluators and project staff and management to realise that changes in their relationships may be a result of a normal cycle in the relationship. In the case of the Heartbeat programme, the cycle moved through to the point where the formative evaluation came to an end. In the case of the Licensing Project the formative evaluation lasted across the formal course of the project. However, the Licensing Project was part of an ongoing process of research support for the community alcohol health promotion organiser work which has progressively moved through a series of cycles of formative evaluation, e.g., CAP, the Licensing Project, and now more recently a new project, set up along similar lines as a Youth Alcohol Project at the request of alcohol health promotion organisers.

As for the aftermath of the formative involvement with Heartbeat, this has not been formally assessed. However the author and Associate Professor Sally Casswell were recently approached at a health promotion conference by one of the key figures still involved in the programmes which grew out of Heartbeat. She

thanked the Unit for its involvement and said that the formative evaluation input had not only helped guide the formation of the programme, it had also created a programme culture for Heartbeat in which evaluation was a key element. The evaluation methods which had been developed in the course of the formative evaluation of Heartbeat had been built upon and the methods were attracting international attention because of their feasibility in real world programme settings (Heather Fear, personal communication, 1997).

Criteria to Distinguish Evaluation Research from Project Planning and Implementation

The last point in this section is the question of how research project planning and implementation can be distinguished for the purposes of research funding of evaluation activity. This is an issue which was put to the author by a Health Research Council representative and was developed by the author when providing a referee's report on a health promotion evaluation grant application. The set of criteria which can be used to assist in determining when research funding is appropriate is as follows:

- the research explores new methodological ground which would be relevant to other health evaluation research in the future;
- the research covers issues beyond those which would normally be within the ambit of an evaluation conducted by a programme funding body;
- the novelty of the programme and its potential to be used in a number of other settings is such that it requires a more intensive evaluation effort than that which would normally be provided by a programme funding body on a routine basis;

- circumstances regarding programme funding are such that they make obtaining evaluation funding particularly difficult (e.g. multiple funding bodies with different agendas);
- the programme funding body has already declined to fund the evaluation research but it is needed from a strategic point of view to inform the health promotion community.

In summary, this section has made the following points:

- comprehensive evaluation is likely to entail formative evaluation and this will result in closer working relationships between evaluators and project staff than has traditionally been the case in evaluation;
- using an evaluation team for formative evaluation, where resources permit, can provide evaluation input which both understands the reality of the programme and has the independence to stretch the programme beyond its current thinking;
- formative evaluators are an important conduit of up-to-the-minute health promotion information as they move across the health promotion sector participating in different programmes;
- formative evaluation can go through a lifecycle and thinking of it in this way helps to put it in context; and
- criteria can be developed which assist in making decisions as to whether formative evaluation should be funded as research.

Summary

This chapter has looked questions which were raised for the author to some extent from the five projects, but also from his general work in health promotion evaluation; in particular his teaching health promotion evaluation in workshops. The Health Promotion Strategic Evaluation Framework has been designed to be robust enough to address the major issues which have arisen from the discussion of the issues in this chapter and in Chapter Seven.

CHAPTER NINE

HEALTH PROMOTION STRATEGIC EVALUATION FRAMEWORK

This chapter sets out a comprehensive framework for health promotion strategic evaluation which has been based on the evaluation and health promotion literature and developed extensively through the author's work on health promotion evaluations. This framework has formed the foundation for the author's teaching (usually in association with one of his colleagues, Dr Sally Casswell, Ms Mary Anne-Dehar, Ms Carla Spinola, Ms Francesca Holibar, or Ms Elizabeth Stewart) of health promotion evaluation to over 150 health promotion workers at a number of workshops in New Zealand (a list of these workshops is attached as Appendix 1). These workshops were usually under the auspices of the Health Promotion Forum of New Zealand. The framework was also used as the basis for a workshop in Australia; it was presented at a conference on Health Promotion Research Methods in Toronto (Duignan & Casswell, 1990); and at the American Evaluation Association Annual Conference in Washington (Duignan & Casswell, 1990); and the community aspects of it were presented at an International Research Symposium on Community Action Projects in San Diego (Duignan, Casswell & Stewart, 1993).

The framework's exposure to health promotion workers in the evaluation workshops has meant that it has had to be able to stand up to the realities of evaluating practical health promotion projects. Lessons learned from the application of the framework to health promotion projects, both those the author has been involved in as an evaluation researcher and those brought forward by practitioners

as examples at workshops, have helped to make the framework more robust and comprehensive and to develop it into its present form.

The framework consists of six elements. These are set out in Figure 3. The elements are:

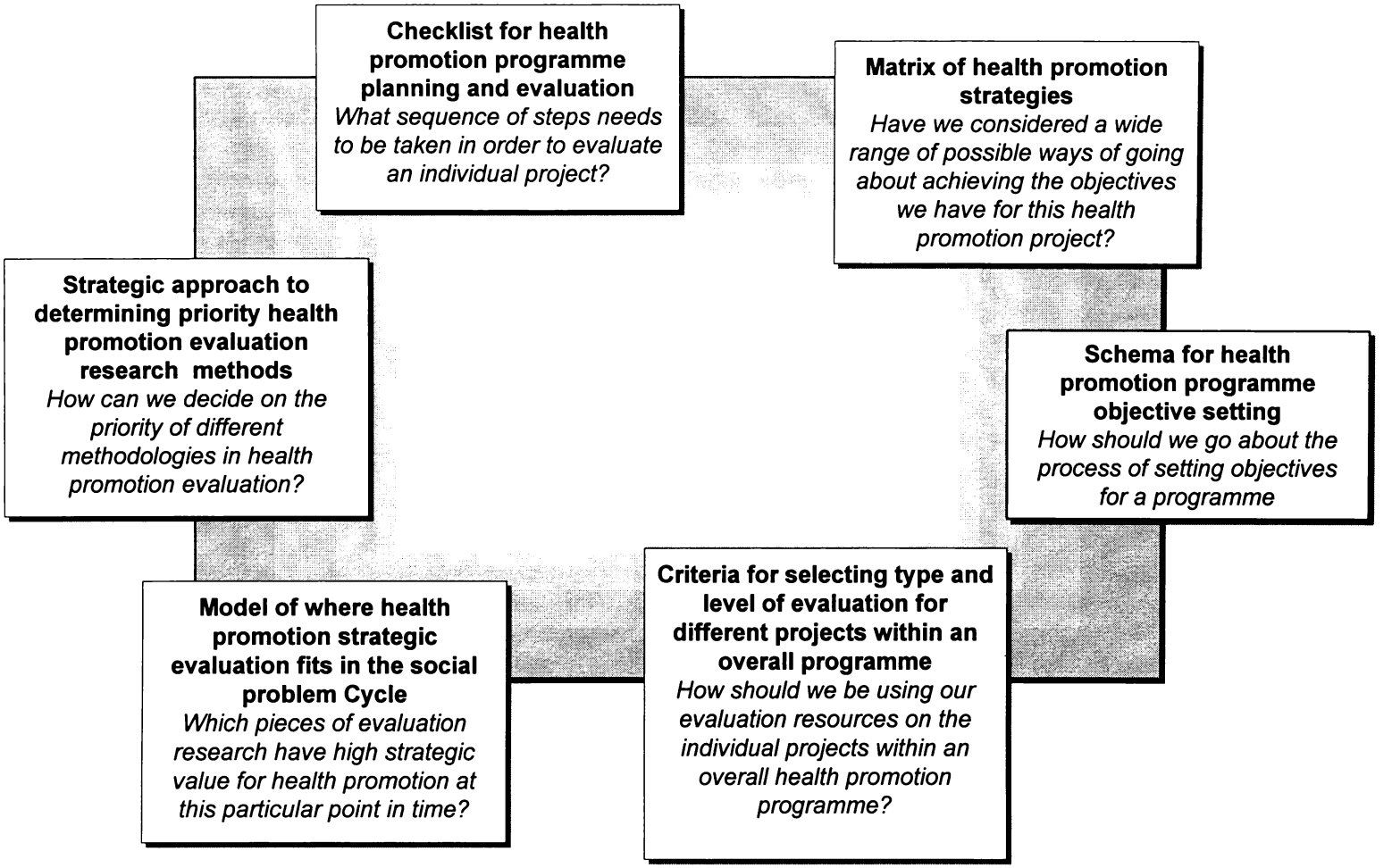
- Checklist for Health Promotion Programme Planning and Evaluation;
- Matrix of Health Promotion Strategies;
- Schema for Health Promotion Programme Objective Setting;
- Criteria for Selecting the Type and Level of Evaluation for Different Projects Within an Overall Programme;
- Model of Where Strategic Health Promotion Evaluation Fits within the Social Problem Cycle; and
- Strategic approach to Determining Priority Health Promotion Evaluation Research Methods.

Each element of the framework is directed at answering a critical question for health promotion. The questions and the elements which assist in answering each are set out below:

What sequence of steps needs to be taken in order to evaluate an individual project? (Checklist for Health Promotion Programme Planning and Evaluation).

Have we considered a wide range of possible ways of achieving the objectives we have for this health promotion project? (Matrix of Health Promotion Strategies).

Figure 3: Overview of Six Elements in Health Promotion Strategic Evaluation Framework



How should we go about the process of objective setting for a programme? (Schema for Health Promotion Programme Objective Setting).

How should we be using our evaluation resources on the individual projects within an overall health promotion programme? (Criteria for Selecting the Type and Level of Evaluation for Different Projects).

Which pieces of evaluation research have high strategic value for the health promotion field at this point in time? (Model of Where Strategic Health Promotion Evaluation Fits Within the Social Problem Cycle).

How can we decide on the priority of different methodologies in Health Promotion Evaluation? (Strategic approach to determining priority Health Promotion Evaluation research methods).

Each of the six elements in the overall framework are discussed in this chapter. Brief examples are given where necessary to clarify the discussion.

1. Checklist for Health Promotion Programme Evaluation

As mentioned above, the purpose of the checklist for health promotion evaluation is to help answer the question: w*hat sequence of steps needs to be taken in order to evaluate an individual project?* The checklist is designed to cover health promotion evaluation from the initial stages of planning through to the final

stages. It was written by the author, with input from Ms Mary Anne Dehar and Dr Sally Casswell and edited by Ms Patricia Burns.

It is set out in the form of a series of questions which need to be asked in order to ensure that a evaluation is well planned. These questions are listed below. Answers for all of these questions are set out in the booklet *Planning Evaluation of Health Promotion Programmes: A Framework for Decision Making* which is included as Appendix 3. The answers are not repeated here in order to avoid duplication. In order to understand the Health Promotion Strategic Evaluation Framework, this appendix should be examined now. The emphasis in the checklist is on formative and process evaluation rather than outcome. This is for three reasons: firstly, the relative traditional neglect of formative and process evaluation, secondly, the difficulty of impact/outcome evaluation in the health promotion field, and thirdly, the number of extensive treatments of outcome evaluation design already available in the literature. The checklist questions are as follows:

General Evaluation Considerations

- Has an evaluation plan been developed?
- Who are the key audiences for evaluation of the programme?
- What resources are available for evaluation?
- What types of evaluation are appropriate for the programme?

Formative Evaluation

- Are there adequate administrative, personnel, and management resources to plan, implement and evaluate the programme?
- What consideration has there been of budgeting issues?

- What training, skills and experience do staff have which are relevant to this programme?
- Is there any appropriate training available which staff can undertake to prepare themselves for this particular programme?
- Do new staff/consultants need to be employed for aspects of the programme?
- What is the planning timeframe for the programme? Has provision been made within this timeframe for the programme to be abandoned at an early stage if it is shown to be likely to be ineffective?
- Are literature reviews available in the area(s) to be covered by the programme? If not, has a literature review been carried out?
- Have there been any similar programmes in the past which do not appear in the research literature? If so, what information has been collected on these programmes? Have programme staff written to/visited existing similar programmes in New Zealand (or overseas)?
- Has there been consultation (or if appropriate, negotiation) with key stakeholders (organisations or individuals with a particular interest in the area) in regard to the fact that programme planning is taking place? What role will such key stakeholders play in programme planning?
- What action has been taken to acknowledge the Treaty of Waitangi?
- What research has there been on the actual situation which exists in the community at the moment (often termed needs assessment/analysis)?
- Has a set of objectives been developed for the programme?
- Are the objectives able to be achieved by the programme?
- What information is available on the strategies being proposed? Are they used in other fields? Can information about them be obtained from these other fields?

- On the basis of previous research, how likely are the proposed strategies to be effective within the timespan of the programme? What will be the cost of using these strategies?
- Has a formal statement of programme logic been prepared?
- Has the formal statement of programme logic been critically examined and commented on by at least one independent person outside of the organisation planning the programme?
- Have those groups which the programme is going to focus on been identified?
- Has there been developmental research on the materials to be used in the programme? Has there been consideration of the range of methods for pre-testing such materials?
- Has the intervention been piloted?

Process Evaluation

- What has the programme actually consisted of?
- What programme monitoring procedures have been put in place?
- What scale of process evaluation should be carried out?
- What sort of information is to be collected in process evaluation?
- What are the most effective ways of collecting information about the programme for process evaluation?
- Who is going to do the process evaluation?

Outcome Evaluation

- Should outcome evaluation be conducted (sometimes called evaluability assessment)?

- What framework can be used for outcome evaluation?
- How much will it cost to measure programme outcomes?
- What baseline information needs to be collected in order to measure changes?
- Is it possible to use some sort of quasi-experimental design?
- What sort of data collection methods and statistical analyses will be used for any outcome evaluation? If statistical analysis is to be undertaken, are the sample sizes large enough to make this appropriate?

In summary, this first element of the framework for Strategic Health Promotion Evaluation is the checklist, summarised here and set out in full in Appendix 3. This has been designed to provide the basis for planning and evaluating a health promotion programme.

2. Matrix of Health Promotion Strategies

The Matrix set out in Figure 4 provides an overview of important health promotion strategies. The need for this type of matrix arose from the author's discussions of health promotion projects with workshop attendees and with practitioners who came to the Alcohol and Public Health Research Unit for health promotion evaluation advice. It was clear from these discussions that there had not always been careful consideration of all of the alternative strategies which could be used in a health promotion programme.

This Matrix is designed to be used as a central tool in formative evaluation and programme planning. Formative evaluation is about making sure that programmes are heading in the right direction. As has been argued earlier, if programmes are not

Figure 4: Matrix of Health Promotion Strategies

Project Name:

Topic/Areas	Approach	Method	Style	Focus/Settin
Recognition of Treaty of Waitangi Housing Employment Sexism Ageism Racism Stress Self-esteem Physical activity Nutrition Alcohol Tobacco Other drugs Heart disease Cancer Trauma	**Educational/ Informational**	One to one Classroom/group Media campaigns	Knowledge acquisition Self-esteem Conscientisation	Individuals Specific Sub-populations Maori Ethnic Groups Geographic Communities Community Organisations and Interest Groups Private Companies Public Institutions Regulatory Authorities Central and Local Policy Makers Central and Local Politicians
	Community Mobilisation	Group formation Use natural community leaders Grass/flax roots community workers Community organisers/activists Providing resources	Community support Voicing community concerns Transformational	
	Monitoring & regulatory enforcement	Information provision Monitoring compliance with requirements Monitoring enforcement	Awareness raising Increasing systems responsiveness Proactive enforcement	
	Institutional infrastructure development	Liaison Sectoral coordinating committees Intersectoral Collaboration	Networking Coordination Restructuring/building infrastructure	
	Policy development	Organisation's policies Local policies, By-Laws National policies, regulations, legislation	Awareness of healthy alternatives Generating policy alternatives debate Advocacy coalitions	

Duignan (1997)

heading in the right direction, there is usually little point in undertaking other types of evaluation. Naturally enough health promoters tend to use those strategies with which they are most familiar and to neglect other strategies. Usually the familiar strategies tend to focus at the educational rather than the policy end of the health promotion spectrum. The Matrix of Health Promotion Strategies is designed to be used to expand the thinking of formative evaluators and programme planners as to which possible strategies can be used in health promotion.

The strategies are divided into potential *topics* (e.g., nutrition, poverty), *approach* (e.g., educational/informational, policy development), *methods* (one to one, media campaigns), *styles* (knowledge acquisition, conscientisation) *and focus/settings* (e.g., private companies, public institutions). The Matrix is designed to be used as a rapid way of checking if a wide range of strategies have been considered for a health promotion project. The idea is that a programme planner or formative evaluator can say "have we thought of...?" in respect of each of the items within the Matrix.

It will be noted that this Matrix does not contain a number of more global terms used in health promotion such as *empowerment, enabling, mediating, advocating, and social marketing.* These terms are important for the field in orientating health promotion workers and researchers towards broad issues and perspectives. However, these terms are too global and non-specific for the particular purposes of this Matrix; too many specific strategies could fit under any one of these terms. The Matrix has tried to break health promotion down into smaller elements rather than grouping it into larger. The intention is that this will enable an overview of the mix of specific strategies a health promotion programme is planning to use.

Each element in the framework is discussed below.

Topic

Within health promotion there are a wide range of possible topics. A number of the most important are set out here as examples of important health promotion subjects. The list is indicative, not exhaustive, and can be expanded as appropriate.

Firstly, there are general topics such as those set out in the document *Promoting Health in New Zealand* (New Zealand Board of Health, 1988). This identifies a series of "prerequisites for community health" in New Zealand. These are recognition of the Treaty of Waitangi, adequate housing, employment, removing sexism, removing ageism and removing institutional racism. These topics are considered to lie at the root of the development and maintenance of good health. In addition to these basic requirements there are more specific health risk factors, such as stress, low self-esteem, lack of physical activity, inadequate nutrition, alcohol, tobacco and other drug use, all of which can be topics to which health promotion strategies are directed. At a more specific level, there are the various illnesses and injuries to which illness and disease prevention programmes can be directed, for instance, heart disease, cancer, and trauma.

