EVALUATING COMPLEX COMMUNITY-BASED HEALTH PROMOTION: ADDRESSING THE CHALLENGES

GWYNETH JOLLEY

**South Australian Community Health Research Unit,
Southgate Institute for Health, Society and Equity
School of Medicine
Faculty of Health Sciences
Flinders University**

**Submitted in fulfilment of the requirements for the
degree of Doctor of Philosophy**

May 2013

APPENDIX: PUBLICATIONS FORMING PART OF THE THESIS

1. Smith, A., Coveney, J., Carter, P., Jolley, G. and Laris, P. (2004) The Eat Well SA project: an evaluation-based case study in building capacity for promoting healthy eating. *Health Promotion International* 19 (3) 327-334.

2. Baum, F. Jolley, G. Hicks, R. Saint, K. & Parker, S. (2006) What makes for sustainable Healthy Cities initiatives? - a review of the evidence from Noarlunga after 18 years, *Health Promotion International*, 21 (4) 259-265.

3. Jolley, G. Lawless, A. Baum, F. Hurley, C. and Fry, D. (2007) Building an evidence base for community health: a review of the quality of program evaluations. *Australian Health Review*, 31 (4) 603-610.

4. Jolley G. Lawless A and Hurly C. (2008) Framework and tools for planning and evaluating community participation, collaborative partnerships and equity in health promotion. *Health Promotion Journal of Australia*, 19 (2) 152-157.

5. Jolley G. (2008) Evaluation of an action research project in workforce development and organisational change: Healthy Ageing-Nutrition *Evaluation Journal of Australasia,* 8 (1) 11-19.

Smith, A. Coveney, J. Carter, P. Jolley, G. and Laris, P. (2004) The Eat Well SA project: an

evaluation-based case study in building capacity for promoting healthy eating.

Health Promotion International 19 (3) pp. 327-334.

Statement of authorship

The Eat Well SA project: an evaluation-based case study in building capacity for promoting healthy eating

Health Promotion International 2004 19 (3) pp. 327-334.
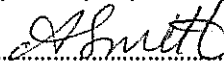
Gwyn Jolley (Candidate)

Had a major role in conceptualising and designing the evaluation, data collection, analysis and interpretation. Co-authored the evaluation report. Drafted and revised the evaluation method and results sections of the paper. Contributed to and critically reviewed the whole paper.

Signed .... Date ....2./.7.(.12.........

Alison Smith

My contribution to this paper involved conceptualising and designing the evaluation, data collection, analysis and interpretation. Co-authored the evaluation report. Contributed to drafting and revising the paper.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ....10.|..7.|.12......

John Coveney

My contribution to this paper involved advising on the evaluation design, and giving feedback on process and results. Framing the paper in terms of a 'capacity building' approach. Drafting manuscript and revising in light of critical feedback. Providing necessary references.
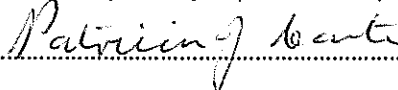
I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date .....11./..7./.12.....

Patricia Carter

As manager of the Eat Well SA project from its inception until mid-2000, I was responsible for oversighting project planning, implementation and evaluation. This included engaging the evaluation consultants (including Gwyn Jolley) and liaising with them regarding the evaluation (eg identifying relevant documents and people to interview). I commented on drafts of the manuscript.
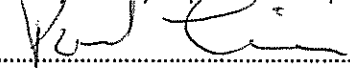
I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ....3/.7./.12....

Paul Laris

My contribution to this paper involved acting as contractor for the evaluation on which the article is based, I reviewed a near final draft and was satisfied with the contents.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed . . .. Date ....7.(.10(.12.........

The Eat Well SA project: an evaluation-based case study in building capacity for promoting healthy eating

ALISON SMITH[1], JOHN COVENEY[2], PATRICIA CARTER[3], GWYN JOLLEY[4] and PAUL LARIS[5]

[1]Centre for Health Promotion, Women's and Children's Hospital, Adelaide, Australia, [2]Department of Public Health, Flinders University Adelaide, Australia, [3] Health Promotion SA, Department of Human Services, Adelaide, Australia, [4]South Australian Community Health Research Unit, Flinders Medical Centre, Bedford Park, Australia and [5]Paul Laris and Associates, Henley Beach, Australia

SUMMARY

The term 'capacity building' is used in the health promotion literature to mean investing in communities, organizations and structures to enhance access to knowledge, skills and resources needed to conduct effective health programs. The Eat Well SA project aimed to increase consumption of healthy food by children, young people and their families in South Australia. The project evaluation demonstrated that awareness about healthy eating among stakeholders across a range of sectors, coalitions and partnerships to promote healthy eating and sustainable programs had been developed. The project achievements were analysed further using a capacity-building framework. This analysis showed that partnership development was a key strategy for success, leading to increased problem-solving capacity among key stakeholders and workers from education, child care, health, transport and food industry sectors. It was also a strategy that required concerted effort and review. New and ongoing programs were initiated and institutionalized within other sectors, notably the child care, vocational education and transport sectors. A model for planning and evaluating nutrition health promotion work is described.

Key words: capacity building; health promotion; nutrition

INTRODUCTION

The Eat Well SA project

Eat Well SA was developed in 1996 in response to the (former) South Australian health promotion foundation outsourcing a statewide nutrition project. The beginnings of the project, including its intellectual origins, have been described elsewhere (Coveney *et al*., 1999). Briefly, the project's goal was to increase the consumption of healthy food by children, young people and families in South Australia. The objectives were

to increase the availability and promotion of healthy food in settings where children, young people and their families live, are cared for, educated and spend their leisure time, and to increase community knowledge and awareness of healthy food choices (Smith, 2002).

Strategies were developed to improve public policy, create supportive environments for healthy eating, support community action and develop personal skills informed by the Ottawa Charter (Baum, 2002). Six areas for strategy

A.S. and P.C. were previously Eat Well SA Managers.

development and implementation were selected for the first 3 years:

- Improving the food supply in rural South Australia;
- Improving food service and promoting healthy eating in child care settings;
- Promoting awareness in the school community of the environmental and health impact of eating;
- Promoting awareness of links between food, health and the environment;
- Supporting community food activities for low-income and non-English-speaking groups; and
- Promoting fruit and vegetable consumption.

As nutrition is an issue that is affected by the work of many sectors, the project approach was to put nutrition and food issues onto the agenda of other agencies and sectors. Inter-sectoral and inter-agency partnerships were developed to increase awareness about nutrition issues among a range of agencies and to increase service providers' capacity to support community action (Coveney *et al.*, 1999).

Capacity building

Use of the term 'capacity building' has increased in the health literature. It first made an appearance in the mid-1970s as a way of discussing the importance of training and development in the context of health service reform (Anon, 1975). It was not until the mid-1990s, however, that the term became commonly used in the health promotion context. Since that time, the idea of building capacity has found its way into Australian health promotion and public health strategic statements at the local, state and national levels (National Health and Medical Research Council, 1996; National Public Health Partnership, 2001; NSW Health Department, 2001).