Clearly, the characteristics of different health promotion topics put different demands on health promotion programmes which are being designed to address them. The topics which are prerequisites for health will often be surrounded by political controversy and subject to competing discourses around the determinants of health. This is due to the number of stakeholders who have an interest in them, and the questions of control and distribution of resources which lie behind them. This obviously applies to a topic such as the Treaty of Waitangi. However, even

topics such as nutrition, drugs, heart disease, cancer and trauma have aspects which can create major political controversy. For example, as discussed throughout this study, alcohol as a health promotion subject shares with tobacco a highly politicised policy environment. This is because of the presence in the alcohol field of major competing interests promoting its usage. These commerical interests are focused on profit maximisation. As a consequence there is pressure from these interests against strategies which may significantly impact on their commercial viability. This means that they tend to emphasise only a limited subset of the wide range of the health promotion strategies which are set out in this framework.

The strategies preferred by the alcohol industry are generally ones which have as their focus individual responsibility and an educational approach. These will be methods such as one to one or group presentations promoting the knowledge acquisition paradigm for health promotion. These strategies are consistent with lifestyle choice models of health and sit comfortably amongst marketing business discourse. In contrast, the approaches supported by the health promotion research literature as most effective tend to be those which use community mobilisation, policy development and regulatory enforcement. These are based on the notion that health is socially constructed and have less emphasis on individual choice as a primary factor in the production and maintenance of health.

Approach

The term *approach* in Figure 4 sets out a list of potential major strategy approaches which can be adopted in health promotion. The starting point for these approaches was the five Ottawa Charter headings discussed in chapter three.

However, in the course of the development of the Matrix a somewhat different set of headings has evolved. The approaches described here are *educational/informational, community mobilisation, monitoring & regulatory enforcement, institutional infrastructure development,* and *policy development.*

These approaches represent a considerably modified version of the headings used in the Ottawa Charter (building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and re-orientating the health services). The Matrix does not simply copy the Ottawa Charter headings because of the author's experience in working with the Charter in workshops and in a formative evaluation role. The Charter (used in New Zealand in association with the Treaty of Waitangi) provides a good method of expanding health promoters' general thinking about health promotion. In particular it provides strong support for moving health promotion away from traditional individual health educational approaches. It does this by highlighting supportive environments, by its policy focus, by using enabling, mediating and advocating strategies, and by its orientation towards empowerment of communities. However, having accepted the need for Health Promotion to have a broad scope, the Charter needs some refinement to function as a practical tool for project planning and formative evaluation.

One of the problems with the Ottawa Charter is the overlap between its headings. This difficulty was raised by health promotion workers in evaluation workshops after the Public Health Commission adopted the Charter headings as part of its contracting process for public health services. The Commission was trying to ensure the use of a broad range of health promotion strategies and the Charter provided a credible and authoritative endorsement of widening the agenda.

However, at a practical level it was difficult to put a particular activity under any one heading. For instance, would working to change the perspective of District Licensing Committees fit under Creating Supportive Environments, Healthy Public Policy or Strengthening Community Action? Is it "generating living and working conditions that are safe, stimulating, satisfying and enjoyable" (Supportive Environments); or is it "strengthening public participation and direction of health matters" (Community Action); or is it making sure that Licensing Committees are "aware of the health consequences of their decisions and ... accept their responsibilities for health" (Healthy Public Policy)? Part of this problem arises because some of the Ottawa Charter headings are procedural type statements (Building Healthy Public Policy) and some have more of a global (almost valuative) flavour to them (Creating Supportive Environments).

Such overlap of course, only presents a problem when one tries to categorise different types of strategies, and it could be asked whether such categorisation is necessary. However, categorising activities in health promotion is required in order to highlight which strategies are being emphasised in a programme and where resources are going. It is often very enlightening to prepare an overview of a project's activities, categorising them across the type of strategy approach being adopted. This will clearly indicate, for instance, if the programme is putting all its emphasis on educational rather than policy initiatives. The Ottawa Charter was used for this purpose by the Alcohol and Public Health Research Unit in its first formative evaluation report to the Heartbeat New Zealand Committee to highlight the strategies which the programme was emphasising. However, as mentioned earlier, the Ottawa Charter often proved difficult to use in this way because a number of activities could fit under several different headings.

The Matrix in Figure 4 has refined the Ottawa Charter headings in an attempt to achieve a set of approaches which are more mutually exclusive. Firstly, the issue of whether the focus is on individuals (Developing Personal Skills) or on organisations has been pulled out to the *focus/settings* column in the figure. Secondly, the two Charter headings, Creating Supportive Environments and Re-orienting Health Services, have been omitted. Creating Supportive Environments has not been included since it is best seen as a result of the other health promotion paths, rather than as a path in itself. As noted earlier in this study, in one sense, all of the paths listed in this framework and those set out in the Ottawa Charter are directed at establishing a supportive environment. It is a wonderfully holistic concept, combining as it does both the social, built and natural environments. However, putting supportive environments in at the same conceptual level as the other headings from the Charter can cause confusion because at the end of the day, almost everything in health promotion can be seen to be contributing to the supportive environments heading in one way or another. While it is of central importance to health promotion, it is too universal a term to be particularly useful in a matrix such as this which is intended to aid the analysis of different patterns of emphasis in health promotion programmes.

The other omitted heading, Reorientating Health Services, has not been used here because any activity undertaken under the heading of reorientating health services can be adequately categorised under other headings in this matrix. For instance, information on exercise given to a client by a health worker can be included in the Matrix under the topic of *physical activity*, using an *educational/informational approach*, a *one-to-one method*, a *knowledge acquisition style* and with the focus on the *individual*.

The term *educational/informational* has been used in this Matrix to replace the term d*eveloping personal skills* from the Ottawa Charter. The term *personal skills* seems a little narrow to encompass the whole compass of approaches which can occur under this heading, which can range from increasing knowledge, through self-esteem building, to conscientisation.

Monitoring and regulatory enforcement has been added as an approach in the Matrix. While this term could come under several Charter headings, it is worthwhile to pull it out as a separate approach because of its importance in health promotion work. *Institutional infrastructure development* has also been included as a specific approach. This approach is also of major importance but, while implicitly present, did not have a specific location within the Ottawa Charter. Attention was drawn to it in the *Promoting Health in New Zealand* document in the section called "Promoting health in New Zealand: Through structural and institutional change" (New Zealand Board of Health, 1988). This section called for funding for health and research in health promotion; establishing new structures for intersectoral collaboration; and strengthening and re-orienting existing organisations and structures to support health promotion. Clearly identifying these as an infrastructure approach assists in categorising health promotion strategies.

For each of the five approaches in the Matrix, there are different potential *methods* and also different *styles*. The methods are the actual way in which activity takes place within a health promotion approach. For instance, within the educational/informational approach there are the following methods: one-to-one interaction, classroom/group based instruction, and the use of the mass media.

Within each approach, using any of the variety of possible methods, there are also a range of different possible *styles*. The style characterises the broad intention

with which the approach and the methods are being used. Taking the example of the educational/informational approach again, the three broad styles used here are knowledge acquisition, self-esteem building and conscientisation.

The six approaches to health promotion are discussed below, together with the range of methods and styles within each approach.

Educational/Informational

The educational/informational approach is based on the idea that increasing people's knowledge about various aspects of health will in some way translate into changes in their behaviour and that this, in turn, will positively affect their health. Health education as a discipline has closely examined many of the ways in which this type of approach can be used for health promotion. A number of educational methods which can be used. One-to-one interaction involves health promoters teaching individuals about health promotion issues. This is generally a very high cost option for health promotion. Classroom/group instruction, the traditional method within health education, has become almost a "knee-jerk" strategy, proposed often and in response to a number of health problems, for instance alcohol, other drug and nutrition issues.

Mass media educational campaigns are a third often used educational method. Mass media campaigns are also a very popular response to health promotion issues, for instance alcohol-impaired driving or nutrition. It should be noted that an educational/informational approach is not the only possible use of the media for health promotion, it can, for instance, be used as a part of the policy development approach set out below.

Within the educational/informational approach there are also different *styles.* These start with an approach seeking to simply increase *knowledge acquisition* and improve skills. This has been the traditional approach within health education. More recently programmes have acknowledged the importance of increasing *self-esteem* as one of the prerequisites for health (James, van Beurden, Steiner, Tyler & Fardon, 1990). More radically, there is a tradition of directing educational strategies at *conscientisation* or development of a fuller appreciation of the sociopolitical environment in which people (or those involved in the programme) live, the role of that social environment in their oppression, and how they can act to change this (Alinsky, 1971; Friere, 1968).

Community Mobilisation

The community mobilisation approach has been discussed in considerable detail in earlier sections of this study. There are five methods identified in this framework: group formation; using natural community leaders; grass/flax roots community workers; community organisers/activists; and providing resources. Natural community leaders were used in the North Karelia Project in Finland where people who had a status in their communities were selected and trained to detect cardiovascular risk factors in their communities and to advise community members of the desirability of lowering those risk factors (Neittaanmaki, Koskela, Puska & McAlister, 1980).

Grass/flax roots community workers work with people within their communities using a 'bottom up' and 'empowering' philosophy. Community organisers/activists work in the community with the intention of putting health on the community agenda, as was done in both the Licensing Project and the Community Action Project. The

way these workers operate depends on whether their organisational activity has to keep within the bounds of their official positions, as was the case for those workers in the Licensing Project who were employed by a district health authority. Those who are not constrained in this way can adopt a more purely activist orientation because they work within a community pressure group such as the anti-smoking group ASH. The last method, that of providing resources to groups in the community for undertaking a range of health promotion activities, was the approach used in part of the Heartbeat New Zealand programme.

Three differing *styles* of the community mobilisation approach have been identified in this framework. The first has the objective of generating positive *community support* or community feeling as an end in itself. This approach is based on the idea that where people feel a sense of support and belonging to their communities this is not only good in its own right but is also health promoting.

The second community mobilisation style, which was used in the licensing project, is called *voicing community concerns*. Here, the objective is to ensure that areas of concern within a community are allowed to be heard in wider forums. In areas such as alcohol and tobacco, where commercial interests actively attempt to construct positive public views, community concerns are often silenced. This style, therefore, becomes an important tool in these areas.

The last style in the community mobilisation approach is to seek a radical *transformation* of the community to eliminate the systems and structural factors which work against health. This style tends to generate health promotion's more revolutionary rhetoric. In contrast to the community support style, which is often consensus based, the voicing community concerns and transformational styles do not shy away from conflict and dissension where these arise. Indeed, conflict is

seen as sometimes necessary in order for a community to move forward and address its health needs effectively This may be the case even if the conflict and dissension temporarily reduce the sense of "community feeling." Empowerment, in the sense of actual changes in political and economic power, is a strong theme in the latter two styles of the community mobilisation approach.

Monitoring & Regulatory Enforcement

The monitoring and regulatory enforcement approach set out in this Matrix consists of monitoring standards, policies, laws or regulations which are currently in place to determine the degree to which they are being adhered to. Three methods of monitoring are set out here: *information provision*; *monitoring compliance with requirements*; and *monitoring enforcement*. Information provision is about ensuring that people who should be governed by a set of standards, policies, regulations or laws are aware of their responsibilities. For instance, in the Licensing Project there was considerable activity directed at ensuring that licensees were aware of their statutory responsibilities under the Sale of Liquor Act. Monitoring compliance means gauging the degree to which people are adhering to policies which have been established. An example of this from the Licensing Project was a survey of where people had last been drinking, with a view to identifying those licensed premises which may have been illegally serving intoxicated patrons. The third method, monitoring enforcement, involves focusing on the agencies which should be enforcing policies or regulations. In the Licensing Project, for example, the police were encouraged to actively enforce licensing laws.

Three styles can be used in monitoring and regulatory enforcement: *awareness raising; increasing systems responsiveness;* and *proactive enforcement.*

The awareness raising style seeks to ensure that all those who should be conforming to standards, policies and regulations are aware of their responsibilities. The increasing systems responsiveness style is directed at making sure that regulatory systems are responsive. For instance, the Licensing Project attempted to make the licensing system more responsive to health issues. Lastly, proactive enforcement is where regulatory agencies reinterpret their brief to become more active in enforcement. This has happened in respect of scale of police enforcement of licensing laws.

Institutional Infrastructure Development

The next approach identified in this Matrix is *institutional infrastructure development*. This involves the building and maintaining of an institutional infrastructure which promotes health. The methods of this approach are *liaison, sectoral coordinating committees* and *intersectoral collaboration*. The first method, liaison, seeks to increase the awareness of institutions of what each is doing through newsletters, networking or in other ways. The second method works to establish coordinating committees and other structures which will facilitate strategising, resource sharing and cooperation within a sector. This occurred in the Wanganui Project in terms of the sector concerned with alcohol problems. The last method, encouraging intersectoral collaboration, moves beyond the traditional institutions within a sector, as, for example, involvement from a health perspective in the institutions involved in housing provision. There are three styles under the infrastructure development approach: *networking; coordination;* and *restructuring/building infrastructure*. Networking is simply directed at ensuring information flow. Coordination is the establishment of more formal structures.

Restructuring is where institutional structures are changed in order to ensure that health perspectives have a greater influence over what is done in all sectors.

Policy Development

The policy development approach seeks to contribute to the development of policies which encourage the availability of the prerequisites of health (housing, employment etc.) and which actively promote health at all levels of society.

Policies are statements or views about how an organisation, institution or government should operate in relation to its purpose or functions (Thomas & Robertson, 1992). They are developed through the policy making process in which different stakeholders seek to have their particular views encapsulated in order to affect the way in which individuals, organisations and institutions will act.

There are several major methods in the policy approach focusing on *organisation's policies; local policies* and *by-laws*; and *national policies, regulations* and *legislation*. The Heartbeat Project provided an example of the attempt to change organisations' policies by working with schools to change their canteen policies. The Licensing Project included the attempt to have local government develop policies regarding the use of alcohol on their premises. It also focused on national legislation in the form of the Sale of Liquor Act.

The styles which are set out here for policy development are: making sure that policy makers are *aware of healthy alternatives*; *generating policy alternatives debate;* and *advocacy coalitions* for particular policies. Much policy debate which is relevant to the prerequisites for health occurs without health consequences being considered as part of the policy agenda. For instance employment policy. A major role for health promotion in the policy area is simply to increase the profile of health

concerns so that they are considered in the policy debate. Another role is to generate public debate about policy alternatives, and still another is active lobbying and advocacy in regard to particular policies.

The six approaches and within them their methods and styles of health promotion are meant to be comprehensive enough to enable any type of health promotion activity to be defined in terms of a particular set of headings.

Focus/Setting

The next section of the Matrix addresses the *focus* or *setting* for health promotion activity. This is the group to which the health promotion activity is directed. These foci range widely: individuals, specific sub-populations (e.g., women, men, children), Maori, ethnic groups, geographic communities, community organisations and interest groups, private companies, public institutions, regulatory authorities, central and local government policy makers and politicians.

Individuals have been the focus of many health promotion and health education programmes. These programmes usually use an educational/informational approach and a one-to-one, group or media campaign method to increase knowledge in the belief that this will change the person's health behaviour. Traditionally, the information provided has been about health risks and how to avoid them at the individual level. Individual education does not, however, need to be limited to this. It can be directed at increasing consciousness of the wider social and policy issues which influence health with a view to gaining people's support for, or recruiting, involvement in social and policy initiatives.

Another frequent focus of health promotion programmes is *specific sub-population* groups. For instance, in the Community Action Project young males were targeted for some of the mass media advertising campaigns because of their high levels of alcohol consumption and of alcohol-related problems.

Maori are the next potential focus for health promotion programmes. As with any health promotion programme, the focus will influence the design of the programmes and the choice of approaches used. In the case of Maori, there are partnership requirements under the Treaty of Waitangi in regard to consultation and control of resources. Maori have developed and are working on their own frameworks for health and its promotion. Other ethnic groups will also have differing perspectives on approaches to health promotion and these will influence the design of programmes.

Particular *geographic communities* are another potential focus for health promotion activity. For instance, the Wanganui Project discussed earlier worked only within the Wanganui geographical community.

Community and interest groups are of major importance to health promotion, for instance, again in the Wanganui Project, Student's Against Drunk Driving were important. Interest groups can also includes professional groups such as the Medical Association.

Private companies are also important in health promotion. For instance, in Heartbeat, initiatives were taken to increase the supply of healthy food to canteens through liaison with food distributors. In the Licensing Project, individual companies running licensed premises were an important focus particularly when they were negotiating for licenses for outlets.

Public institutions are another focus for health promotion activity used in this Matrix. To give an example of this focus, again in the case of Heartbeat, canteens in Government Departments were eligible for awards on the basis of improving their menu choices and facilities.

Regulatory authorities can also be another focus for health promotion activity. These can be any authority which has the power to regulate. In the Licensing Project the health promotion organisers promoted health perspectives on licensing issues so that District Licensing Committees would take these perspectives into account in their regulatory work.

Central and local government policy makers and politicians are another potential focus for health promotion activity. For instance, in the Licensing Project, policy officials in the Ministry of Transport became the focus of an approach over standardising data collection on alcohol impaired driving incidents. Elected politicians determine policy by way of legislation and through leadership and role modeling in their community. A politician (the Under-Secretary of Transport) was the motivator behind the Wanganui Project. Politicians often have very little information regarding the effectiveness of different health promotion methods. As with anyone in their situation they tend to promote unexamined approaches to health promotion problems. They are also interested in the political profile of programmes, their cost, and their political acceptability. Policy relevant health promotion advocacy is often directed at informing and influencing politicians and policy makers.