At its broadest, most general level, capacity building refers to the ability of an initiative or program to build upon, or add value to, existing resources to promote effective, efficient, sustainable outcomes. More specifically, capacity building in health promotion is about investing in existing communities, organizations and structures to enhance access to the knowledge, skills and resources needed to conduct effective health programs (Jackson *et al.*, 1994). It is also about increasing the capability to choose the most appropriate methods or actions (Kickbusch, 2001).

The benefits of capacity building have been discussed elsewhere in relation to community development (Maton, 2000), program effectiveness (Schwartz *et al.*, 1993), program evaluation (Brazil, 1999), and training and education (Young, 1999). This literature suggests that building capacity has a number of potential gains for health promoters, health service funders and communities.

Hawe *et al.* have described the three dimensions of capacity building (Hawe *et al.*, 1997). These are: (i) health infrastructures or service development; (ii) problem solving capability of organizations and communities; and (iii) program maintenance or sustainability.

'Health infrastructure or service development' creates the organizational culture required to deliver effective health promotion programs. Organizational capacity is achieved by developing health promotion skills and knowledge in the workforce, by incorporating health promotion goals into the organization's strategic directions and leadership, and by committing adequate human, financial and information resources (NSW Health Department, 2001). Development of health promotion capacity is necessary for health services to provide a full range of early intervention, preventive, health promotion and therapeutic services.

Organizations and communities require 'problem-solving capabilities' as a basic component of undertaking community empowerment and organizational development work (Labonte and Laverack, 2001; Laverack and Wallerstein, 2001). Capacity building here refers to the ways in which health promotion agencies contribute technical, administrative, evaluation and other expertise, which will assist efforts to influence conditions that affect health and development (Fawcett *et al.*, 1995). If successful, the resulting relationship, whether this be with organizations or communities, allows not only for immediate problems to be addressed, but also for new ones to be effectively tackled through the development of key problem solving skills (Hawe *et al.*, 1997).

'Program maintenance and sustainability' through capacity building refers to the extent to which work initiated by one agency is taken on by the same or another agency or network of agencies as their core business. Capacity building in this area relies on the ability of health promoters to sustain a program's focus of activity. This can be enhanced by ensuring that

both project (and evaluation) design and implementation are developed through a participatory approach between funders, service providers and communities (Shediac-Riskallah and Bone, 1998).

Investment is also required to achieve these types of capacities. First, the investment of resources, whether in terms of staff, funding or information access, is crucial for successful capacity building. Secondly, capacity building requires specific (though not necessarily formal) training and education. Finally, the institutionalization of initiatives allows organizations or communities to invest in health promotion activities as part of their core business.

The aim of this article is to describe the evaluation outcomes of the Eat Well SA project, to analyse further the evaluation results using a model of capacity building, and to propose a planning and evaluation model for building capacity for healthy eating at a local or regional level.

EVALUATION METHOD

An external evaluation of Eat Well SA (Laris *et al.*, 2001) was undertaken during 2000. Qualitative and quantitative data were collected, analysed and reported based on a framework of key questions. These were designed to assess: (i) process (e.g. what happened, who was reached and what methods were effective?); (ii) impact (e.g. what changes were observed in terms of food service, knowledge, awareness and policy development?) (Hawe *et al.*, 1990); and (iii) generative impact (e.g. changes in organizational relationships and in the context for promoting healthy eating) (Pawson and Tilley, 1997).

In order to answer these key questions from a wide range of sources, four methods were used to collect data for the evaluation. One hundred and sixty-five project documents were analysed, including plans, minutes, reports, terms of reference, project materials and evaluation reports. Interviews were undertaken with 50 key informants, identified from a list of key partners and stakeholders. Project staff were also interviewed about all areas of involvement. Three focus groups were undertaken with 16 people, including two groups of grant holders and one group of project partners. A telephone survey was conducted of 180 respondents from a sample of 300 people selected from the project newsletter mailing list. They represented the

broader target group the project was trying to reach. The survey data were collected about project recall and perception of support provided by the project (Laris *et al.*, 2001).

The outcomes of the project described by the evaluation were analysed further, to investigate and describe the type of capacity developed by the project. Project outcomes were categorized using the framework described by Hawe and colleagues (Hawe *et al.*, 1997; NSW Health Department, 2001). The program logic model (Weiss, 1998) was then applied, to propose an evaluation model based on the type of capacity building developed by the project.

RESULTS

The evaluation described the project as using awareness raising, partnership development and implementing collaborative action across all six strategy areas of the project. Methods used for increasing awareness included a campaign promoting fruits and vegetables, dissemination of pamphlets and newsletters, a conference, a cookbook, a literature review and a research study. Eat Well SA formed coalitions with agencies from the health, migrant health, community services, vocational education, schools education, child care, research, community health, rural health and primary producer sectors. The project supported the development and maintenance of partnerships. These supported the provision of small grants to schools and community organizations working with non-English-speaking and low-income groups to increase their access to healthy food, to plan development of vocational training for child care cooks and to provide resources for early childhood services (Smith, 2002).

Project achievements

The contribution of the project to increasing consumption of healthy food among children, young people and families by awareness raising, problem solving and development of sustainable programs is shown in Table 1. The telephone survey found that three-quarters of targeted workers were aware of the project, while between one-third and one-half reported receiving support from Eat Well SA for their work promoting environmentally friendly food, hygienic and safe food, and nutrition. These activities raised awareness of the project among key stakeholders

Table 1: Description of project achievements

Increased awareness about:

The high cost and variable quality of food in rural and remote areas, its health consequences, and ways of improving food supply among health services, transport planners, rural organizations, community services and government agencies

The importance of nutrition in child care and ways of improving nutrition in child care, among peak child care organizations, health sector workers and parents

The need for high quality food service in child care centres, among child care staff, vocational education organizations, health services and policy makers

The links between food, health and the environment, among staff, students and administrators in four school communities, health, education and environment sector workers, and among the wider community

Food, nutrition and healthy eating, among up to 500 participants in 24 low-income and non-English-speaking projects, and workers across a range of health and community services organizations

The relationship between food and health, among the primary production sector, supermarkets and independent fruit and vegetable retailers

The environmental aspects of eating, among conference attendees and community members

Increased problem-solving capacity through:

Shared learning with and among community agencies about promoting healthy eating in vulnerable groups

Formation of new and extended partnerships and relationships between and among project partners and other agencies, including a partnership to promote nutrition in early-years settings and a partnership to improve food supply in rural areas

Joint advocacy for healthy public policy

Development of sustainable programs:

Institutionalization of child care training and workplace assessment in nutrition for cooks by the vocational education sector

Institutionalization of support for improved rural and remote food freight transport by the state transport department

Achievement of changes in the child care licensing system

New funding to improve food access in remote areas

New funding to promote food preparation in schools

New funding to train and support child care workers to provide healthy eating advice to parents

and developed their readiness to be involved in other activities.

Eat Well SA was found to have successfully formed significant and effective partnerships and relationships with 50 organizations, in each of the six strategy areas of the project. The project was found to have contributed to improving the context for promoting healthy eating in South Australia through relationship building, collaborative planning and advocacy across the breadth of food and nutrition issues, thereby increasing capacity, knowledge and skills among a broad range of workers.

Tensions related to differing values were found when working collaboratively with other organizations. One example was the tension between a community development paradigm and a professional nutrition paradigm. In another case, a partner organization stated that work requiring environmental expertise undertaken by project nutrition staff would have more appropriately been contracted out.

Five new projects and formal partnerships were developed, which garnered funding across several areas. In addition, training of child care cooks and improving rural and remote freight transport have been institutionalized into the work of the vocational education and transport sectors, respectively (Table 1).

Type of capacity developed

Specific activities in each dimension are summarized in Table 2. The Eat Well SA project 'infrastructure' included recruitment of a staff team of between two and three members, with administrative and practical support from the Women's and Children's Hospital, Adelaide, the

Table 2: Capacity outcomes related to project activity areas and capacity-building dimensions

Project activity areas	Capacity-building dimensions [based on (Hawe *et al*., 1997)]		
	Project infrastructure development	Organizational problem-solving capabilities	Program sustainability
Project initiation and maintenance	Staff recruitment, development of project management structure	New consortium developed	Gained commitment from the host and funding organizations
Awareness raising activities		Increased knowledge and awareness about food and nutrition issues leading to readiness to undertake collaborative activity	
Development of coalitions		New knowledge and skills through cooperative learning leading to increased breadth of perspective and context	Broad commitment of other organizations and sectors to strategies to support healthy eating
Collaborative actions for sustainable outcomes		Organizational skills and knowledge gained to undertake collaborative action. Community skills developed through funding for schools and community groups	Strategies developed and owned by coalition members. Institutionalization of activities in other sectors. Increased opportunities for gaining funding

auspicing organization. Support for the project's capacity to develop, implement and evaluate projects was provided by the funder, a management group, reference groups, working groups, formal partnerships, consultants and steering committees, many of which included representation from consortium member organizations.

The Eat Well SA project facilitated the development of 'problem solving capabilities' through the development and coordination of partnerships and coalitions (Table 2). The evaluation results found that partners strongly appreciated the partnerships developed by the project, as a unique and valuable contribution to promoting healthy eating. These provided avenues for people from different agencies and organizations to share their skills and perspectives and to work together. Newsletters, professional development workshops and interagency forums also supported skills development. In addition, community capacity was supported through information dissemination strategies (e.g. a parent newsletter distributed through child care centres), provision of 28 small grants to community-based organizations and schools, and through the implementation of grant projects in the community.
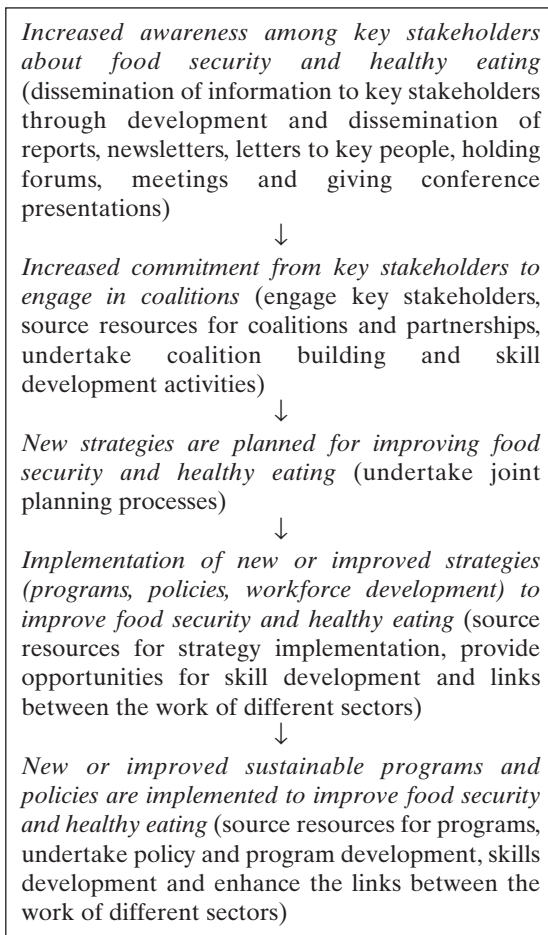
'Program sustainability' was enhanced by the commitment of project partners, for whom the outcomes sought were part of their core business. Three types of program sustainability have been identified: first, activities were institutionalized in the business of other sectors; secondly, new programs were developed jointly and owned by all partners; and thirdly, funds were sourced to develop new programs in partnership with service delivery agencies.

Evaluating capacity building

A model for planning and evaluating a capacity-building project situated within a health promotion group in a statewide health service is shown in Figure 1. Based on the capacity-building model developed for the project, this model is built around awareness raising and advocacy, gaining commitment from key stakeholders, joint development of new strategies followed by implementation, and joint development and implementation of sustainable programs and policies. Information dissemination was used as an awareness-raising activity, but also as a catalyst for action, which led to sustainable outcomes and capacity building.

Activities to support these outcomes are also shown in Figure 1. These include gathering and disseminating information, identifying key stakeholders, allocating resources to coalition

Increased awareness among key stakeholders about food security and healthy eating (dissemination of information to key stakeholders through development and dissemination of reports, newsletters, letters to key people, holding forums, meetings and giving conference presentations)

↓

Increased commitment from key stakeholders to engage in coalitions (engage key stakeholders, source resources for coalitions and partnerships, undertake coalition building and skill development activities)

↓

New strategies are planned for improving food security and healthy eating (undertake joint planning processes)

↓

Implementation of new or improved strategies (programs, policies, workforce development) to improve food security and healthy eating (source resources for strategy implementation, provide opportunities for skill development and links between the work of different sectors)

↓

New or improved sustainable programs and policies are implemented to improve food security and healthy eating (source resources for programs, undertake policy and program development, skills development and enhance the links between the work of different sectors)

Fig. 1: Eat Well SA program theory model, showing capacity outcomes and impact indicators (italics), and project activities (parentheses).

development work (including staff time), seeking financing from funding agencies, facilitating activities, and providing leadership (NSW Health Department, 2001) and nutrition and health promotion expertise. Capacity-building outcomes are used to develop indicators of increased capacity, from which performance indicators for the project are developed in different project areas.

DISCUSSION

Capacity building was found to be a useful framework for analysing this health promotion project. Partnerships have been suggested to be

vitally important in increasing capacity to address health issues, as many health problems are outside the influence of the health sector (NSW Health Department, 2001). Research has shown that stronger relationships between agencies and a greater allocation of resources to health promotion are desirable for future collaborative action. In addition, partnerships need to support a learning culture and increased problem-solving capacity to tackle difficult issues, through providing opportunities for exchange of skills between workers from different sectors (McGlone *et al.*, 1999). Partnership development also requires a high level of clarity about the purpose of the partnership and the role of the participating organizations (Tasmania Department of Community and Health Services, 1999). The Eat Well SA evaluation indicated that relationships and willingness to collaborate along with problem-solving capacity were developed through effective partnerships, which require ongoing review and evaluation.