Use of Matrix

As has already been indicated, the Matrix of Health Promotion Strategies set out in Figure 4 is designed to assist in answering the question: *Have we considered a wide range of possible ways of going about achieving the objectives we have for this health promotion project?*

In order to assist in this, programme planners or formative evaluators may wish to chart the strategies they are contemplating on the Matrix and look for the approaches, methods, styles or focus/settings where programme strategies are few or absent. As an illustration, this has been done for each of the health promotion projects set out in this study. The strategies are marked in by hand rather than printed onto the Matrix in order to reflect the way in which the Matrix can be used in practice. Multiple circlings indicate more extensive use of that particular strategy.

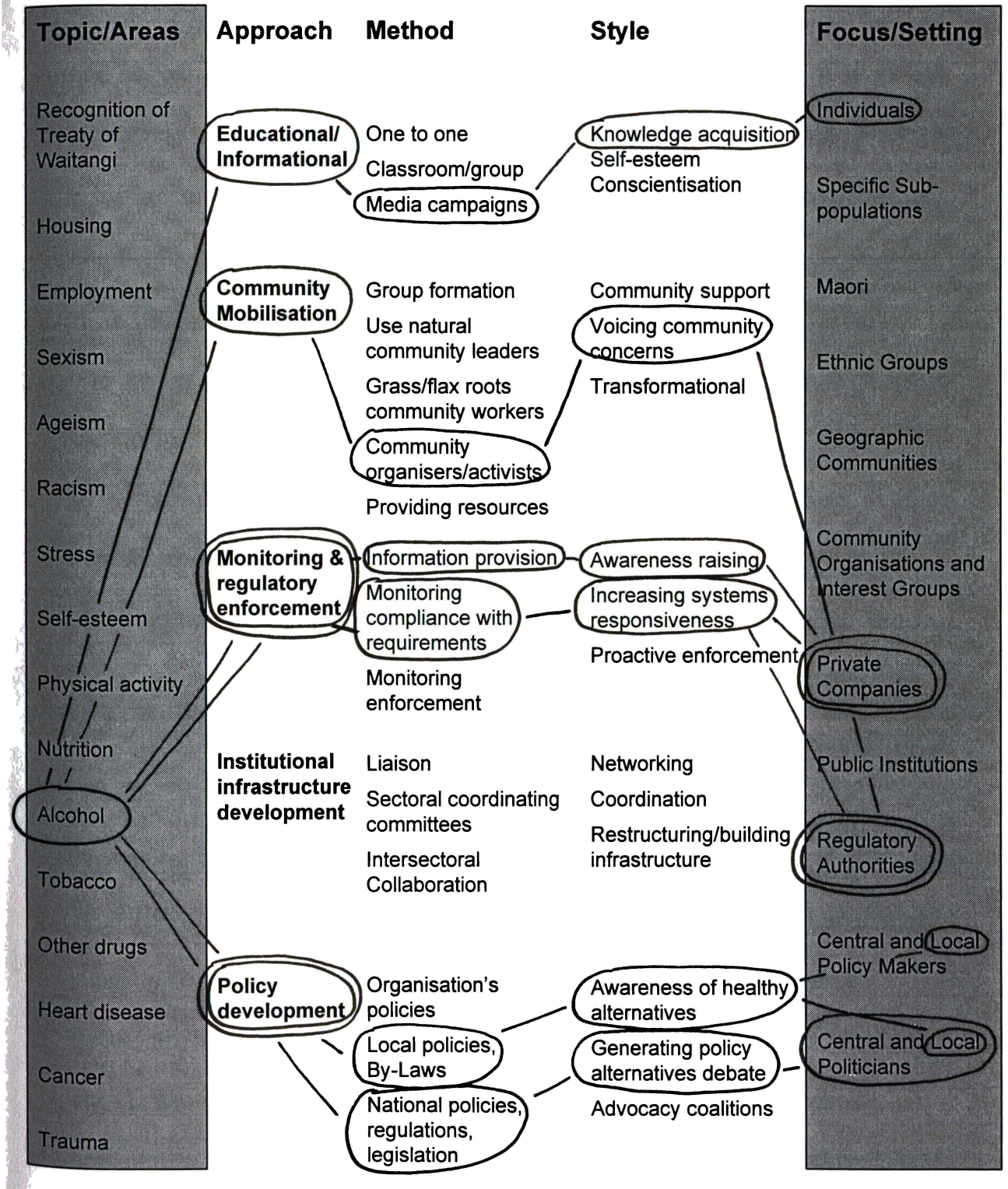
Community Action Project

Figure 5 sets out the strategies which were used in the Community Action Project. The project consisted of the following elements. Local authority alcohol policies were promoted including guidelines on the use of alcohol at authority functions and the use of alcohol on authority controlled land. This is a policy development approach using local policies and by-laws using the awareness of healthy alternatives style and focused on local policy makers and politicians.

Training sessions on responsible server behaviour were held for catering course participants at local tertiary institutions. Hence this was a monitoring and regulatory enforcement approach, using information provision in an awareness raising style with the focus on private companies.

Figure 5: Matrix of Health Promotion Strategies

Project Name: Community Action Project



Local residents who were opposed to the introduction of new alcohol licenses in an area were assisted. This is using community mobilisation approach using community organisers as the method, voicing community concerns as the style and directed at regulatory authorities.

Media advocacy was used to draw attention in the local media to a hotel which had been the source of many alcohol-related disorderly incidents. This is using a monitoring and regulatory enforcement approach with the method being monitoring compliance with requirements, the style being increasing system responsiveness and the focus being private companies and regulatory authorities.

There was also a mass media campaign to encourage people to drink responsibly. This was an educational/informational approach using a mass media campaign method, a knowledge acquisition style and directed at individuals.

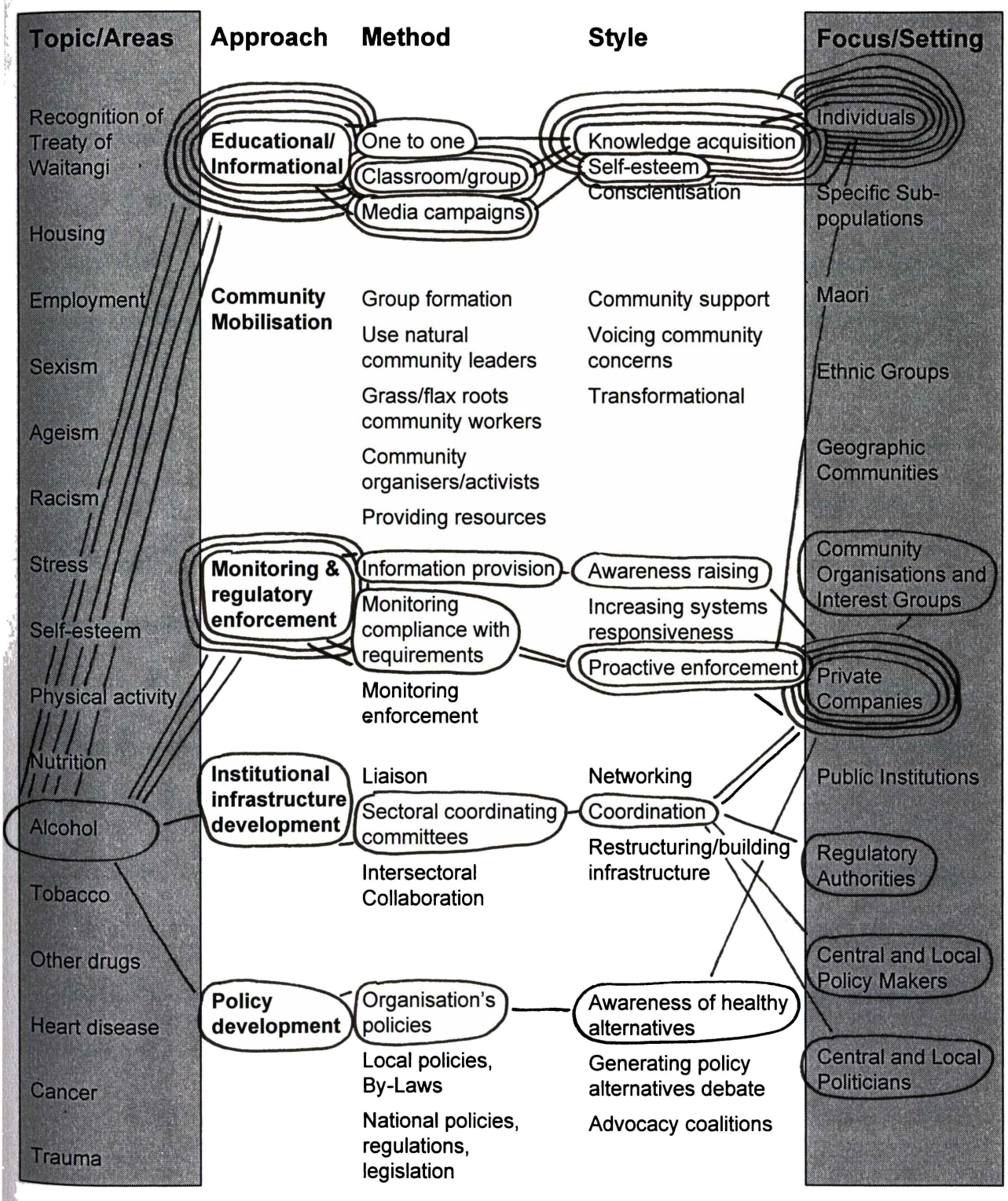
In the course of this campaign controversy arose over one of the advertisements which was used, this opportunity was used to generate further public awareness when the advertisement in question was banned. This was a policy development approach directed at national policies using the generating policy alternatives debate style and directed at central policy makers and politicians.

Wanganui Community Alcohol Action Project

The Wanganui Project is charted in Figure 6 as follows. Regular meetings of a Working Group and Steering Committee. This is institutional infrastructure development using a sectorial coordinating committee method and a coordination style between some community organisations and interest groups, private companies, regulatory authorities, central and local policy makers and politicians.

Figure 6: Matrix of Health Promotion Strategies

Project Name: Wanganui Programme



Seven extra traffic officers worked on enforcement in the Wanganui area for the duration of the programme. This was monitoring and regulatory enforcement with the monitoring compliance with requirements method and the proactive enforcement style focused on individuals.

An educational kitset on alcohol for young adults was produced by the Ministry of Transport. This was an educational/informational approach using a classroom/group method a knowledge acquisition style and focused on individuals.

A second education programme was run, this time by the Department of Education as a trial in some Wanganui schools. This is an educational approach the classroom/group method, which this time was based on a self-esteem building style and focused on individuals.

A Patron Care programme involved police talking to staff of licensed premises. This was a monitoring and regulatory enforcement approach which used an information provision method, an awareness raising style focused on private companies.

Regular patrols of licensed premises by police. This was a monitoring and regulatory enforcement approach using a monitoring compliance with requirements method, and a proactive enforcement style directed at private companies.

An *I'm Safe Mate* campaign initiated by the Hotel Workers Union, suggesting that one person in a social group be elected as the non-drinking driver. This strategy can be seen as an educational/informational approach, using a media campaign method, a knowledge acquisition style and directed at individuals.

Low alcohol beer made available on some licensed premises. This is a policy development approach with the method being organisations' policies, the style being awareness of healthy alternatives and the focus being private companies.

Publicity material on alcohol problems and treatment. This is an educational/informational approach using a one to one method, a knowledge acquisition style and focused on individuals.

A poster competition for schools run by the Accident Compensation Corporation. This is an educational/informational approach using a classroom/group method, a knowledge acquisition style and directed at individuals.

Lastly there were T-shirts produced for Students Against Drunk Driving. This can be seen as an educational/informational approach using an informal media campaign, a self-esteem style and focused on individuals.

The completed matrix for the Wanganui Project clearly shows the preponderance of an educational approach focused on individuals. It highlights the fact that inspite of Wanganui being billed as a community project, it actually had very little in it that could be called a community approach. The emphasis was on educational/informational approaches mainly with a considerable amount of monitoring and regulatory enforcement, some institutional infrastructure development. If the strategies were charted in terms of the resource input into each area this same result would be reflected.

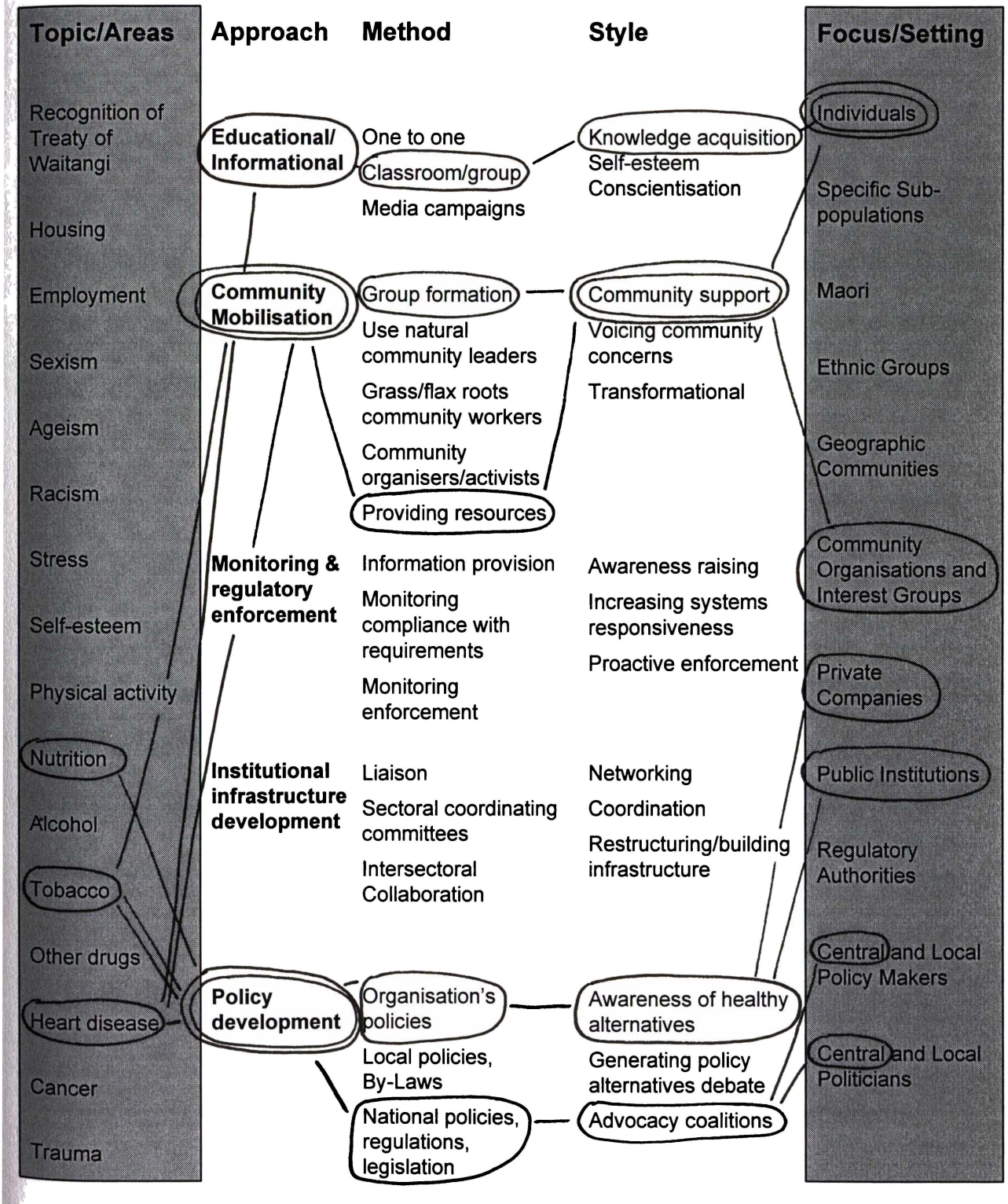
Heartbeat New Zealand

The Heartbeat New Zealand Project is charted on Figure 7. It covered a wide range of activities due to the size of the project. Some of the key activities are charted here.

Heartbeat Awards sought to influence policies relating to school and workplace canteens in the three areas of food choices, hygiene and non-smoking. This was a policy development approach aimed at organisations' policies using an awareness

Figure 7: Matrix of Health Promotion Strategies

Project Name: Heartbeat New Zealand Programme



of healthy alternatives style and directed at private companies and public institutions.

Another part of Heartbeat was the Heartbeat Community Network. This was a community project in which small groups were set up and leaders trained to educate groups of people about heart disease. This was an educational/informational approach using a group method, a knowledge acquisition style and focused on individuals.

Heartbeat also contributed to the expansion of the Stop-Ourselves Smoking smoking cessation programme. This was a community mobilisation approach using the group formation method, a community support style and directed at individuals..

A further aspect was supporting a coalition in support of the Smokefree Environments Bill. This was a policy development approach using the national policies method, an advocacy coalition style and directed at central policy makers and politicians.