Hawe *et al.* (Hawe *et al.*, 1997) point out that an appreciation of capacity building could better inform decisions about health program investment. They suggest that decisions be guided by attention to return on investment in terms of size of health gain on the one hand, and sustainability of outcomes on the other hand. For example, it might make sense to invest in health programs that show modest health gains but have engaged other stakeholders to take on the issue, and demonstrate high potential to tackle other health problems. These considerations seriously challenge traditional views of program success, which have been understood in terms of individual changes in health status.

Indeed, also challenged are the evaluation methodologies that are employed in assessing program success. Hence, capacity-building indicators have been developed to evaluate the process and impact of the project. The project evaluation utilized the idea of evaluating generative changes in the context within which the project was working (Pawson and Tilley, 1997) which allowed capacity building changes in relationships to be described by the evaluation. This evaluation approach is important because a narrower focus on behaviour change would have failed to appreciate the value added to the project and the field of public health nutrition through attention to capacity building.

Shediac-Riskallah and Bone suggest that institutional strength of the host organizations is

positively associated with program sustainability (Shediac-Riskallah and Bone, 1998). In the case of the Eat Well SA project, the host organization (Women's and Children's Hospital, Adelaide) has a strong focus on health promotion through the development of its strategic plan and the employment of a management-level health promotion director. The host organization provides a well developed organizational structure to sustain the project (Hawe *et al*., 1997; McGlone *et al*., 1999), including accommodation, facilities and a management system. The project also employed nutrition professionals who were able to develop partnerships with community and government agencies at a statewide level, an opportunity not available to many nutritionists operating within the often local geographic constraints of the organizations in which they work (McGlone *et al*., 1999).

CONCLUSIONS

This research shows that understanding the capacity-building effects of health promotion projects provides clarity about outcomes and planning and evaluation methods. The Eat Well SA project developed a useful model for undertaking sustainable, intersectoral, collaborative work to promote healthy eating, which can also be used by other organizations to address other nutrition issues. The hard issues like improving food security of vulnerable groups require continued development through local and statewide partnerships and actions. The project's evaluation framework requires further development in order to establish project outcomes in health and social terms.

ACKNOWLEDGEMENTS

Address for correspondence:
Alison Smith
Centre for Health Promotion
Women's and Children's Hospital, Adelaide
72 King William Rd
North Adelaide SA 5066
Australia
E-mail: smitha@mail.wch.sa.gov.au

REFERENCES

Anonymous (1975) The Mega-Proposal: comprehensive HEW simplification and reform. Capacity building: introduction. *Policy Analysis*, **1**, 387–390.

Baum, F. (2002) *The New Public Health: An Australian Perspective*, 2nd edition. Oxford University Press, Melbourne.

Brazil, K. (1999) A framework for developing evaluation capacity in health care settings. *International Journal of Health Care Assurance*, **10**, vi–xi.

Coveney, J., Smith, A. and Carter, P. (1999) The art and science of public health nutrition: from theory to practice in South Australia. *Australian Journal of Nutrition and Dietetics*, **56**, 151–155.

Fawcett, S., Paine-Andrews, A., Francisco, V. and Schultz, J. (1995) Using empowerment theory in collaborative partnerships for community health and development. *American Journal of Community Psychology*, **23**, 677–689.

Hawe, P., Degeling, D. and Hall, J. (1990) *Evaluating Health Promotion: A Health Worker's Guide*. MacLennan and Petty, Sydney.

Hawe, P., Noort, M., King, L. and Jordens, C. (1997) Multiplying health gains: the critical role of capacity-building within health promotion programs. *Health Policy*, **39**, 29–42.

Jackson, C., Fortmann, S., Flora, J., Melton, R., Snider, J. and Littlefield, D. (1994) The capacity-building approach to intervention maintenance implemented by the Stanford Five-City Project. *Health Education Research*, **9**, 385–396.

Kickbusch, I. (2001) Health literacy: addressing the health and education divide. *Health Promotion International*, **16**, 289–297.

Labonte, R. and Laverack, G. (2001) Capacity building in health promotion. Part 1: for whom? And for what purpose? *Critical Public Health*, **11**, 111–129.

Laris, P., Jolley, G. and Smith, A. (2001) *Eat Well SA Evaluation Report October 1997–October 2000*. Paul Laris and Associates, South Australian Community Health Research Unit and Department of Public Health, Flinders University Adelaide, Adelaide.

Laverack, G. and Wallerstein, N. (2001) Measuring community empowerment: a fresh look at organisational domains. *Health Promotion International*, **16**, 179–185.

Maton, K. (2000) Making a difference: the social ecology of social transformation. *American Journal of Community Psychology*, **28**, 25–57.

McGlone, P., Dobson, B., Dowler, E. and Nelson, M. (1999) *Food Projects and How They Work*. York Publishing Services, York.

National Health and Medical Research Council (1996) *Promoting the Health of Australians*. Australian Government Publishing Service, Canberra.

National Public Health Partnership (2001) *Eat Well Australia. An Agenda for Action for Public Health Nutrition*. National Public Health Partnership, Canberra.

NSW Health Department (2001) *A Framework for Building Capacity to Improve Health*. NSW Health Department, Sydney.

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. Sage, London.

Schwartz, R., Smith, C., Speers, M., Dusenbury, L., Bright, F., Hedlund, S. *et al*. (1993) Capacity building and resource needs of state health agencies to implement community-based cardiovascular disease programs. *Journal of Public Health Policy*, **14**, 480–494.

Shediac-Riskallah, M. and Bone, L. (1998) Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research*, **13**, 87–108.

Smith, A. M. (2002) *Promoting Healthy Eating for South Australian Families. The Eat Well SA Project 1997–2002*. Women's and Children's Hospital, Adelaide.

Tasmania Department of Community and Health Services (1999) *Partnership Framework*. Tasmania DHHS, Hobart.

Weiss, C. (1998) *Evaluation*, 2nd edition. Prentice Hall, NJ.

Young, H. (1999) Public nutrition in emergencies: an overview of the debates, dilemmas and decision-making. *Disasters*, **23**, 277–291.

Baum, F. Jolley, G. Hicks, R. Saint, K. and Parker, S. (2006) What makes for sustainable

Healthy Cities initiatives? - a review of the evidence from Noarlunga after 18 years. *Health*

Promotion International, 2006; 21 4: 259-265
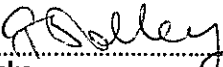
Statement of authorship

What makes for sustainable Healthy Cities initiatives? - a review of the evidence from Noarlunga after 18 years

Gwyn Jolley (Candidate)

Major role in conceptualising and designing the research. Retrieved and reviewed literature, extracted data, analysed and interpreted findings. Co-authored and critically reviewed the whole paper.

Signed .... Date ..1 8 1 6 12..........

Richard Hicks

My contribution to this paper involved ensuring the paper included an overview of the big picture, where support was coming from and the leadership. These factors are reflected in the paper as the nine factors which emerged as important to ensuring sustainability. Linking local government, health, University and the community was an important role as the Chairperson.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ..13 07 2012..........

Fran Baum

My contribution to the paper involved conceptualising the paper and the research design, writing parts of the first and subsequent drafts and critical review of drafts and final copy.
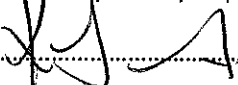
I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ..3/10/12..........

Kate Saint

My contribution to this paper involved being the contact person between Healthy Cities Noarlunga, Noarlunga Health Services and Flinders University, involvement in the initial discussions and research design meetings and critically reviewed document for publication.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ..29 5 2012..........

Steve Parker

My contribution to this paper involved sourcing and supplying information and evaluation documents and reviewing the final paper.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .....Stephen Parker............................... Date ..22/6/2012 .

What makes for sustainable Healthy Cities initiatives?—a review of the evidence from Noarlunga, Australia after 18 years

FRAN BAUM, GWYNETH JOLLEY[1], RICHARD HICKS[2], KATE SAINT[2] and STEVE PARKER[2]

Department of Public Health, Flinders University, Adelaide, Australia, [1]SA Community Health Research Unit, Flinders University, Adelaide, Australia and [2]Noarlunga Health Services, Adelaide, Australia

SUMMARY

This paper examines the factors that have enabled the Healthy Cities Noarlunga (HCN) initiative to be sustainable over 18 years (1987–2005). Sustainability related to the ability of the initiative to continue to operate continuously in a manner that indicated its existence was accorded value by the community and local service providers. The analysis is based on a narrative review of 29 documents related to HCN, including a number of evaluations. Nine factors emerged as important to ensuring sustainability: strong social health vision; inspirational leadership; a model that can adapt to local conditions; ability to juggle competing demands; strongly supported community involvement that represents genuine engagement; recognition by a broad range of players that Healthy Cities is a relatively neutral space in which to achieve goals; effective and sustainable links with a local university; an outward focus open to international links and outside perspectives; and, most crucial, the initiative makes the transition from a project to an approach and a way of working. These sustainability factors are likely to be relevant to a range of complex, community-based initiatives.

Key words: healthy cities; health promotion programs; sustainability; evaluation

INTRODUCTION

This paper examines the factors that have contributed to the sustainability of Healthy Cities Noarlunga (HCN) by using data from a series of evaluations of the project and the initiatives it has given rise to. The lessons concerning sustainability of community-based health promotion initiatives are presented.

The World Health Organization (WHO) developed the Healthy Cities project as a means of operationalizing the Ottawa Charter for Health Promotion (WHO, 1986; Ashton and Seymour, 1988). HCN was directly modeled on the WHO's European Healthy Cities Program (Hancock and Duhl, 1988) but adapted to an Australian suburban setting (Baum *et al.*, 1990).

It commenced in April 1987 when the Australian Community Health Association received funding from the Australian Government to pilot the WHO Healthy Cities concept in three cities—Canberra, Illawarra and Noarlunga. Noarlunga, the subject of this paper, is an outer suburban area of Adelaide, the capital city of the State of South Australia. In 1988 its population was 77 000.

The Australian pilot phase ran for 3 years (1987–89) and was followed by a funded network project (1990–92). These national initiatives were evaluated (Worsley, 1990; Whelan *et al.*, 1992), and it was concluded that they had some successes but also room for improvement.

HCN was based in the State Government funded Noarlunga Health Services (NHS). NHS was then a new primary health care service that, in 1991, was integrated with a new community hospital. Project funds were used to employ a full-time project manager and a half-time administrative assistant. A two-tier committee structure was established with a Reference Committee that met quarterly with senior agency staff and community representatives, and a Management Committee that met monthly. HCN also attracted significant in-kind contribution from NHS and other agencies. During this period numerous initiatives were undertaken, and a clear vision was established for a 'Healthy Noarlunga'. This vision evolved from a community process and built on a needs assessment that had been conducted before HCN was established (Baum *et al.*, 1986). The project followed the WHO Twenty Steps (WHO, 1995) that are conceived as three stages of project development: getting started, getting organized, taking action.

Dedicated funding was withdrawn following the pilot period, and HCN then relied on in-kind contributions, primarily from the local health service. The community activists in HCN initiated a review of the management of the project in 1991, and this resulted in a decision to incorporate HCN as a non-government organization. The constitution of HCN stipulates that there must be a majority of community members on the Management Committee.

Through the 1990s, HCN continued to initiate and be involved in many projects. Three of particular significance were the *Noarlunga Towards a Safe Community* (NTSC) and *Noarlunga Community Action on Drugs* and the *Onkaparinga Collaborative Approach for the Prevention of Domestic Violence*. Each of these health promotion initiatives had their origins in HCN and then developed and established their own identity. NTSC became an accredited WHO Safe Communities Project in 1996 and was redesignated in 2003. HCN's relationship with the Department of Public Health at the local university continued to develop. From 1991, the two organizations have cooperated in running training programs and developing a post-graduate course on Healthy Cities.

Evaluation has been a central concern of Healthy Cities since its inception. Healthy Cities initiatives are complex in design and execution. The more complex a health promotion initiative is the more difficult it is to evaluate (McQueen and Anderson, 2001). Most significantly, the assignment of causality to a Healthy Cities project is difficult. There are so many other factors that have a direct or indirect impact on city health that isolating one intervention as the cause of change is problematic (Costongs and Springett, 1997; Baum, 2002). Essentially, Healthy Cities is about mobilizing communities and local agencies, and so local politics play a very central role in the project, and evaluations have to incorporate this dimension (de Leeuw and Skovgaard, 2005). These complexities mean that it is not easy to demonstrate a direct causal link between a Healthy Cities project and a health outcome. However, evidence can be marshaled that a Healthy Cities initiative has given rise to activities that can be reasonably linked to expected health outcomes based on articulated program logic. Such approaches to evaluation formed the basis of the evaluation of the Health Action Zones in the UK (Judge and Bauld, 2001). In addition, one of the criteria for success of a health promotion program is that it is sustainable (Shediac-Rizkallah and Bone 1998; Pluye *et al.*, 2004) even though this has proved difficult to define (St Leger, 2005). We consider the HCN project to be sustainable because it has been in continual operation from 1987 until the present and has strong support from community members, local politicians and service providers (shown by willingness to sit on committees, attendance at AGMs and feedback in periodic reports and evaluations). This support reflects HCN perceived success in changing organizational cultures towards a focus on health promotion, in involving community members in health promotion and in building local capacity. These criteria have been identified as important elements of sustainability (Swerissen and Crisp, 2004).

METHOD

This study is based on a narrative review of 29 documents related to HCN that have been published since 1987. Documents include evaluations, annual reports and material describing activities within the initiative (document list is available at http://som.flinders.edu.au/FUSA/PublicHealth/AcademicHome/FB_home.htm). The documents were reviewed by two of the authors (FB/GJ) and analyzed to identify themes relating to the sustainability of the Healthy Cities initiative. The development of these themes drew

on the extensive knowledge of the reviewers of the international Healthy Cities literature. There is not sufficient space to include a review of this literature here but much of the reviewers' knowledge of Healthy Cities is available in Baum (Baum, 2002, Chapters 22 and 24). The themes were then discussed with the other authors and refined in light of this discussion.

FINDINGS

Between 1987 and 2005, HCN has been involved in 25 significant projects (see for details http://som.flinders.edu.au/FUSA/PublicHealth/AcademicHome/FB_home.htm). These include environmental, safety, school-based, drug use and service access projects.