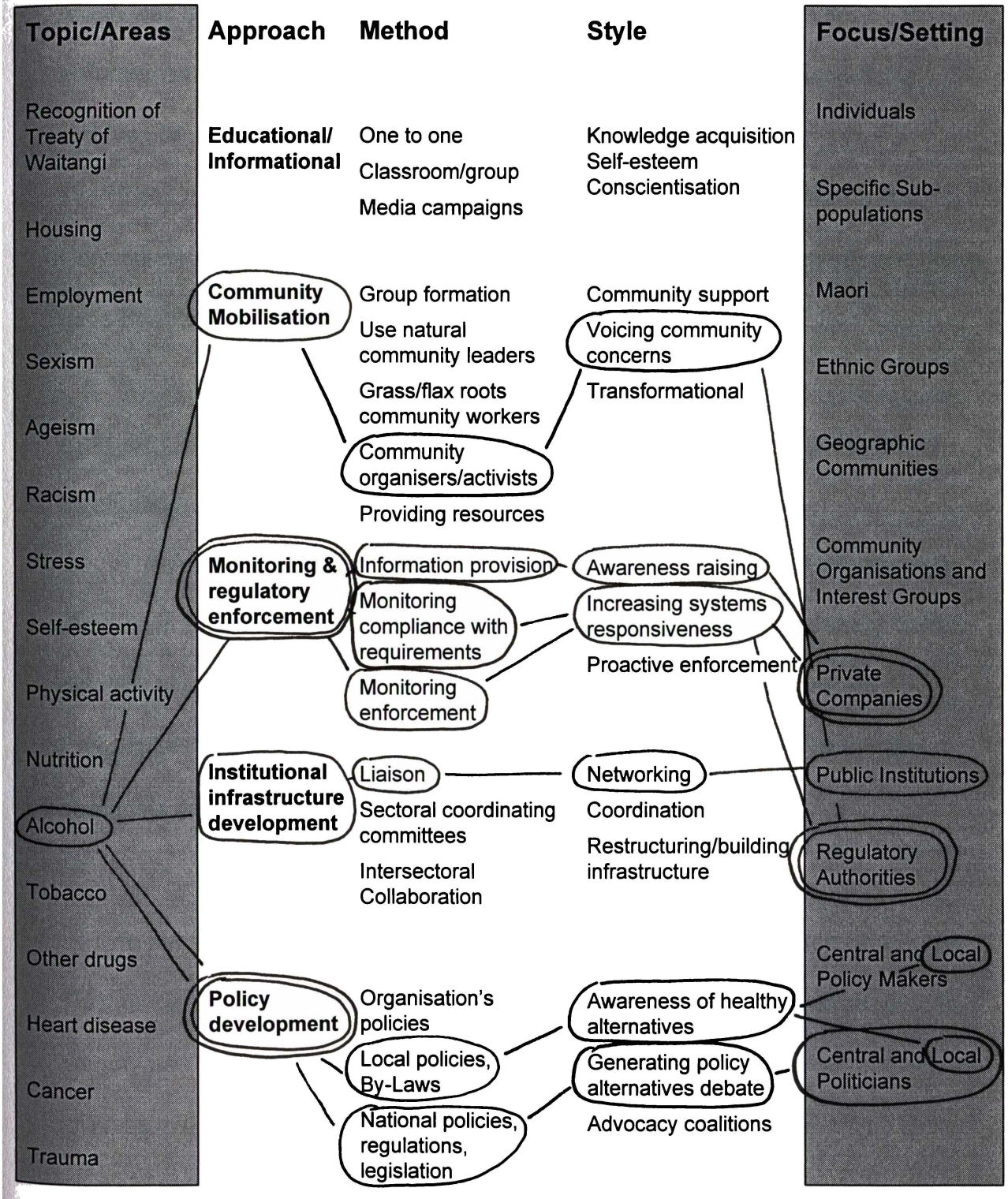
Lastly there was funding for small projects by community groups in the heart health area. This was a community mobilisation approach using a providing resources method, a community support style and focused on community organisations and interest groups. The charted Heartbeat Matrix shows a mix of strategies making up this programme.

Licensing Project

The Licensing Project is charted on Figure 8. It was based around regular meetings of community health promotion organisers. This was an institutional infrastructure development approach using liaison, a networking style and directed at public institutions and to a few community organisations (most of the organisers

Figure 8: Matrix of Health Promotion Strategies

Project Name: Licensing Project



worked for public health institutions or community organisations which were publicly funded).

The main work of the project was community organisers working to have District Licensing Authorities implement the new Sale of Liquor Act in a manner which was supportive to health issues. This is a monitoring and regulatory enforcement approach using a monitoring enforcement method, an increasing systems responsiveness style and directed at regulatory authorities.

The Licensing Project also contained a number of aspects similar to the Community Action Project (without the national mass media involvement) and these have been added into Figure 8.

Accident Compensation Corporation Accident Prevention Programme Evaluation

The Accident Compensation Corporation Accident Prevention Programme Evaluation Project was different from the other projects set out in this study. It was directed at developing a policy for evaluation of the Corporation's Accident Prevention Programme. Because it did not involve a range of health promotion strategies there is no chart for it on the Matrix.

Summary

In summary, this section has set out a Matrix of Health Promotion Strategies. This matrix is one of a range of ways of setting out health promotion strategies. Its primary use is as a way of rapidly checking whether a health promotion programme involves a wide range of different strategies, or whether it is sticking within a limited range of options. Of course there is no problem with health promotion projects which

are directed at only a limited range of strategies, if this is a deliberate decision of project planners, rather than the result of a lack of awareness of the potential strategies which could be used. The Matrix is designed to be used in the early stages of programme planning to assist programme planners and formative evaluators to think about the range of possible strategies. It can also be used in a process evaluation of a programme to look at how the strategies used in the programme stack up against the range of possible approaches set out on the Matrix.

3. Schema for Setting Health Promotion Programme Objectives

The third element in the Health Promotion Strategic Evaluation Framework is a Schema for Health Promotion Programme Objective Setting. This section elaborates on the description of this process set out in Appendix 3. There are two reasons for setting programme objectives. The first is to provide a basis for thinking about the type of strategies which should be used in a programme (i.e., those which are most efficient at achieving the objectives). The second is that clear objectives are required in order to evaluate outcomes.

There is no one right way of setting out objectives. Traditional approaches to objective setting emphasise specificity and measurability. These need to be included in an overall objective setting and evaluation process, however, in the author's view they should not be allowed to dominate too early in the objective setting process. If objectives are too specific and point towards particular health promotion strategies, then such objectives can lock a programme into a narrow set of health promotion strategies. Objective setting should be structured so as to

encourage wide critical thought about the range of possible strategies which could be used to achieve an objective. Equally, as is discussed below, measurability should not be allowed to dominate too early since we should seek to do what should be done, not just that which can be easily measured.

The schema for objective setting which is proposed here is designed to keep thinking as broad as possible before specific strategies are adopted and to leave measurability questions until after objectives have been set. It divides the objective setting task into establishing a goal, objectives, strategies, and performance indicators. Using this format, the *goal* should state the overall purpose of the programme, in other words why the programme is being undertaken. The *objectives* should identify what it is that the programme aims to achieve, without including the methods by which objectives will be achieved. If the method of achieving the objective is included in the objective itself then it can stop programme planners and formative evaluators from considering other, perhaps better, methods of achieving the objective.

Once objectives have been specified, then *strategies* can be worked out for the programme. Strategies are concerned with the *how* of achieving the programme objectives. At this stage there needs to be critical examination of all of the possible strategies which could be used to achieve the objectives. The Ottawa Charter or the Matrix of Health Promotion Strategies which sets out a wide menu of health promotion strategies can be used at this stage in the objective setting process to broaden project planners' and formative evaluators' thinking about possible strategies.

Most good strategies within a programme are likely to be relevant to more than one objective, therefore both conceptually and in terms of layout, it is not necessary to fit strategies under only one objective. Once the list of strategies has been developed, the objectives should be re-examined to see whether the total range of strategies proposed will be likely to be able to achieve the objectives.

At this stage programme planners can go on to set performance indicators for each strategy. These are concerned with the specific targets of *who, where, how much* and *when*. Setting performance indicators helps to keep activity focused, provides a structure for programme staff to work within and allows ongoing assessment of progress. Table 3 illustrates how the system of a goal, objectives, strategies and performance indicators can be used in planning for a back injury prevention programme run by a health promotion organisation with a National Office and District Offices throughout the country. It is a simplified example, in practice, objective setting for such a programme would be likely to be considerably more complex.

Looking at this example in more detail, it can be seen that the strategies are not just directed at only one objective. For instance, Strategy 2, the public advertising campaign, could contain references to the Code of Practice on Safer House Design; such a campaign might also create increased awareness of back injury among policy makers in relevant organisations; and part of the liaison with other organisations would be to make them aware of the advertising campaign and the Code of Practice.

Table 3: Example of Laying Out Objectives Using the Schema for Objective Setting

PROGRAMME GOAL:
To reduce back injury in the home and the workplace.

PROGRAMME OBJECTIVES:

-Increased public knowledge of how to prevent back injury.
-Increased action by relevant organisations directed at reducing back injury.
-Increased safety of the physical environment in homes and in the workplace.
-Decreased compensation costs for old back claims.
-Decreased new back claims.
-Reduction in the number of self-reported adult back pain sufferers in the population.

STRATEGIES AND PERFORMANCE INDICATORS

Strategy 1. Liaise with relevant organisations to increase collaborative action to prevent back injury.

Performance indicator 1.1 Meeting organised by National Office between relevant organisations to promote collaboration on injury prevention to be held by 30 May.

Strategy 2. An advertising campaign directed at increasing public awareness of the prevention of back injury.

Performance indicator 2.1 Campaign material produced by National Office and pre-tested by 30 May.
Performance indicator 2.2 Campaign run from 7 July to 30 October by National Office.
Performance indicator 2.3 Three national news items generated about the campaign by 30 August by National Office.
Performance indicator 2.4 Three National Office organised radio talkback shows broadcast by 30 August.

Strategy 3. Developing and implementing a Code of Practice for Safer House Design.

Performance indicator 3.1 National Office to have commissioned and published a new Code of Practice for Safer House Design by 30 January.
Performance indicator 3.2 National Office to prepare and publish a flyer to promote the code by 30 March.
Performance indicator 3.3 By 30 September, District Offices to have sent a copy of this code to major builders in their area and to have met with them to discuss it.

Strategy 4. Develop with the Occupational Safety and Health Service of the Department of Labour a set of guidelines for Backcare in the Workplace.

Performance indicator 4.1 National Office publish the Guidelines for Backcare in the Workplace by 30 September jointly with the Department of Labour.

It should be noted that objectives and strategies should be regarded as a flexible foundation for programme planning in the early stages of programme development. It is quite appropriate for objectives and strategies to be reviewed early in a programme and, of course, performance indicators will be changed at regular intervals as the programme proceeds.

Once objectives and strategies have been set out in this way the Schema can be used as the basis for an ongoing project plan. Under each of the performance indicators progress can be reported and new performance indicators added. This can then be kept as a record of the programme progress and can provide detailed information for process evaluation about what happened in a programme.

This Schema for setting out programme objectives also forms the basis for thinking about outcome evaluation for the programme. In preparation for outcome evaluation, each objective is examined as to the ways in which it can be measured. As noted above, traditional wisdom in project planning is that objectives need to be measurable. However programmes should not be driven by what is measurable. It is not a rational strategy to just do that which can be measured. The issue of measurability needs to be addresssed but it is a secondary step. It is particularly important for health promotion to hold firmly to this view in the face of the push for evidence based medicine. If proponents of evidence based medicine suggest that only information obtained from controlled trials should be used as the basis for determining what approaches to adopt in health promotion, this would lead to health promotion only using those strategies which have been confirmed in controlled trials. Such an approach would very severely restrict the range of strategies available to health promotion and would force practitioners into doing just that which

is measurable rather than that which careful analysis would suggest should be done to effectively promote health.

While measurability should not drive objective setting, it is of course central to outcome evaluation. In terms of the Schema for Health Promotion Programme Objective Setting, outcome evaluation is based around a careful examination of how to measure each of the programme objectives.

To look at the example in Table 3, the ways of measuring the programme objectives would be as follows:

- Increased public knowledge of how to prevent back injury

  - sample survey of public knowledge before and after the programme

- Increased action by relevant organisations directed at reducing back injury

  - measuring the number of media stories indicating organisations undertaking action before, during and after the project.

- Increased safety of the physical environment in homes and in the workplace

  - information on the number of new houses which conform to safe design standards

- Decreased compensation costs for old back claims

  - from the records of the national compensation organisation

- Decreased new back claims

  - from the records of the national compensation organisation

- Reduction in the number of self-reported adult back pain sufferers in the population

  - questions a general population survey looking at awareness of the programme (this may require a longer time frame than the public knowledge survey used to measure the first objective; the time frame depends on the incidence of back pain in the community and may require a larger sample size than the public knowledge).

Two key issues in thinking about specifying measurements for each objective in a programme is the timeframe over which such measurement should be taken and the cost of measurement. It may be theoretically possible to measure an objective but it cannot be concluded from this that it should be measured. The amount to be spent on measuring outcomes of objectives needs to be considered in relation to the cost of the programme and the strategic importance of the information which will be provided. If a programme is a routine programme which has been undertaken many times before and has undergone rigorous formative evaluation there will be less case for spending a large amount of resources on specific outcome measurements. Dealing with this issue is taken up in the next two sections of the Health Promotion Strategic Evaluation Framework.

The timeframe issue is even more difficult than the cost one, in measuring objectives' outcomes. Unless measurement takes place over a long period of time, outcome evaluation results can always be challenged. Those who support a programme can always say that it takes a long time to yield results and that the effect of the programme will not be felt for a number of years. This is particularly the case for developmental programmes which are directed at starting processes which

will ultimately lead to results in the long term. Equally, opponents of a programme can argue that any outcome results which have been found soon after a programme are a temporary phenomena and that longer term measurement would have shown a fall off in the effects being measured. This highlights the fact that outcome evaluation has its own problems and advantages just like formative and process evaluation. The ideal situation is to use all three rather than adopting an option for only one approach.

In summary, the Schema for Health Promotion Programme Objective Setting provides a way of developing goals, objectives and strategies for a programme which encourages a broad consideration of strategies, provides a basis for programme planning and implementation and also can be used to structure thinking about outcome evaluation.

4. Policy for Selecting Type and Level of Evaluation for Different Projects Within an Overall Health Promotion Programme

The fourth element in the Health Promotion Strategic Evaluation Framework seeks to answer the question: *how should we be using our evaluation resources on the individual projects within an overall health promotion programme?* Obviously, the type of health promotion project or intervention obviously influences which specific evaluation methods are used. For instance, a programme to promote policy change on smoking will require different evaluation strategies from a programme directed at children's nutritional health. The issue of how to develop an integrated approach to evaluating a number of projects under the one overall programme had to be addressed in the project looking at the Accident Compensation Corporation

Accident Prevention Programme Evaluation Policy. It was also a central issue which was grappled with in the booklet *Evaluating Health Promotion: A Guide for Health Promoters and Health Managers* (Appendix 2). This booklet was prepared for the Health Promotion Programme of the Department of Health and was designed to provide guidance for health promoters and managers. Twenty health and health promotion managers were interviewed in order to collect information on their concerns and approaches as input into the writing of the booklet.

The key issue in looking at developing an approach to evaluating a number of projects within an overall programme is to look at the factors which are likely to influence the choice of the appropriate type and level of evaluation for all health promotion projects. These are set out below:

1. How much is already know about the intervention? Clearly if a type of intervention has already been extensively evaluated in the past then it does not need to be subject to such a rigorous review. The more innovative a project is, the more important it is to find resources for a process and outcome evaluation.

2. The experience and training of the staff involved. Many of the staff moving into health promotion are new to the area and have trained in other disciplines. For new staff in a new unit, reviewing previous research is particularly important. A review of the research literature and other programmes can be particularly useful.

3. The importance of the programme as a pilot project. If it is intended that the programme be initially introduced on a small scale and then expanded if thought useful, a more elaborate evaluation is needed. Particularly important is formative

evaluation, which helps to clarity the objectives of the programme.

4. The resources available to evaluate the programme.

5. The demands of the stakeholders involved in the programme. Different groups in the community have different expectations about evaluation. For example, Maori people seek, as a right under the Treaty of Waitangi, control over the evaluation process in addition to control over the direction and use of funding. It is essential that the wishes of the stakeholders are negotiated in the evaluation programme if the results are to be valuable to all involved.

6. The level of certainty required in answering evaluation questions.

These six factors are important in determining the appropriate mix of types of evaluation for particular health promotion projects. In order to illustrate how these criteria can be used, a series of health promotion projects run within an overall health promotion programme can be looked at and an appropriate mix of types and levels of evaluation can be developed for the projects. A central question which needs to be addressed is developing a realistic approach to evaluating small projects. Demanding that small projects (for instance those only funded for several thousand dollars) have a full scale evaluation is totally unrealistic because of the level of resources such evaluations would require.

The approach developed here has two aspects. The first is that the overall programme, of either a local health organisation, or in the case of the Accident Compensation Corporation, its overall programme, should be subject to evaluation

evaluation, which helps to clarity the objectives of the programme.

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The approach developed here has two aspects. The first is that the overall programme, of either a local health organisation, or in the case of the Accident Compensation Corporation, its overall programme, should be subject to evaluation

as a whole. This can be done by what is termed an *external evaluation programme review.* This concept is similar to the idea of a *site visit*, *accreditation* and *programme audit*. There is where a programme is examined by other people familiar with the field who draw together any qualitative or quantitative information available on the programme. It answers the question: *as outsiders, after looking at the programme's objectives and functioning, evaluations of similar programmes, and drawing on our own experience, what suggestions can we make as to how this programme could function better?*

The concept is that such an external evaluative review would look at whether is seems, based on the reviewers' knowledge of the health promotion area, that the projects within the programme are related to the programme's overall objectives in some consistent and integrated way, and generally how well the programme is run. If there is tight integration in terms of linkages between overall programme goals and those of specific projects within the programme then this gives some confidence that at least there is the possibility of the individual projects being headed in the same direction as the programme as a whole. The second aspect of the approach to dealing with evaluating small projects within an overall programme is to specify some "bottom line" of evaluation which the small projects will be subject to.