Our analysis of the documents and drawing on our knowledge of the broader Healthy Cities literature indicated that nine factors had been central to the sustainability of the Healthy Cities initiative in Noarlunga. These are:

  (i) Social health vision
 (ii) Leadership
(iii) Model adapted to local conditions
 (iv) Juggling competing demands
  (v) Strongly supported community involvement
 (vi) Recognized as 'neutral gameboard'
(vii) University links and research focus
(viii) International links and WHO leadership
 (ix) Transition from project to approach

Each of these factors is discussed in more detail below.

Social health vision

From the start of the WHO Healthy Cities project, the value of a social health vision has been stressed (Ashton and Seymour, 1988; Hancock and Duhl, 1988). The visions developed as part of Healthy Cities initiatives were based on a sophisticated understanding that the roots of ill health lie in social and economic factors. Documentation from the first 3 years (1987–1990) shows the extent to which a social health vision was the base for the HCN project. It was seen as important to spend time at the beginning of the project in discussing the WHO Health for All Strategy and deriving locally appropriate goals. These first HCN goals stressed the need to promote awareness and participation by organizations and community groups in social health issues (HCN, 1987).

The pilot project established a community vision based on a series of workshops attended by government agency representatives and community members. The workshop participants produced their vision for a healthy Noarlunga in 20 year's time. This led to a community arts project that produced 'The Dream Machine', a three-dimensional display of the community visions for Healthy Noarlunga. The vision project provided a strong basis for HCN.

An understanding of health as a social issue was supported by State Government policies at the time, including a Social Health Strategy (SA Health Commission, 1988) and a Primary Health Care Policy (SA Health Commission 1989) that aimed to address inequities in health status and increase access to living conditions promoting health and wellbeing. While the political commitment to these policies was strongest at the start of the Healthy Cities initiative, the commitment has been strongly maintained at Noarlunga by the local health service and local government. As one key informant noted in an early evaluation:

We have a head start in Noarlunga because we have so many agencies committed to a social concept of health care. (HCN, 1987)

Throughout the history of HCN, an emphasis on the role of social, economic and environmental factors on health has continued. Many of the earlier activities focused on environmental issues (e.g. pollution of waterways, green area planning). More recently, attention has turned to issues such as the impact of illicit drugs in the community, supporting opportunities for young people and indigenous health and wellbeing.

Leadership

Legge *et al.* (1996) identify inspirational leadership as an important pre-condition for good practice in primary health care. HCN has had consistent leadership over its 18 year history. The project was initiated by one of the authors (RH), who holds a senior management position in the regional health service, and he has chaired the Management Committee over the entire period. A consistent theme in evaluations has been that this leadership is a crucial success factor. For example:

The energy, administrative skills, networking capability, tenacity and positivity of key players was seen as

a key feature in the Noarlunga Towards a Safe Community process. (Rosenfeld and Cooke, 1997 p. 21)

The City of Noarlunga and its successor (following local government re-organization), the City of Onkaparinga, have had the same Mayor for the entire period. He has given consistent support to the notion of Healthy Cities, and although this has not translated into direct financial support, this endorsement has added legitimacy to the initiative and provided a strong link between the Healthy Cities project and the local government.

Following the cessation of Australian Government funding, the Management Committee, and in particular the Chair, took on the project management role with the support of NHS. While the loss of a paid project officer was of concern, there was also the view that HCN was able to continue owing to the 'enthusiasm and driving force' of the Chair (Barkway, 1992).

Model adapted for local conditions

The Healthy Cities movement started in Europe (Ashton *et al.*, 1986) and was based in local government. In Australia, health and social services reside with the State Governments; thus, placing Healthy Cities in local government is a less obvious approach. The Noarlunga project has, from the outset, been based in the local community health service, a State Government agency, and this has worked well in most respects. Following the pilot project, HCN was legally incorporated. HCN has a community-directed governance model, which could appear loose but in fact has proved to be a robust mechanism for encouraging action across local government and the many State Government agencies that have responsibilities in the Noarlunga region (including housing, education, health, welfare). The documents reviewed, especially those in the later years, stressed repeatedly that initiatives were often only felt to have happened because of the previous collaborations that Healthy Cities has encouraged. In effect these had laid the seed bed on which future projects grew.

Juggling competing demands

Throughout the history of Healthy Cities there has been a series of competing demands, and the project has had to decide between priorities across a wide range of possibilities. The tensions in these decisions have remained constant from the outset. The project has to ensure that it is seen to achieve short-term goals while also working on longer-terms ones.

HCN has also had to reconcile priorities coming from social planners (in local and State Government) with those coming from community members directly. Local government was reported as reluctant to fund Healthy Cities directly as the social action component might be critical of council actions (Baum *et al.*, 1992). Indeed HCN has been seen as a mediator between residents, and local and state governments:

. . .when a community member has a good idea, how do they get support for it? Local government reluctance to become involved. (Baum et al., 1990, p. 39)

This juggling of demands is not always easy but the synergies between the two approaches have lead to two very significant initiatives: *Noarlunga Towards a Safe Community* (a community injury project) and the *Noarlunga Community Action on Drugs Forum*. These initiatives came originally from ideas within the HCN Management Committee and were then developed as separate initiatives. Both were founded on the strong methods of working that HCN had developed in community participation and working across sectors. Thus an evaluation of a youth peer project auspiced under the Forum concluded that the project was able to make significant advances in a relatively short period of time because:

. . . the Forum drew on the networks and tradition of collaborative networking and action established by the Noarlunga Healthy Cities initiative. (Baum et al., 2003, p. 20)

Strongly supported community involvement

An assessment of community participation in HCN found both instrumental and developmental participation occurring simultaneously (Cooke, 1995). Community members hold 8 of the 15 positions on the Management Committee and the extent of community involvement evident in HCN is noted consistently as a strength in the analysis of the documents reviewed.

The Onkaparinga River pollution initiative provides an example of a resident-driven project that was facilitated by HCN provision of:

access to the system and to the key people that can get attention paid to community issues. (Cooke, 1995 p. 99).

Some community members reported this experience was personally empowering and went on to join the HCN Management Committee or become involved in other community issues. Community members have been supported to attend and present at conferences and sponsored to attend the Healthy Cities training course.

HCN recognized as a 'neutral game board' (Hancock, 1992)

Over the 18 years of its operation HCN has engaged with a range of government and non-government organizations. Consistent players over that period have been the South Australian Government departments responsible for health, welfare and housing; local government and community representatives. Other State Government departments have been involved intermittently. For instance, the education sector was involved when the Healthy Schools initiative was being established. As this became a mainstream state program the Education Department withdrew from the HCN committee and later rejoined to become involved in the injury prevention program. The local police have also been active supporters, have been represented on the Management Committee and attend the AGM. A government review of HCN concluded that its existence made it easier for State Government departments to work in Noarlunga, because the cross-sector networks and community involvement were already in place and sustainable. In many ways the success of HCN creates the 'complex, hardly recognizable web of social structures' that Grossmann and Scala (Grossmann and Scala, 1993, p. 25) talk of as crucial for effective health promotion intervention.