In looking at the idea of this bottom line, two parts of formative evaluation were unpacked, the idea of ensuring *standard management practice,* and that of *reviewing previous research and experience*. These two elements were pulled out because it was thought that they contained a set of practices which should be demanded of any programme no matter how small. Standard management practice includes specification of goals, objectives and targets; routine collection of data useful for monitoring activity; accounting for day to day use of funds; routine review

of the programme; overview of staff training and development; and quality assurance. In addition to this it was thought that there needed to be some idea of a review of previous research and practice in an attempt to ensure that the project, no matter how small, was building on knowledge in health promotion and was not reinventing the wheel or repeating mistakes which have been identified from programmes in the past.

Having unpacked these elements of formative evaluation and including the idea of external evaluative programme review, an approach to the issue of what type and mix of evaluation should be employed over a group of projects within an overall programme can be developed. The approach here builds on the set of criteria for determining the type and level of evaluation which were laid out earlier in this section. An example of how this approach could be applied is set out in Table 4. This table is from *Evaluating Health Promotion: A Guide for Health Promoters and Health Managers* (Appendix 2). The notes at the bottom of this table indicate how the criteria for determining the type and level of evaluation were used to arrive at the proposed level and type of evaluation for each project.

This kind of approach can also be set out in terms of a policy for evaluation which can be used to guide decisions about the type and mix of evaluation of individual projects within an overall programme. A draft of such a policy is set out in Table 5. This table is also from *Evaluating Health Promotion: A Guide for Health Promoters and Health Managers* (Appendix 2).

In summary, this fourth part of the Health Promotion Strategic Evaluation Framework has looked at the criteria for selecting the type and level of evaluation for different types of project and it has shown how these criteria can form the basis

Table 4: Evaluation for a Set of Individual Projects Within an Overall Programme

Some examples of health promotion projects with which Area Health Boards (AHB) could be involved, and suitable types of evaluation

	Standard Management Practice	External Evaluative Programme Review	Review of Previous Research & Experience	Formative Evaluation/ Developmental Research	Process Evaluation	Impact/ Outcome Evaluation
Area Health Board (AHB) small scale project ($2,000) 1	●					
AHB staff member writing a report on smoking bylaws and liaising with local city council ($10,000 includes salary) 2	●		●			
AHB Christmas Drink Drive programme 3	●		●		◒	◒
Funding to a community group for health promotion ($50,000 per annum) 4		●				
Health Awards Scheme for food outlets meeting health criteria ($40,000) 5	●		●	●	●	◒
AHB women's health promotion programme ($100,000 per annum) 6	●		●	●	●	◒
National demonstration project (over $200,000 per annum) 7	●		●	●	●	●
National advertising campaign to reduce smoking in young people ($250,000) 8	●		●	●	◒	●
All activity of the Health Promotion or Health Development Unit of AHB ($500,000 per annum) 9	●	●				

A half circle indicates a small-scale evaluation

1. In a small scale project a large commitment to evaluation cannot be justified, so standard management practice is sufficient. There will however be some small element of reviewing previous research and experience and of formative evaluation even on a small project. A small project such as this can also be included in the overall evaluation of the health promotion programme of an area health board.
2. Commitment of this level of resources means that a more detailed review of previous research and experience is necessary. Outcomes, apart from the production of the report are difficult to measure in this case.
3. Since Christmas Drink Drive programmes are regularly carried out by other Area Health Boards it is particularly important that information on these previous attempts is examined in the planning of a new programme. A small scale process evaluation to document the programme could be attempted. In addition, if it is able to be done cheaply, an outcome evaluation using hospital data would be most useful.
4. When a separate organisation is funded by a body such as an Area Health Board, one option is to specify in detail at the time of negotiation over funding what evaluation measures should be employed by that organisation. Another approach is to agree that the programme will be evaluated by way of external evaluative programme review. A team made up of members agreed to by the parties involved visits the programme and writes a report on how the team believes the programme is working. In this report there would be discussion of the evaluation measures the programme is using.
5. A novel programme for the country, using considerable resources, this would require examination of the experience of other countries in this type of programme through a review of previous research and experience. It would be important to subject any materials being considered to formative evaluation and developmental research to ensure that they would work with the target groups for the project. A process evaluation on some scale would be important to document the programme and to provide clues as to how to overcome the difficulties of this type of programme in the future. Lastly, if possible, some type of impact/outcome evaluation could be attempted if resources were available.
6. The sizable commitment of resources to this programme suggests that there should be a comprehensive evaluation effort. This would include investigation of previous experience and research on such programmes, consultation with stakeholders regarding their expectations about the programme as part of formative evaluation, a process evaluation to document what happened, and some attempt at impact/outcome evaluation, perhaps changes in awareness and reported behaviour in those involved.
7. A national demonstration programme with a heavy outlay of resources requires an equivalent evaluation effort covering all the areas of evaluation.
8. A national campaign of this sort would require considerable evaluation because of the level of resources expended. The process evaluation may be on a small scale just to highlight problems in running this sort of campaign in New Zealand for the information of programme planners in the future. The outcome measure of rate of cigarette consumption by teenagers could be used if it could be obtained without great expense.
9. All the activity of the Health Promotion or Health Development Unit of an Area Health Board could be evaluated using an external evaluative programme review. A team of reviewers perhaps including an overseas reviewer, could be asked to write a report on the programme as a whole. They would suggest ways of improving the programme and areas where they thought it was doing well.

Table 5: Draft Evaluation Policy for an Overall Health Promotion Programme

A draft policy for area health boards on evaluating health promotion programmes

- Evaluation is not a separate activity but is an integral part of policy and planning for the board. It is directed at answering the question for programmes and projects 'Is this the best way of doing it?'
- All evaluation procedures will be based on the recognition of the Treaty of Waitangi.
- All evaluation activity will be sensitive to culture, gender and class perspectives.
- The nature of evaluation of Maori and community initiatives will be negotiated as part of the funding process, not imposed subsequently.
- An administrative framework to support evaluation services for the Board will be established, for example an evaluation unit and/or contracting outside researchers.
- Usually all health promotion programmes will be subject to evaluation by way of:
  Standard management practice.
  Review of research and experience.
  Formative evaluation (including needs assessment and developmental research at some level).
- Novel projects will have high priority for process evaluation.
- Where review of research and experience and formative evaluation suggest it is appropriate then an impact/outcome evaluation should be considered.
- The choice of an external or internal evaluation will depend on the size of the project, degree of innovation, skills of staff, and resources available.
- External evaluation will always be undertaken in close collaboration with the project implementers.
- Internal evaluation will be undertaken in association with outside evaluators where necessary, to assure quality assurance of the evaluation effort.
- External evaluative review will be considered for community initiatives funded by the Board and for the Board's health promotion programme as a whole.
- Staff training about evaluation will be provided for staff at all levels within the Area Health Board to ensure both realistic expectations of evaluation and evaluation skills at an appropriate level.
- Adequate resources will be made available for evaluation; as a rough guide 10% of the usual programme budget will be available.
- The results of evaluation research will be freely available to the public from the Board.

for policies about the type and mix of evaluation for projects within an overall health promotion programme.

5. Model of Where Strategic Health Promotion Evaluation Fits Within the Social Problem Cycle

The fifth element in this overall framework for health promotion strategic evaluation is a model of the social problem cycle, including the place of health promotion in this, and the most useful areas for strategic evaluation input within the cycle.

This model is concerned with *strategic* evaluation. It is strategic in the sense that the assumption is made that the amount of effort put into evaluation should be related to the strategic value of the results of the evaluation effort, whether it be formative, process or outcome evaluation. This is not always the case with evaluation. As Shadish (1987) comments, evaluation is probably done more often than it is needed in a world with limited resources. There is no special merit in an elaborate evaluation of a programme simply for the sake of evaluation. Evaluation uses up the scarce time and resources of both evaluators and project staff. Strategic choices need to be made regarding how much effort should be spent on evaluation in contrast to actually running the programmes.

There are three elements to the consideration of whether, and which, evaluation efforts should be undertaken. The first involves looking at the evaluation in relation to a particular project; the second examines it in relation to the particular organisation or programme of which the project is a part; and the third analyses the strategic position of the evaluation effort within the health promotion field as a whole

at a particular point in time. The first two issues have been discussed in the previous sections of the chapter; the strategic fit with the health promotion field as a whole is discussed here. In the long run, this third element may be the most important consideration in ensuring that evaluation resources are used wisely.

The Social Problem Cycle

Looking at the strategic fit of any piece of evaluation commences from developing a model of the social problem cycle such as the one which has been developed here. The concern about a health promotion topic such as alcohol is driven by the perception that it is causing social problems of one sort or another. The term social problem here is used broadly to include the health and other concerns which bring to prominance a health promotion issue. Figure 9 sets out the basic social problem cycle. The cycle starts with the *definition of a social problem*, say for instance the problems associated with alcohol use.

The next stage in the cycle is that the definition of a problem naturally leads to a *desire to solve the problem*. From simply a human point of view, almost certainly all of the people from stakeholder groups involved in a social problem would like to see it solved in order to reduce the human suffering it causes. If no stakeholders are threatened by potential strategies aimed at solving a social problem the cycle rapidly moves through to problem solution. Given most people's general good will in regard to reducing unnecessary human suffering, most social problems only tend to remain unsolved in those instances where the strategies which need to be implemented for their solution threatens the interests of powerful stakeholders. This is represented by the arrows running upwards on the left hand side of the social problem cycle

which indicates *resistance from threatened stakeholders*. The initial unexamined responses which are not particularly threatening to stakeholders tend to be *undertheorised "knee-jerk" reactions*. These are the initial strategies proposed in any area when people first start to think about a social problem. They are based on unexamined theories of what causes and is likely to change behaviour based on an individualistic ideology. Such reactions tend to be those which are politically easy, have a positive public relations profile, and generally do not draw too heavily on the public purse.

In the case of drug problems, for instance, these are strategies such as a visiting speaker going to warn school children about the dangers of illicit drugs, financed by donations or fees from parents and by corporate sponsorship. Mass media campaigns about problem drinking which are not integrated into a suite of other health promotion strategies are another example. The undertheorised knee-jerk reactions tend to be largely palliative and do little to reduce the social problem they are attempting to solve. If the solution to the problem was as easy as the "knee-jerk" reactions suggest, it is likely that the problem would have been solved a long time ago. The model sets this out by showing the "knee-jerk" reactions leading to *palliative interventions* and hence simply returning to the start of the social problem cycle once again.

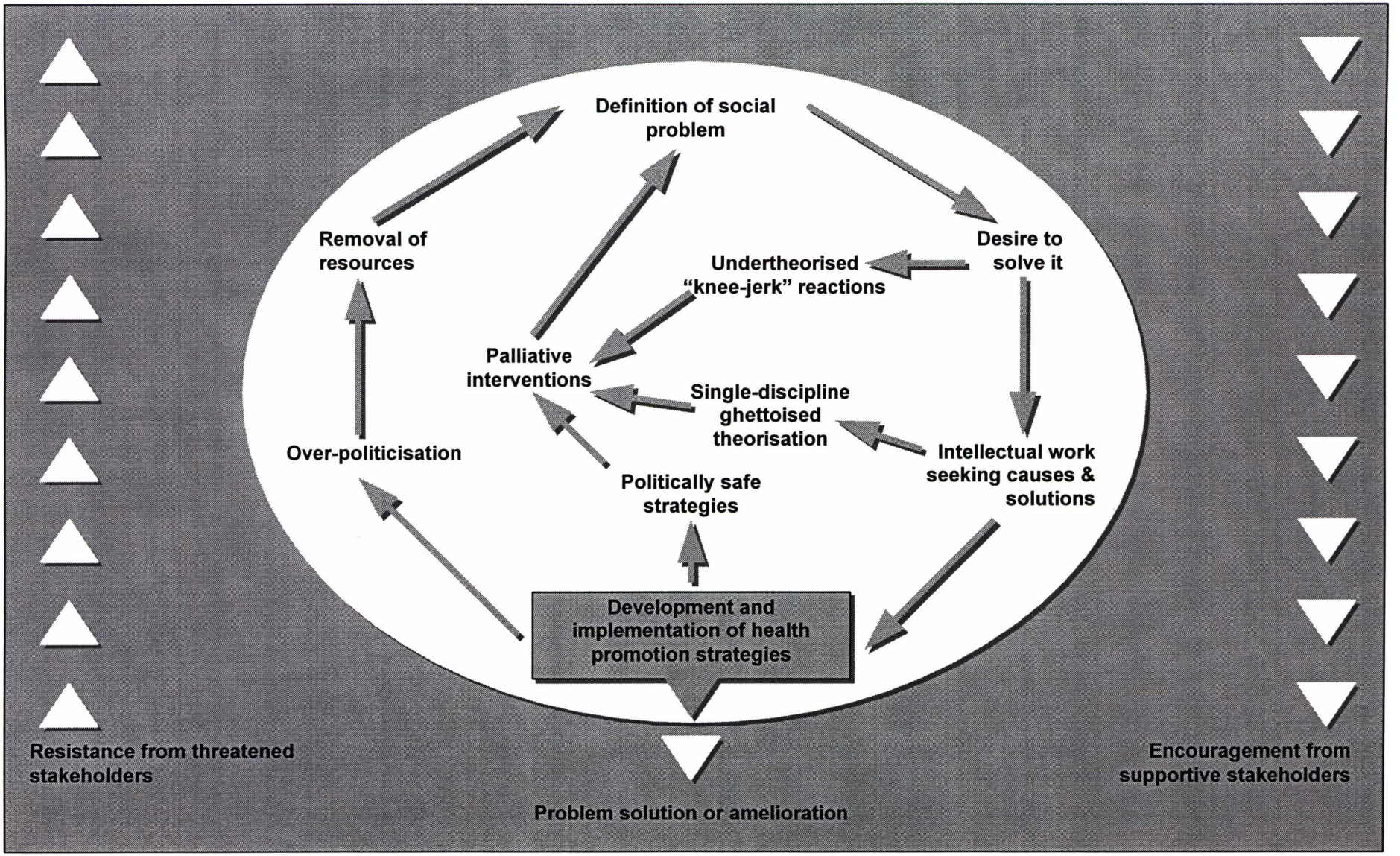
In addition to these initial "knee-jerk" reactions, in areas which become defined as major social problems, resources are often dedicated to *intellectual work seeking causes and solutions* to the problem. This work is financed by society because of the cost attendant upon the social problem. The Alcohol and Public Health Research Unit is a good example of a unit established to undertake such work. The health promotion and social science literature is made up of this intellectual work as

researchers and practitioners grapple with the issue of what are the causes of ill health and how health can best be promoted.

Within the model set out in Figure 9, at this point, such effort can be channeled in two major directions. On the one hand it can go into what is here termed *single-discipline ghettoised theorisation.* This consists of discipline-specific theorisation which builds elaborate theories of the causes of health problems without integrating such theories with those from other disciplines. This can lead to a myriad of different theory systems using different languages which are then unlikely to be able to be validated against actual health promotion experience because they are ghettoised in one disciplinary discourse. Such activity usually fails to provide either a parsimonious account of the social world or to significantly contribute to the amelioration of social problems. In Figure 9, this type of activity has been characterised as also contributing to palliative interventions. This is because where theorisation is locked in a single discipline and disengaged from policy debate it has little traction in assisting in developing and assessing proposals for action on the social problem.

Figure 9 sets out the alternative direction which can be taken at this stage. This is for intellectual work to focus on building a basis for the development and implementation of health promotion strategies to alleviate the social problem. This is the central focus of the policy-orientated multidisciplinary health promotion research literature. There are three possible results of a move in this direction: the use of only *politically safe strategies* which again have a tendency to lead to palliative solutions; *problem solution or amelioration*; or if strategies become *over-politicised*, intervention by powerful stakeholders which are threatened, and *removal of resources* for the intervention effort.

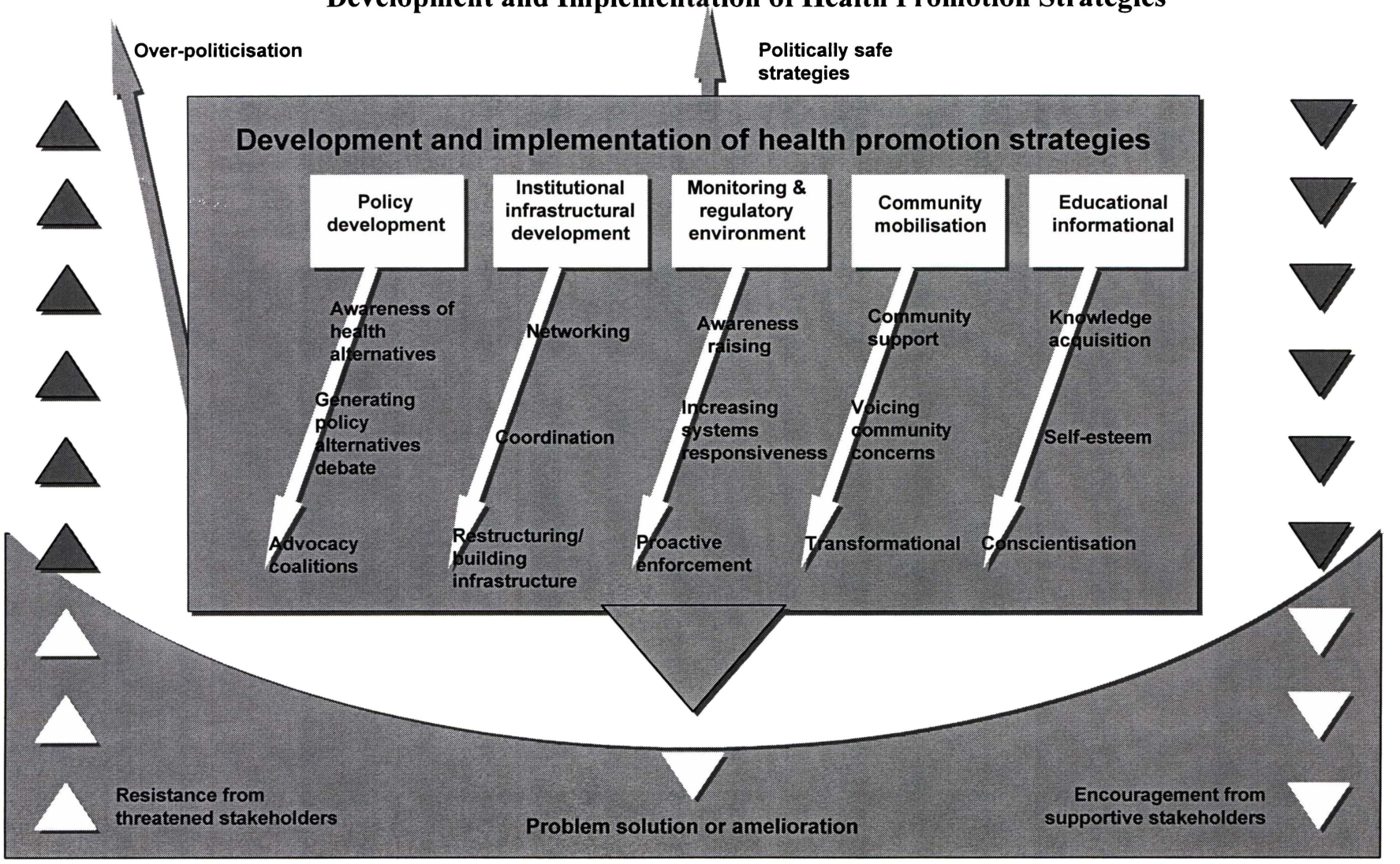
Figure 9: Health Promotion and the Social Problem Cycle



This part of the process is detailed in Figure 10 which examines more closely the phase in the social problem cycle concerned with the development and implementation of health promotion strategies. Within this phase, each of the six *approaches* to health promotion set out in the Matrix of Health Promotion Strategies (Figure 4), which was discussed earlier in this chapter, are available (educational/informational, community mobilisation, monitoring and regulatory enforcement, institutional infrastructural development and policy development). For each approach, the figure lists the three possible *styles* identified in the Figure 4 Matrix. Each of these sets of three styles can be roughly positioned along a continuum. At one end of this continuum are those which have a relatively positive public relations profile and do not politically offend the interests of powerful stakeholders. At the other end are styles which have the potential to have a more negative public relations profile; could be of relatively high immediate cost to the public purse; and are often politically offensive to powerful stakeholders.

For example, a programme using the educational/informational approach may use a style based on increasing an individual's knowledge acquisition about life-style risks. This is at the "safe" end of the spectrum. It has a positive public relations profile, it may be able to attract corporate rather than taxpayer sponsorship, and it does not generally offend any powerful stakeholders in any serious way. In the middle of the spectrum would be a style which used educational attempts to build self-esteem. While such approaches would be nominally endorsed by almost all stakeholders, in certain areas, depending on the way in which the growth of self-esteem may manifest itself, It could meet with some resistance from some stakeholders. Further along the continuum, still using an educational/informational approach, there could be the attempt to conscientise people so that they become

Figure 10: Detail from Figure 9
Development and Implementation of Health Promotion Strategies



increasingly aware of the role of the stakeholders who are promoting unhealthy behaviour (for instance, through tobacco and alcohol advertising) and in whose interests such advertising works. Such conscientisation would then lead to people taking concrete political action to counter the activities of such stakeholders. These attempts are obviously more likely to be resisted by the interest groups which are affected by them.

Developing and implementing strategies which lie at the more politically difficult end of the spectrum relies on there being tacit, or in some cases active, political support from at least some of the more supportive stakeholders with an interest in the area. This is represented in the figure by the downward facing arrows on the right hand side. The major stakeholders from which such support is likely to come are those with a community of interest with health promotion. These tend to be the social movements (Maori, the women's movement, the environmental movement, and the consumers movement). In specific areas, other groups will also provide political support. For instance, on alcohol issues there may be political support from church groups; on issues related to the working environment support is likely to come from the trade unions. This support can come in a variety of guises. While it may be in the form of support for particular strategies, it may also be framed as criticism of health promotion strategies at the politically safe end of the continuum; hence increasing the pressure for strategies which are at the more politically difficult, but potentially more effective, end of the continuum.

In general, the more politically difficult a strategy, the more likely that it is getting at the "source" of a health promotion problem. Hence, the desire to get to the root causes of a problem leads toward the more politically difficult styles in each of the approaches. However, a shift towards the more politically difficult end of the

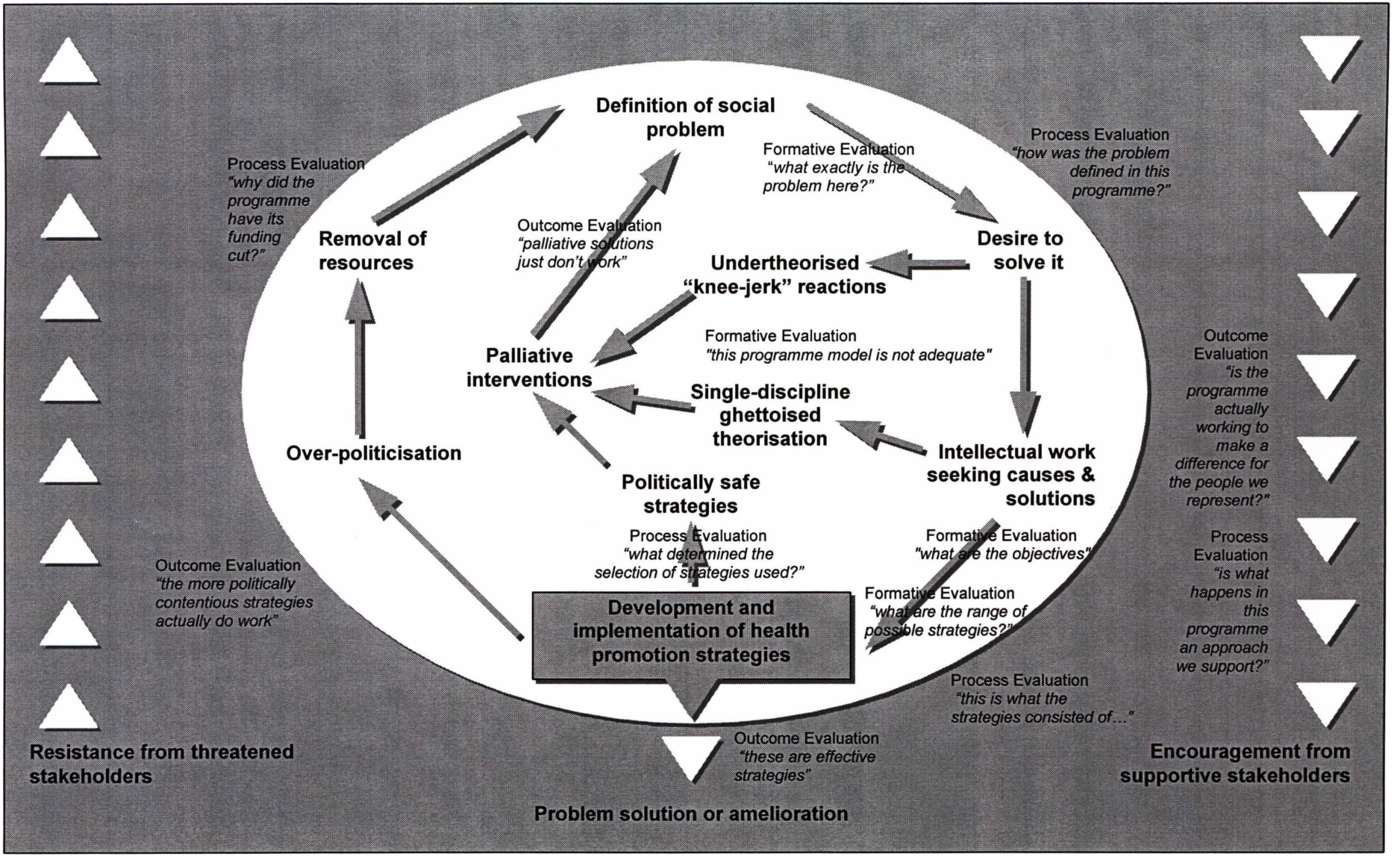
continuum also increases the risk of "over-politicisation". This occurs when a strategy has become politicised and publicised to an extent that the gains in political support from sympathetic stakeholders are outweighed by the backlash reaction of stakeholders who believe that the strategy threatens their private interests. In this case, the cycle tends to move to removal of resources and back to the continuation of the social problem for at least this round of the cycle.

Place of Strategic Evaluation in the Social Problem Cycle

This description of the social problem cycle provides a foundation for examining the role of strategic evaluation. Figure 11 identifies key phases for strategic evaluation input into the social problem cycle. At the problem definition phase, formative evaluation can assist with needs assessment and basic research identifying "what exactly is the problem here?" For instance, in the case of the Wanganui Community Alcohol Action Programme, which did not have formative evaluation input, formative evaluators would have asked what exactly the problem was that the Wanganui Project was attempting to address; was it Christmas road-toll, or was it, as came to be the case, every alcohol related problem in Wanganui? Process evaluation also has a role at this stage in asking about programmes which have been run in the past, “how was the problem defined in this programme?” This was done in the case of the Wanganui process evaluation.

Formative evaluation of palliative interventions can question the reasoning behind the programme and point out that “this programme model is not adequate” in those cases where the methods being used are unlikely to do anything significant about the problem. For instance, pointing out that very little of the variance in young

Figure 11: Health Promotion Strategic Evaluation Questions and the Social Problem Cycle



people's alcohol related behaviour is likely to be explained by what happens in a one hour session within a school. Moving down the cycle to the stage of the intellectual work seeking causes and solutions. Formative evaluation's input is to help ask the question "what are the objectives" of programmes. It can also assist in answering the question "what are the range of possible strategies" which can be employed to achieve a set of health promotion objectives. This was done in the case of Heartbeat, CAP and the Licensing Project. Process evaluation at this stages looks at "this is what the strategies consisted of" so that other health promoters can consider implementing them in their programmes. This was done in the case of Heartbeat, CAP and the Licensing Project. This information feeds directly into the development and implementation of health promotion strategies. In addition outcome evaluation indicating that "these are effective strategies" is obviously an important component in the development and implementation of health promotion strategies.

At this stage in the social problem cycle, evaluation information is also of interest to potentially supportive stakeholders. Firstly, because they will only support the politically more difficult health promotion strategies if they are convinced that the strategies being used actually work to reduce the problems faced by the people they represent. Outcome evaluation can assist here by answering the question "is the programme actually working to make a difference for the people we represent?" The outcome information from CAP can be used in this way. Secondly, they will want to know exactly what happens within a health promotion programme to answer the question "is what happens in this programme an approach we support?" For instance, is the programme empowering to those who are involved? Information on this can be provided by process evaluations. For instance, in the case of the

Licensing Project, the process evaluation pointed out that one of the ways of working was to provide a voice for community concerns about how alcohol problems were affecting community members, something which was likely to be supported by a wide range of community, women's, Maori and Church groups.

Proceeding on to the stage where politically safe strategies may be adopted, process evaluation looking at the overall context of a programme can examine how strategies were selected. The Wanganui process evaluation examined this issue and critically analysed the political factors behind the selection of approaches and methods. Outcome evaluation also plays a role further on, at the stage of over-politicisation in defending effective but politically difficult strategies from criticism indicating that "the more politically contentious strategies actually do work." For instance, the outcome evaluation from CAP can be used in this way to support the alcohol health promotion organisers' approach. Process evaluation at the stage of removal of resources can ask the question "why did the programme have its funding cut?" and point to the role of threatened stakeholders in such events.

So, in summary, the fifth part of the framework for strategic health promotion evaluation has been a Model of Where Health Promotion Strategic Evaluation Fits Within the Social Problem Cycle. This model has been developed to assist in answering the question: *which pieces of evaluation research have high strategic value for health promotion at this particular point in time?* Careful analysis of which stage of the social problem cycle a particular health promotion topic has reached can provide a good idea of which evaluation questions it may be useful to address next. A look at the problem of alcohol in the New Zealand context using the evaluation questions set out in Figure 11 can provide an example of this process. The question of "what exactly is the problem here?" is continuously contributed to by

the Alcohol and Public Health Research Unit and other researcher's work in tracing the role of alcohol in social problems. The original Community Action Project (CAP) helped to look at the questions at the bottom of the figure which deal with exploring a new strategy, saying what it consists of and trying to work out if it is effective. This having been done, the focus in the Licensing Project was more on optimising the approach and providing information and evaluation of what was being done for supportive stakeholders (in this case the public health sector) so that it would continue to be supported as a viable strategy in the face of any opposition which arose. Involvement in the Wanganui Project was part of attempting to ensure that palliative interventions were not being promoted over more difficult but effective interventions (this is not to say that the enforcement aspect of the project was just palliative). At each point, these evaluation projects addressed strategically important aspects of the social problem cycle for alcohol.

6. A Strategic Approach to Determining Priority Health Promotion Evaluation Research Methods

The last element in the framework for health promotion strategic evaluation is a strategic approach designed to answer the question: *how can we decide on the priority of different methodologies in health promotiom evaluation*?

There are many factors which can impinge on a researcher's selection of evaluation topics and methodologies. These include disciplinary background, their values, where they work, etc. However, in health promotion evaluation, it is not adequate to simply say that researchers should choose whichever research methodologies they like. This section argues that a structured approach can be

developed around the concept of designing evaluation methodologies robust enough to withstand methodological critique by key unsympathetic stakeholder audiences. It should be noted that this criteria is being advanced for health promotion *evaluation* rather than for health promotion research as a whole.

Any approach to selecting health promotion evaluation methodologies has to be rigorous enough to deal with three important considerations: the politicised nature of the health promotion field; the ascendancy of a strong relativism in the social science community; and the call for *evidence based medicine.* Each is examined briefly here.

Firstly, the politicised nature of the health promotion field means that researchers who want stakeholders to listen to them cannot just base their work on their own values and perspectives. Such a position can be summarised as reseachers saying "because science is not value free, I will decide my methods and approaches on the basis of my values and perspectives." In situations where the researcher's audience has similar values and perspectives this approach is fine and many researchers may spend most of their research time on such research. However, when the researcher is wishing to establish dialogue with others who do not share the same values, a different approach may be needed. This is because the researcher's initial position is likely to be greeted with the response from a value-divergent stakeholder: "well, that is fine for you but I don't plan to listen to your research findings because they are determined by your values and perspectives and I don't share these." In the author's view, a different approach is needed to deal with this situation. When a researcher is dealing with value-divergent stakeholders they could take the following approach. "You and I have different values and perspectives, we can discuss these and see if we can change them. If on the other

hand, we don't change our values, can we agree, for particular purposes, on methods for collecting and analysing information which we will both take into account in thinking about this issue?" Unless there is the possibility of this sort of partial agreement on method, it is not clear how value-divergent stakeholders can dialogue about issues. Of course, it cannot be presumed that researchers will always be able to find common methodological ground with all value divergent groups. So, for instance, in the alcohol policy area it may be that this ground cannot be reached with the alcohol industry but it may be able to be reached with the media, or policy makers. It should be noted that such common ground is not being reached on the basis of both sides changing their values, rather seeking areas where both sets of values can accommodate certain methods of generating knowledge claims which will have some acceptance by both parties.

Secondly, in addition to the issue of the political context and health promotion evaluation methods, there is the ascendancy of a strong relativism in the social sciences which have resulted from large shifts in Western intellectual culture. Komesaroff (1990) talking in the context of medicine and health research has summarised these developments as follows:

> While the 'Enlightenment project of ethics' was being subjected to a barrage of criticisms and alternatives, important cultural changes were occurring in society as a whole - changes with the capacity to produce a profound, direct effect on both the theory of morality and the practice of medicine. The integrity of the project of modernity itself was being thrown into question and its most fundamental assumptions subjected to a searing critique. For some, these changes amount to an epochal transition: from modernity to postmodernity. Now, it is important to

> note that the nature of 'postmodernism' and its status as a concept remain controversial. Nonetheless, there are certain novel features of the contemporary cultural configurations of developed Western societies which demand to be acknowledged. These include a rejection of the commitment to certain knowledge and the search for an irrefutable foundation for truth. They include a particular emphasis on the need for an ongoing reflection on, and awareness of, the process of the generation of cultural products, including, in particular, of knowledge itself. And they include a rejection of the 'grand narrative' as historically obsolete - especially the great cultural constructions of 'humanity', of the 'proletariat', of 'womenkind', of 'beauty', of 'truth' and of the project of universal 'liberation'. The central subject from which truth and knowledge have flowed for 300 years is abolished; and the notion of a single totalising reason as the organon, guarantor and guardian of knowledge is abandoned. (p. 41)

This set of developments in Western intellectual culture has flowed through to the social sciences in the form of a rejection of the idea relativism and no longer having absolutes such as "scientific fact" arrived at by a standard cannon of scientific methods. There has been an accompanying blossoming of different methodologies in the social and health sciences (de Koning & Martin, 1996; Layder, 1993; Steier, 1991). The postmodern lack of a cannon of scientific practice makes selecting between such new methodologies extremely difficult.