There has also been support from Federal, State and local politicians. Recent AGMs have been well attended by the local members or their staffers. HCN has been skilful in avoiding association with any one political party and so has attracted bi-partisan political support. The local Mayor has been a consistent supporter of HCN and has willingly hosted visiting delegations, provided representatives for the Management Committee and talked favorably about achievements on many occasions.

de Leeuw and Skovgaard (2005) and Kingdon (1995) talk of the importance of 'windows of opportunity' and spaces that enable innovations in public health agenda and actions. The skill of HCN has been to use these windows on a number of occasions to promote local community and public health issues. Kingdon (1995) also notes that the policy process environment is forever changing and those wishing to influence it have to be opportunistic. The leadership of HCN has been very effective in doing just this. For example, HCN used the very favorable climate towards environmental issues in 1990 Federal politics to advance the cause of the clean up of the Onkaparinga River; used the political focus on drugs to establish the *Noarlunga Community Action on Drugs Forum*; and locally demonstrated the need to establish *Tackling Injury Prevention in Small Business*.

University links and research focus

Since its inception HCN has been linked with the State Government funded South Australian Community Health Research Unit. This Unit was responsible for the original evaluation of the pilot project (Baum *et al*., 1990; Baum and Cooke, 1992). It has also been represented on the HCN Management Committee continually over its history ensuring more emphasis was put on evaluation than is often the case in community-based health promotion.

The Unit was linked with Flinders University from 1989 and from this connection evolved the series of short courses and training undertaken by the University in conjunction with HCN. A training course on 'Healthy Cities and Communities' has run since 1991 and in the last 5 years has attracted, on average, 40 participants. In addition, training has been conducted for WHO and AusAID for people from Thailand, China, Vietnam, Malaysia and South Africa. Staff from NHS and community members of the HCN Management Committee have regularly undertaken the training. This increases the network of people with a detailed understanding of Healthy Cities, the theories behind it and the ways it is implemented in Noarlunga.

Value of international links

From the beginning HCN has focused both inwardly and outward. The original pilot project was designed to test the European idea of Healthy Cities in an Australian context. In the first years of the project there were visits by key figures from the European movement including Dr Ilona Kickbusch from the WHO European office, Dr Trevor Hancock (Toronto Healthy

Cities) and Dr John Ashton from the Liverpool Healthy Cities project. These visits have been important in legitimizing the Healthy Cities approach to local actors and in providing encouragement to those implementing the project. Visits have continued with the most recent being from Dr Ilona Kickbusch in April 2005. That international visits have been maintained across the span of the project is in part owing to the training courses. Each year the course has brought a variety of people with whom the HCN team have been able to learn and share ideas. This has been invaluable in providing positive feedback to the project and bringing new ideas and inspiration. The buzz around HCN following a lively visit from overseas colleagues is palpable and certainly an important input to the sustainability of Healthy Cities. HCN's association with WHO programs and membership of the WHO Safe Communities network have been significant in increasing the profile of the initiative locally. HCN acceptance as foundation member of the Western Pacific Healthy Cities Alliance also had this effect and so contributes to the sustainability of the project.

Another innovation that has maintained an international focus has been the relationship between the Sherpur Safe Community and *Noarlunga Towards A Safe Community* programs. During the period 2000–2005 these programs have worked together in developing and implementing an innovative eye injury prevention program at the grass-roots level for metal workers in small businesses located in Sherpur, Bangladesh. Both Noarlunga and Sherpur share a strong belief in the effectiveness of practical community-based, health and injury prevention programs to safeguard workers employed in small business. Staff from NHS and a local community member have made a number of training visits to Sherpur and in total over 950 workers and child laborers have attended the eye-injury prevention workshops and over 1400 pairs of new safety glasses have been distributed to metal trade workers. HCN and local Noarlunga businesses raised the funding to allow for the training of Sherpur Safe Community health coordinators in workplace eye safety risk assessment. This commitment to supporting an injury prevention project in a poor country has increased community involvement in, and understanding of, Healthy Cities among small business people in the city and led to their sustained involvement and support for HCN.

Transition from project to approach

It was through the determination of local community people that the HCN was formally incorporated with its own constitution. In the 1990s HCN moved from being a time-limited project to being an approach to addressing community health issues. The framework of the Ottawa Charter applied though the Healthy Cities model has encouraged NHS to see that 'health is everyone's business'—and in the case of HCN has included meaningful involvement and sustained commitment from local government, public housing, mental health, police, education and welfare sectors.

DISCUSSION AND CONCLUSION

Our analysis of the documentation on HCN indicates that sustainability of complex, community-based projects depend on a myriad of factors. We have deliberately used the term 'sustainability' in this article rather than 'success' because we consider a sustainable initiative provides a base for achieving health promotion outcomes over time. The documents reviewed suggest that HCN has been successful at engaging some community members who report that this has had a lasting positive impact on their lives. Key informants from agencies report that the mode of operation of HCN means that working across sectors in Noarlunga has become a taken-for-granted mode of operation, which makes it easier for central agencies to engage with the region. HCN has also achieved outcomes that have a direct impact on health, such as removing injury hazards from the community, cleaning up the local river estuary so it is safer for swimmers and engaging in community development, which provides social support and networks that have a positive impact on health. However, as with most community-based initiatives, it is very difficult to attribute any action of HCN directly with a defined and discrete health outcome. This has made it hard to gain external resources for evaluation as large grant funding agencies are most likely to fund research where the causal pathways are relatively straightforward (Kavanagh *et al.*, 2002). Our approach to evaluation is based on being able to show that HCN has brought about change in aspects of community life that other evidence suggests is likely to lead in the longer term to health improvement (see Baum *et al.*, 2001 for more details). The data used for this paper certainly

suggest ways in which HCN is likely to have laid the basis for improved health in many cases and led more directly to improved health in other cases.

The comprehensiveness of the data we have analysed for this study provides a sufficient basis to argue that complex, multi-sectoral community-based health promotion initiatives can be sustained longer term and do bring significant benefits to their communities, at little cost.

Address for correspondence:
Fran Baum
Department of Public Health
Flinders University
Adelaide
Australia
E-mail: fran.baum@flinders.edu.au

REFERENCES

Ashton, J., Grey, P. and Barnard, K. (1986) Healthy cities—WHO's new public health initiative. *Health Promotion*, **13**, 319–323.

Ashton, J. and Seymour, H. (1988) *The New Public Health*. Open University Press, Milton Keynes.

Barkway, P. (1992) Noarlunga healthy cities: an evaluation two years after the end of the pilot project. Unpublished manuscript, Flinders University, Adelaide.

Baum, F. (2002) *The New Public Health*. Oxford University Press, Melbourne.

Baum, F. and Cooke, R. (1992) Healthy Cities Australia: evaluation of the pilot project in Noarlunga, South Australia. *Health Promotion International*, **7**, pp. 181–193.

Baum, F., Cooke, R. and Wright, J. (1986) *Noarlunga's Health Apathy or Action?*. Southern Community Health Research Unit, Adelaide.