Thirdly, and somewhat ironically, in addition to a strong push for relativism, there is also a movement within health promotion for evidence based medicine - the

"growing emphasis, both in New Zealand and internationally, on the evidential basis for current health practice" (Paterson, 1996, p.2). A reflection of this is the growth of the Cochrane Collaboration, an "international network of individuals working together to prepare, maintain and disseminate systematic reviews of the effects of health care. In general, these reviews are based on the results of random controlled trials" (Health Research Council, 1996, p. 2). This is the classic medical science paradigm at its best.

For the author the practical manifestation of the tensions in this area comes to the fore when he is sitting on a Health Research Council research granting committee involved in discussions about which of a series of projects scarce research funds should be allocated to. What can be the basis for making a decision in such a situation? The committee members enter the room with some degree of shared understanding that evaluation research can be potentially useful in addressing health promotion issues. However, in thinking about which projects they are going to fund they need to consider the three factors outlined above. First, a political context where there may be strong attacks from stakeholders on findings which threaten their interests; second, the blossoming of a wide range of new qualitative methodologies often with diverse, complex and relativistic theoretical bases; and third, the push for what looks to some like the old logical positivism being promoted this time under the heading of *evidence based medicine.*

It is useful here to look at three *fictional* examples of health promotion evaluation research projects which could possibly come before a Health Research Council research grants assessing committee (to my knowledge these fictional projects on these particular subjects have never come before an assessing committee, but they are designed to be typical of the sort of application which could

well be received). Before starting this discussion, it should be noted that what is being considered here is how to decide between methodologies for health promotion evaluation. The issue of prioritising research funding for such evaluations against more general health promotion research is a much more complex question and is not dealt with in this study.

The three fictional proposals are:

- a Foucaultian discourse analysis approach to evaluating a women's nutrition project;
- a key informants' study of the stakeholders involved in a heart health programme; and
- a quasi-experimental design comparing several different types of smoking prevention programmes.

First, let us look at how the projects might present themselves. The Foucaultian discourse analysis application would argue that its methodology is state of the art, and that it is an appropriate methodology for its subject matter in that it is based on Foucault's analysis of discourses of power in professional situations. It would be directed at uncovering such discourses at the base of the women's nutrition health promotion programme being evaluated. In particular it would look at ways in which notions of "disciplining the body" play a central role in such programmes. The insights from this study would help inform the whole area of nutrition programmes for women. At the same time, the study would be building theory in this important and cutting edge theoretical area and it would help to train young New Zealand health researchers in this promising qualitative research methodology.

The second study, the key informant study, would justify itself in terms of being a standard process evaluation methodology which is aimed at looking at key informant's views as to what worked and what did not work in the implementation of the heart health programme. The researchers would tape record each interview, have them transcribed and then write a report drawing together conclusions from the points made by those interviewed. The justification put forward would be that such a study would do much to make sure that similar programmes run in the future in New Zealand and internationally, avoided any mistakes made in this programme. It would also ensure that the positive lessons from the implementation of the programme could be learned by those who wish to implement such programmes again.

The third study, a quasi-experimental design study of smoking prevention programmes, is likely to be justified on the grounds that it is consistent with the emerging push for evidence based medicine and that this approach needs to be applied in the health promotion area more than it has been in the past so that the field can establish its credibility. The methodology would consist of before and after measures, with control groups. Participants would be tracked for one year after the prevention programmes had finished, and the researchers would remain at arm's length from the programmes so as to maintain their objectivity. The research project would provide useful information for deciding which prevention programmes to use in the future. It would help to build capacity in the health promotion workforce in terms of researchers capable of carrying out large scale quasi-experimental designs. These types of designs will be demanded more and more in the health promotion field as the evidence based medicine movement spreads across the health sector.

All of these claims for the evaluation projects sound good. How can the committee work through the issue of which, if any, of them should be funded? Presuming, for this discussion, that all three topic areas have been identified as priority areas for health promotion by the research funding body after consultation with the health sector, there would be two elements to making this kind of decision. One is to consider the topic of the study, the other is to look at the methodology.

But what criteria can be used to compare the proposed methodologies of the research projects when there is now no clear cannon of social science or, for that matter health promotion evaluation, methodology? One approach could be to compare the methodology of a proposed study against similar methodologies currently being used in related social science disciplines. One of the uses of a peer review systems such as that used by the Health Research Council, is the provision of information on how a proposed grant application's methodologies compare with state of the art methodologies being used in relevant social sciences. The assessing committee looking at our three proposals would have available to it comments from peer reviewers on each of the projects. In respect of methodology, these experts will have commented on how the proposed methodology compares with what others with a similar orientation and theoretical approach are doing in the wider social and health sciences. The reviewers will also have commented on the apparent ability of the researchers to actually undertake the study. For the sake of this discussion, let us assume that the reviewers have generally indicated that the specific methodological approaches are all state of the art in terms of the way in which these methodologies are currently being used by others in the core social science disciplines.

The assessing committee now needs to work out how it is going to decide on which projects to fund. Whatever criteria are established for comparing the studies need to be robust enough so that they can be argued as fair in front of advocates for each of the studies. Depending on the makeup of the assessing committee, advocates for any of the three methodologies may or may not be present. If such advocates were present they may well argue the following in respect of each of the projects (admittedly the arguments are taken to something of an extreme here in order to illustrate the different perspectives on the projects).

The Foucaultian discourse methodologist may argue that the key informants' study was woefully inadequate when assessed on its qualitative methodology. What is its theoretical underpinning? All methodologies have at base a theory, and just because a theory is not stated this does not mean that it is not there. The actual method is also highly problematic since it would not look at the text produced from the transcripts from the point of view of analysing that which has not been said as much as that which has been said. The opposite terms absent from a discourse are as revealing, if not more so, as those which are present. As for the quasi-experimental design study, how could someone seriously in the 1990's propose an approach which is based on so "privileged" a notion of "scientific" knowledge; growing as it is out of the hegemonic position of medicine in people's lives which is maintained by the medical and scientific establishment's use of discourses of power - the use of technical rhetoric to distance others and maintain power positions.

The key informants' study advocate, on the other hand may argue that the Foucaultian discourse analysis application is simply an exercise in building social science theory at the expense of carrying out practical health promotion research. This proposed project, the advocate might say, is just one of an endless number of

projects which could be proposed up by people of different theoretical orientations in the social sciences. These orientations come and go depending on the intellectual fashion of the times. Why bother building Foucaultian theory when you can fund practical research by way of a key informant's study? As for the quasi-experimental design, the timeframe for getting the results is so long that the money would be better spent on projects here and now. It is also unethical for the evaluators to not intervene if they see that one of the programmes they are evaluating is heading in the wrong direction, and this makes the whole study ethically questionable.

Finally, the quasi-experimental study advocate might argue that in the Foucaultian study the researcher's interpretations would be hopelessly tangled up with those of the experimental subjects. Also, the study would do nothing to help us understand what does and does not work in terms of the outcome of womens' nutrition programmes. Moreover, the use of obscure Foucaultian jargon in the application is, ironically, a superb example of using a discourse to exercise power. As for the key informant's study, it should not be funded because it is not even a piece of research. It is really just an administrative review of the area, and does nothing to add to the scientific experience-based knowledge we are trying so desperately to build up in health promotion.

These comments are of course somewhat stereotypical and fortunately researchers are usually more generous about each other's methodologies that this. However, the possibility of such extreme criticism needs to be considered in thinking about fair criteria for deciding between methodologies for health promotion evaluation research.

The approach which is being proposed here is a structured approach involving the following steps:

- determine what exactly is it planned to do in the study. What concrete steps are going to be taken in terms of methods for finding out and analysing information;
- from an analysis of the social problem cycle of the problem being discussed determine the priorities for evaluation research at the current time;
- seek to work out the perspectives of the stakeholders interested in these particular priority questions as to the concrete methods which are being proposed in the studies; and
- select as a priority the piece of research which is most likely to speak to the key stakeholder audiences interested in the priority questions because they would (even if grudgingly) have to accept the concrete methods which have been used to produce the study's findings.

For instance, in the case of our examples here, the question to be put to the Foucaultian study is, "what exactly are you planning to do in terms of interviewing the women in the study?" The same question applies in the case of the key informant's study and similar questions can be formulated regarding the quasi-experimental design.

Thus the first move in this proposed structured approach to selecting the priority of research projects is to develop a clear understanding of exactly what each researcher is actually going to do step by step. This description should be separated out from the particular theoretical orientation which is accompanying the concrete steps in the research process. To the extent that theoretical orientations are incommensurable they cannot provide a basis for deciding which project should

receive funding. The second step is to identify the current key strategic questions in the social problem cycle. The third step is to let the question of who the audiences for such a piece of research are to assume centre stage. This can be done by imagining that key audiences for each project are being asked, "if the particular concrete research steps proposed in this study were carried out would you, prior to knowing the results, be willing to say that these steps are a reasonable way of finding out information; or would you have alternative steps which you think it would be more reasonable to use to find out this information?"

We can imagine for example, that some womens' groups might be very interested in a highly sensitised Foucaultian researcher's detailed reflections on the series of interviews with women in the nutrition programme, because they might be wanting to ensure that such programmes did not contain, for instance, a hidden victim-blaming agenda. An administrator for a heart health programme, on the other hand, might be entirely happy with the steps in the key informant's study on heart health programmes. And a policy analyst might rejoice at the steps being taken by the quasi-experimental design researcher to measure the outcome of the smoking prevention programmes.

For any study, it is usually not difficult to imagine several potentially sympathetic audiences which would be interested in the study findings and would be happy with the steps being taken in the research process. Given the call for "multiplism" (Cook, 1985) and triangulation (Hakim, 1987), in a world of infinite resources the needs of all audiences could be catered for. However, in a situation of scarce resources for health promotion evaluation there needs to be critical reflection on which are the priority audiences for any piece of research at a particular point in time.

Of course, determining who are the *key* audiences regarding a health promotion subject at a particular time is a difficult judgment call. One way of assisting in making this assessment is to return to the social problem cycle presented in the last section, and in particular to look at Figure 11, where the strategic evaluation inputs into the social problem cycle are set out.

Say, for example, we take the Foucaultian analysis of the nutrition research project. It may be that the nutrition project is something of a palliative intervention in the long term because it does not allow women to gain control of their lives, but maintains a dominant control by the medical establishment. If this seems to be the case, in terms of the social problem cycle (as indicated in Figure 11), the most important issue is then to establish this proposition in respect of this particular nutrition programme, i.e. that it one of the palliative health promotion solutions that "just don't work".

Who is it who needs to be convinced of this proposition about the nutrition programme? One key audience is policy analysts within health promotion funding agencies which may be funding such programmes at the current time or may do so in the future. What sort of steps in the research process are they going to find acceptable before they are going to be willing to act on the findings from the research study? Let us assume that there are powerful stakeholders with a traditional medical perspective behind the existing nutrition programme. The policy analysts are going to want a research process which can stand up to methodological attack from a traditional medical perspective.

Looking at the methodology being proposed in this study, it is likely that a traditional "scientific" medical viewpoint would argue that the Foucaultian discourse analysis study would simply be a case of researchers subjectively interpreting the

results to suit their preconceived notions about the attitude of medicine towards women. If the policy analysts want a research process able to withstand attack from this traditional medical perspective, and if it is thought that the problems with the nutrition programme are such that the programme would prove ineffective in assisting women a different study might be needed. A traditional outcome evaluation study may be more useful as a strategic evaluation input into this particular debate at this particular point on the social problem cycle (discrediting palliative solutions) than the proposed Foucaultian discourse analysis study.

Equally, in the case of the heart health key informants' study, it could possibly be argued that the central problem in New Zealand around the heart health issue is that policy makers' deeply held belief that New Zealand is a dairying nation is driving our policies in the area. It could then be argued that it is unlikely that anything serious will be done about dairy food sources of cholesterol until that issue is faced, and that further optimisation of heart health programmes (such as would presumably be the objective of the key informants study) will be ineffectual. We could further imagine that the audience for this message is the health promotion community, because it is desirable for them to become skilled up in strategies for influencing decision makers views. This may call for an indepth qualitative study on influencing decision maker's world views using discourse analysis would be a higher priority for research than the key informants' study. This would be based on the assessment that the health promotion community would accept the methodology used. Acceptable methodology makes it more likely that the health promotion community will take on board the findings and use the strategies developed to work to change policy makers' views. In terms of the social problem cycle this piece of research would fall under the formative evaluation question "what are the range of

possible strategies?" (Figure 11) and would serve to alert health promoters to, and assist them in using, this new strategy for cardiovascular disease prevention.

Lastly in the case of the smoking prevention quasi-experimental study, if the audience is those who are setting up and running smoking prevention programmes, it may be that by the time a long term study comes out they will dismiss it no matter how well it is designed claiming, for instance, that it did not track people for a sufficiently long period of time. It may be that they would be more likely to accept at an earlier stage the findings from a key informants study about what is current best practice in the area of smoking prevention to assist them in setting up their programmes. On the social problem cycle this is again an example of providing formative evaluation information on "what are the range of possible strategies?" (Figure 11).

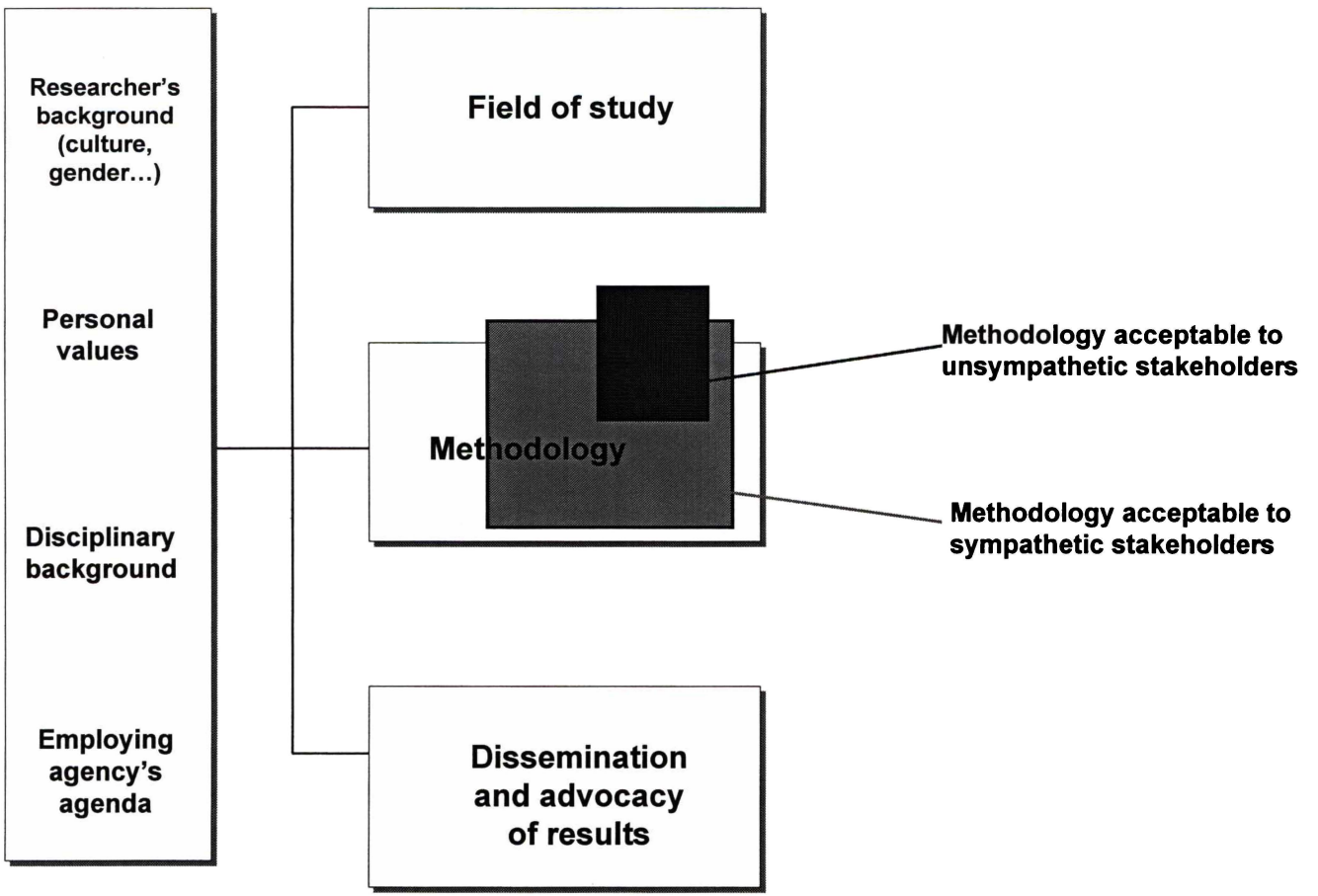
The examples given here are meant simply to illustrate the approach, and there is room for considerable discussion about who the key audiences are in each of these three cases. However, regardless of the specifics of these cases, what is being argued here is that in a structured approach to determining the appropriate methodologies for health promotion evaluation, there needs to be some careful analysis of the identity of the key audiences for a particular piece of research. Methodological decisions should be driven by considering what it is going to take to convince key audiences about the next important strategic evaluation point on the social problem cycle for a particular health promotion topic. Where this point is on the social problem cycle will differ widely for different topics.

It could be argued that the analysis here is rather dismal as it seems to be saying that health promotion evaluation researchers need to be driven simply by the needs of their most unsympathetic audiences. Where do a researcher's values and

background fit into such a scenario? Figure 12 looks at this issue and sets out the influences on the *field of study*, *methodology* and *dissemination and advocacy of results* adopted by a researcher. On the left of the figure are the main factors which influence a researcher, their general background (including culture, gender, etc.), their personal values, their disciplinary background, and their employing agency's agenda. These all flow into influencing the *field of study* a researcher is involved in. For instance, this author's interest in studying the prevention of alcohol problems stemmed from working as a social worker and clinical psychologist with people with alcohol problems, he wanted to do something about this because of his value base, his background as a psychologist meant that he had some tools for this field of study and he was fortunate enough to find employment in a research unit which was consistent with his values and interests--the Alcohol and Public Health Research Unit. Therefore his choice of field of study was strongly influenced by his background and values.

Leaving *methodology* to the side for one moment and moving right down to *dissemination and advocacy of results*, we see that this area is also obviously influenced by the factors on the left hand side of the figure. In the case of the author, his background meant that he wanted the information he had found out to be actively disseminated in the policy domain. His values supported the ethical need for action to stem from research, his disciplinary background in community psychology supported this and the Alcohol and Public Health Research Unit had a tradition of active dissemination in the policy domain. His decision to be involved in active dissemination was not based on considering the views of stakeholders. He was uninfluenced, for example, by the Liquor industry's probable lack of enthusiasm for

Figure 12: Researcher and Stakeholder Influences on Field of Study, Methodology and Dissemination



dissemination of evaluation results showing methods of reducing overall consumption as a way of reducing alcohol problems.

So, the two areas of *field of study* and *degree of dissemination and advocacy of results,* while influenced by the factors on the left of the figure (background, values, disciplinary background and employing agency) are not particularly influenced by the demands of critical stakeholders. It is only in the area of methodology, that the focus turns to one's critical stakeholders as an important determinant of the methodology which a research project should be using. The figure illustrates that acceptable methodology for sympathetic stakeholders is likely to overlap substantially with the methodological preferences of a researcher. It may go beyond the researcher's methodological preferences, for instance a sympathetic stakeholder may be interested in econometric studies as a preferred methodology but the researcher may not have these as part of their methodology due to their disciplinary background. Looking now at the smaller darker square, this is the methodologies acceptable to an unsympathetic stakeholder. They are likely to have firm criteria as to what they will and will not accept as adequate methodologies. However, as discussed at the start of this section, it may be that an accommodation can be reached with some unsympathetic stakeholders whereby they can agree with the researcher on methods for collecting and analysing information which they would take into account. This is the area of common methodology between the unsympathetic stakeholder and the researcher indicated on Figure 12.

So, what is being suggested here is certainly not that researchers allow themselves to be controlled by the agendas of their most unsympathetic audiences. It is only in the methodological realm that they have to attend to such considerations. In regard to choice of topic, they might chose to study many things

which unsympathetic stakeholders would rather were left unstudied and in regard to dissemination they may also chose to disseminate and advocate for their research findings as actively as they like, even when this flies in face of what unsympathetic stakeholders want. It is only in the methodological realm that the unsympathetic stakeholders are allowed to determine the methodological approach and this is only for the reason that unless the methodology is acceptable to this group the research is likely to be dismissed on methodological grounds and the potency of the results in the policy debate neutralised. This is similar to Patton 's (1986a) argument about evaluation users *believing* in the data: "it is crucial that intended users participate in the making of measurement and methods decisions so that they understand the strengths and weaknesses of the data - and so that they believe in the data." (Patton, 1986a, p. 180)

This approach allows a clear response to potential stakeholder criticism of health promotion or other researchers in social policy areas. As long as their research is based on methodologies which can be argued with key potentially critical stakeholders on a project by project basis, researchers stand on strong ground when they go on to disseminate such information. Of course, as noted before, there may be some groups who will never agree to listen to researchers no matter what sort of methodology they use, however such a position is hard to maintain if such stakeholders wish to enter into policy debate with other parties. It should also be noted that key stakeholders for one piece of research may be entirely irrelevant for another. For instance the demands of the alcohol industry are not relevant in regard to a piece of research being done to assist health promotion workers in doing their work, say for instance in the case of the Licensing Project. In

this case methodologies which are acceptable to the health promotion workers need to be selected.

In summary, this section has argued that in regard to health promotion evaluation (not necessarily health promotion research in general):

- researchers personal background, values, disciplinary background and employing agency will influence their field of study and the enthusiasm with which they disseminate the results of their evaluation research;
- priority topics for health promotion should be determined by:
    - examining a health promotion topic in terms of the social problem cycle and determining places where strategic evaluation input is needed;
    - determining what methodologies would be acceptable to key critical stakeholders concerned with an interest in that particular part of the social problem cycle;
    - detailing proposed evaluation research in terms of what is planned to be done step by step in terms of methodology;
    - evaluating proposed evaluation research by matching the proposed methodological steps with the demands of potentially critical stakeholders along the lines of "what methodological steps would you be prepared to accept for generating information which you would consider admissible into the policy debate around this issue?"

Summary

This chapter has set out the end point to which this study was directed, the development of a practical but theoretically justified framework for strategic health promotion evaluation. Earlier versions of this framework have been used in various contexts by the author, either as an evaluator or in teaching evaluation in workshops. Although there are undoubtedly many other equally good frameworks for approaching health promotion, this one provides a basis for systematically approaching a large number of the problems and issues in the health promotion area which the author has encountered in the course of work in this area.

CHAPTER TEN

SUMMARY AND CONCLUSIONS

The objective of this study was to produce a comprehensive framework for evaluating health promotion. There were six steps undertaken in developing this framework:

- the evaluation and health promotion literature was examined for lessons relevant to health promotion evaluation;
- the author was involved as an evaluation researcher in a series of health promotion projects (five of which are reported here);
- a set of key practical, political and theoretical issues arising from these evaluation projects were identified and addressed;
- taking these issues into account, an initial Health Promotion Strategic Evaluation Framework was developed;
- the framework was exposed to health promotion practitioners at a series of workshops run by the author and colleagues; and
- the Strategic Evaluation Framework for Health Promotion was further refined in the light of the author's continuing involvement in health promotion evaluation practice.

The five projects examined in this study were: the Alcohol Health Promotion Organiser Approach; process evaluation of the Wanganui Community Alcohol

Action Project; evaluation of Heartbeat New Zealand; the Licensing Project evaluation; and lastly, developing a policy and approach for the Accident Compensation Corporation Accident Prevention Programme. The major findings of the study which underpin the Strategic Evaluation Framework for Health Promotion are set out below.

Health promotion has developed within a complex set of political, economic and ideological changes. Particularly important have been changes in the political climate coincident with the growth or resurgence of a number of political movements of relevance to health, including the women's, indigenous peoples', and environmental movements. Changes in the economics of health have also been important, in particular, the potentially limitless demand for services as the range of treatments expands, the pressure to reduce Government social expenditure, the growth of managerialism in the health sector, and the restructuring of the New Zealand health sector. Finally, changes in ideology have had a bearing on the way in which health is viewed; in particular, the growth of new right ideology and the narrowing of mainstream economic discourse, the promotion of individualism, the growth of interest in the concept of community, and the development of systems/ecological/holistic thinking.

Within this complex of factors, health promotion has been something of a "protected realm" where some ideas which have been absent from mainstream policy discourse have continued to be discussed. However, in spite of this isolation, health promotion discourse, as a child of its times, also contains major tensions stemming from its origin and context. In particular, there is an ongoing tension in the discourse between empowerment and the notion of governmental authorities and experts "knowing best" about health and its promotion. In the author's view, this

tension will continue as health promotion discourse remains a site in which larger social conflicts and debates are played out.

Health promotion is culturally embedded. This means that the way in which health and its promotion are viewed within particular cultures will influence how health promotion is conceptualised. It should not be assumed that the scope, meaning and strategies used in Western health promotion will fit with other cultures. For instance, it may be that Maori at the current time want a closer integration between health services delivery and health promotion activity than is likely to be the case in general population health promotion in New Zealand. There is likely to continue to be a diversity of ways of looking at health promotion within different cultures.

Consistent with the contemporary interest in "community strategies", much health promotion activity is located within communities. This raises challenges for the way health promotion conceptualises community and how it undertakes evaluations of community programmes. This study has argued that community should not be unquestionably identified as health promoting and as in opposition to government, bureaucracy and "expert" knowledge. Community programme evaluations need to recognise that community programmes are usually just one of a number of activities within a community which are concurrently affecting the outcomes being sought; that pilot programmes cannot be simply thrust in and pulled out of communities without regard to maintaining community optimism and morale; and that community level, rather than individual level, outcome measures need to be used for community programmes.

Definitions of health promotion can be divided into four types. First is the definition by list of activities (e.g. health protection, health education, public policy

development to promote health), second, the definition by exclusion (e.g., not disease prevention), thirdly, definition by expansion (e.g., health on the agenda of all sectors in society), and last, definition by core process (e.g., empowerment). The approach suggested by this study has been firstly to be fairly inclusive as to what should fall within the definition of health promotion activity. Secondly, to promote frameworks and mechanisms (such as those set out in the study's Strategic Evaluation Framework for Health Promotion) which will, early in programme planning, stretch the menu of health promotion strategies planners are considering and actively encourage the use of the usually more effective systemic, rather than traditional individualistic, strategies.

The political context of health promotion means that there will be pressure to adopt strategies which have a high public profile, do not offend powerful political stakeholders and do not draw too heavily on the public purse. These are often not the most effective strategies and it is the responsibility of health promoters to push health promotion strategies away from this end of the spectrum and into the politically more difficult, but also more effective territory. Pressure from supportive stakeholders is very important in assisting this drive. However, there would seem to be limits as to how far health promotion strategies can be pushed against strong political opposition. If strategies become too political and are unable to be legitimitised in terms of a clear connection to health (in other words, if they start to sound like calls for generalised revolutionary societal change) there is an increased risk that, in the current New Right climate, unsupportive stakeholders will push for the removal of resources for these strategies, and supportive stakeholders will not be sufficiently strong to resist this.

Evaluation plays a key role in the process of pushing into the more politically difficult strategies by providing information on the effectiveness of programmes which can be used to counter unsupportive stakeholders; by reducing the credibility of popular but merely palliative solutions; and by providing information to key supportive stakeholders about the type and outcomes of work being undertaken in health promotion.

Planning for evaluation of a particular project should take into account the topic's position on the wider social problem cycle, whether the project is part of a wider health promotion programme (in which case it may be subject to some evaluation as a part of the overall programme) and the demands of evaluation stakeholders.

Outcome evaluation should be structured around finding a group of measures which will enable the measurement of programme objectives and other effects of the programme. Measurement considerations should follow from the setting of overall objectives rather than the other way around. We should be measuring what we are trying to do, rather than only trying to do that which we can measure.

It is important that evaluation input takes place right across a programme's lifecycle. The formative, process and outcome evaluation typology facilitates this by emphasising and legitimising the use of evaluation resources early in the formative stages of a programme.

Finally, moving to a higher level issue, this study has noted that the paradigms debate in health promotion mirrors that which has taken place in evaluation over the last two decades. Particular paradigmatic positions, such as constructivism, can be unpacked into a set of constituent questions each of which can be answered in a different way for different projects. Hence, in the author's

view, the focus should be on the way in which these constituent questions are to be answered in the case of specific health promotion evaluations, rather than on bundling a particular set of answers and seeking endorsement within health promotion for one specific paradigmatic position.

However, the challenge by the constructivist and associated paradigms to the dominant positivist paradigm has had the effect of clearing a space within the research community for the flowering of a number of new methodologies many with quantitative and interpretative flavours. All methodologies, from the traditional quantitative through to emerging qualitative methodologies, should be considered as potential contenders for use in any health promotion evaluation.

Researcher backgrounds, values, disciplinary training and their employing agency will be the dominant influence on the subjects they study and the enthusiasm with which they disseminate their results. The demands of unsupportive stakeholders as to what researchers should or should not study or speak out about are likely to play a more minor role. In contrast, however, the researcher's choice of *methodology* may have to take more account of the views of unsupportive stakeholders. If researchers want to increase their chances of forcing unsupportive stakeholders to attend to their research findings, researchers need to carefully consider their choice of methodology. Rather than simply determining evaluation methodology on the basis of their own background, values, disciplinary training, and employing agency, researchers may rather choose to focus on the types of methodology which unsupportive stakeholders are likely to accept as providing valid knowledge claims. This will make it more difficult for such stakeholders to dismiss uncomfortable findings on methodological grounds.

Lastly, the author has argued that the central problems facing health promotion are more political than a lack of theoretical development. Of course, theory development is important for health promotion as a discipline, however the major problems facing health promotion today are that its mainly systemically-orientated solutions run up against the dominant ideology of individualism and in a number of cases are resisted by powerfully influential stakeholders.

All of the above considerations have contributed to the development of the Strategic Evaluation Framework for Health Promotion. This consists of five elements: a health promotion strategies matrix, a health promotion evaluation checklist, a set of criteria for selecting the type and level of evaluation for different health promotion projects, a model of the strategic importance of different types of evaluation at different stages of the social problem cycle, and a structured approach to deciding on the specific methodologies to use in a particular health promotion evaluation. This framework is intended to achieve the following for the field of health promotion evaluation:

- to ensure that decisions about evaluation are strategically driven; meaning that all possible project evaluations are subject to prioritising and that type and level of evaluation are tailored to the specific programme to be evaluated;

- assigning equal priority to all possible project evaluations and proposing similar types and levels of evaluation for all types of programme;

- to decouple project objectives from too early identification with a set of specific strategies challenging project planners with the question of "what are the range of possible strategies which we could use to achieve these

objectives?" This provides the potential for health promotion planners to move on, not just to use the strategies and approaches they are familiar with;

- to promote the use of a tool which further encourages health promotion planners to consider the widest possible range of strategies for achieving their objectives. The Ottawa Charter can serve this purpose while this framework's Matrix of Health Promotion Strategies is a variant of this designed with the same end in mind;
- to emphasise the importance of formative evaluation and the use of formative evaluators to provide constructively critical independent input into programme planning and implementation. Again this should broaden planner's thinking away from a small set of familiar, individually orientated strategies;
- to integrate evaluation planning for a project with evaluation planning for the overall health promotion programme of which it is a part;
- to provide a structured approach for determining what type of methodologies should be used in a particular health promotion evaluation.

Postscript: The Future of Health Promotion

This study has discussed health promotion evaluation in terms of health promotion's current position. Where health promotion will go in the future is difficult to determine. It has a continuing interest in many of the issues which are central to the major social movements of the age - empowerment, social justice, economic development, equality and environmental sustainability. The discourse of, and in fact the name of, *health promotion* are themselves not static entities to be tightly held to, but are best

looked upon as particular ways of talking about some of these important issues at a particular point in time. To a considerable extent, health promotion has continued to talk about some of the issues which have been sidelined in recent policy discourse. What is now being seen is the emergence under other headings of some of these themes; i.e., the discussions of social capital, trust, and social cohesion. While the way some of these are being used can easily be dismissed as serving the dominant ideological agenda, the fact that they are even being talked about in the policy community is indicative of a growing perception in policy circles that the New Right ideological canon does not provide a comprehensive set of answers to social issues.

While the titles under which health promotion activity is carried out are likely to change over time, the future of the core health promotion and illness prevention activity within public health and health promotion seem assured as policy makers continue to be confronted by the economics of burgeoning health care costs and the inescapable logic of "why don't we try to prevent some of these health problems?" Because of the important topics of social justice and equity which such work raises, health promotion will continue to be a potential site for debate, raising awareness of and proposing solutions to these issues. Within these debates, health promotion's first responsibility is to continue to expose palliative solutions for what they are and to push for the use of more difficult but ultimately more effective systemic strategies. Such work, if effective, will put health promotion under the spotlight and the more effective it is the more the legitimacy of its voice in the policy debate will be questioned. Stakeholders threatened by effective social change are likely to remain vehement in their opposition and to continue to question the legitimacy of health promotion. Despite this potential for conflict, however, it is the author's view that

health promotion, as a largely publicly-funded activity, has a public mandate to bring to attention the set of strategies which are actually likely to do something significant about the causes of disease and ill health, to reduce the toll of pain and suffering, and to foster healthy psychological, social and physical environments in which people can thrive.

APPENDIX ONE: LIST OF WORKSHOPS ON HEALTH PROMOTION PLANNING AND EVALUATION RUN BY THE AUTHOR AND COLLEAGUES

This Appendix sets out workshops on evaluation which the author ran with various of his colleagues. These were usually two day workshops, it does not include a number of brief presentations and short workshops.

Programme Planning And Evaluation. Health Promotion Forum of New Zealand Health Promotion Concepts and Practice Workshop. Auckland, 21-22 March 1991.

Theory and Practice of Evaluation Workshop. New Zealand Dietetic Association Community Dieticians Special Interest Group. Wellington, 12 August, 1991.

Programme Planning Workshop for Health and Safety Programmes. Council of Trade Union's. Wellington, 20 February 1992.

Evaluation Workshop for Health Care Hawkes Bay. Health Promotion Forum/Alcohol and Public Health Research Unit. Napier, 5-6 May 1994.

Evaluation and Planning for Health Promotion. Health Promotion Forum/Alcohol and Public Health Research Unit. Whakatane, 10-11 May 1994.

Evaluation and Planning for Health Promotion. Health Promotion Forum/Alcohol and Public Health Research Unit. Nelson, 23-24 May 1994.

Workshop on the Use of the Ottawa Charter and Programme Evaluation Techniques. Health Promotion Forum. New Plymouth, 9 June 1994.

Evaluation and Planning for Health Promotion: A Practical, Skills Development Workshop for Health Promotion Workers. Christchurch, 18-19 October 1994.

Evaluation and Planning for Health Promotion: Level II. Research Activities: A Skills Development Workshop for Health Promotion Workers. Christchurch, 7-8 March 1995.

Evaluation and Planning for Health Promotion: A Practical, Skills Development Workshop for Health Promotion Workers. Whangarei, 24-25 July 1995.

Evaluation and Planning for Health Promotion Level II. Napier, 2-3 October 1995.

Evaluation and Planning for Health Promotion: Level II. Rotorua, 16-17 October 1995.

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