Baum, F., Cooke, R., Crowe, E., Traynor, M. and Clarke, B. (1990) *Healthy Cities Noarlunga Project Evaluation*. Southern Community Health Research Unit, Adelaide.

Baum, F., Traynor, M. and Brice, G. (1992) Health policy implementation at a local level: Healthy Cities Noarlunga. Chapter 14. In Gardner, H. (ed.) *Health Policy: development, implementation and evaluation in Australia*. Churchill Livingstone, Melbourne.

Baum, F., Jolley, G. and Bament, D. (2001) *Healthy Cities Evaluation Framework Testing Project*, Report to WHO WPRO, Manila.

Baum, F., Jolley, G. and Kyriacou, M. (2003) *Process Evaluation of the Youth Drug Peer Action Project, Community report no. 3*. SACHRU, Adelaide.

Cooke, R. (1995) Two Healthy Cities in South Australia. Chapter 6. In Baum, F. (ed.) *Health for All: the South Australian experience*. Wakefield Press, Adelaide.

Costongs, C. and Springett, J. (1997) Towards a framework for the evaluation of health-related policies in cities. *Evaluation*, **3**, 345–362.

de Leeuw, E. and Skovgaard, T. (2005) Utility-driven evidence for Healthy Cities: problems with evidence generation and application. *Social Science and Medicine*, **61**, 1331–1341.

Grossman, R. and Scala, K. (1993) *Health Promotion and Organizational Development: Developing Settings for Health, European Health Promotion Series No. 2*. WHO, Europe/IFF Vienna.

Hancock, T. (1992) The healthy cities: utopias and realities. In Ashton, J. (ed.) *Healthy Cities*. Open University Press, Buckingham, UK.

Hancock, T. and Duhl, L. (1988) *The Parametres of a Healthy City. Promoting Health in the Urban Context. WHO Healthy City Papers No. 1*. WHO, Copenhagen.

Healthy Cities Noarlunga (1987) *Healthy Cities Noarlunga progress report.*, HCN, Adelaide.

Judge, K. and Bauld, L. (2001) Strong theory, flexible methods: evaluating complex community-based initiatives. *Critical Public Health*, **11**, 19–38.

Kavanagh, A., Daly, J. and Jolley, D. (2002) Research methods, evidence and public health, *Australian and New Zealand Journal of Public Health*, **26**, 337–342.

Kingdon, J. W. (1995) *Agendas, Alternatives and Public Policies,*. 2nd ed. Addison Wesley, Longman, New York.

Legge, D., Wilson, G., Butler, P., Wright, M., McBride, T. and Attewell, K. (1996) *Best Practice in Primary Health Care*. Centre for Development and Innovation in Health & Commonwealth Department of Health and Family Services, Victoria.

McQueen, D. V. and Anderson, L. M. (2001) What counts as evidence: issues and debates. In Rootman, M., Goodstadt, B., Hyndman, D. V., McQueen, L., Potvin, L., Springett, J. and Ziglio, E. (eds), *Evaluation in Health Promotion. Principles and Perspectives*. WHO Regional Publications, European Series, 92, WHO, Copenhagen, pp. 63–82.

Pluye, P., Potvin, L., Denis, J. and Pelletier, J. (2004) Program sustainability: focus on organizational routines. *Health Promotion International*, **19**, 489–500.

Rosenfeld, E. and Cooke, R. (1997) *Evaluation of Noarlunga towards a Safe Community*. SACHRU, Adelaide.

Shediac-Rizkallah, M. and Bone, L. (1988) Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research*, **13**, 87–108.

South Australian Health Commission. (1988) *A Social Health Strategy for South Australia*, SAHC, Adelaide.

South Australian Health Commission. (1989) *Primary Health Care Policy Statement*, SAHC, Adelaide.

St Leger, L. (2005) Questioning sustainability in health promotion projects and programs. *Health Promotion International*, **20**, 317–319.

Swerissen, H. and Crisp, B. (2004) The sustainability of health promotion interventions for different levels of social organisation. *Health Promotion International*, **19**, 123–130.

Whelan, A., Mohr, R. and Short, S. (1992) *Waving or Drowning? Evaluation of the National Secretariat, Healthy Cities Australia*. Australian Community Health Association, Bondi Junction, NSW.

World Health Organization (1986) Ottawa charter for health promotion. *Health Promotion*, **1**, iv.

World Health Organization (1995) *Twenty Steps for Developing a Healthy Cities Project*, WHO Regional Officer for Europe, Copenhagen.

Worsley, T. (1990) *National Evaluation of Healthy Cities Australia Pilot Project*. Australian Community Health Association, Bondi Junction, NSW.

Jolley, G. Lawless, A. Baum, F. Hurley, C. and Fry, D. (2007) Building an evidence base for community health: a review of the quality of program evaluations. *Australian Health Review*, 2007; 31 (4) 603-610.

Statement of authorship

Building an evidence base for community health: a review of the quality of program evaluations.

Australian Health Review, 2007; 31 (4) 603-610.

Gwyn Jolley (Candidate)

Major role in conceptualising and designing the research, including critical examination of qualitative research assessment tools and adaptation for this research. Contributed to reviewer training. Retrieved and reviewed evaluation reports, extracted data, analysed and interpreted findings. Major contribution to synthesis of findings. Led the drafting and revisions of whole paper and acted as corresponding author.

Signed .... Date ...26/9/12......

Angela Lawless

My contribution to this paper involved additional data analysis on the findings, drafting and rewriting the paper.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ...27/9/12......

Fran Baum

My contribution to this paper involved conceptualising the research including co-development of the assessment tool, conducting assessments of the evaluations, contribution towards first draft of manuscript and critical assessment of drafts of the manuscript

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ...3/10/12...

Catherine Hurley

My contribution to this paper involved conducting the research, including assessing the papers for review, participating in the analysis and interpretation of findings. Contributed to construction and review of the paper.
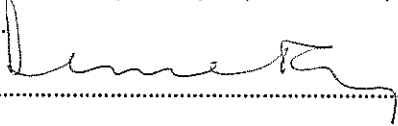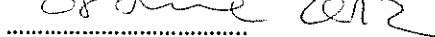
I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ...28/9/12......

Denise Fry

My contribution to this paper involved reviewing program evaluations, analysing data and contributing and commenting on the paper.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... Date ....

Denise Fry

My contribution to this paper involved reviewing program evaluations, analysing data and contributing and commenting on the paper.

Building an evidence base for community health: a review of the quality of program evaluations

Gwyn M Jolley, Angela P Lawless, Fran E Baum, Catherine J Hurley and Denise Fry

Abstract

An assessment of the quality of program evaluations conducted in South Australian community health services investigated how effective evaluation reporting is in producing an evidence base for community health. Evaluation reports were assessed by a team of reviewers. Practitioner workshops allowed an understanding of the uses of evaluation and what promotes or acts as a barrier to undertaking evaluations.

Community health services do undertake a good deal of evaluation. However, reports were not generally explicit in dealing with the principles that underpin community health. Few engaged with program theory or rationale. Typically, reports were of short-term projects with uncertain futures so there may seem little point in considering issues of long-term health outcomes and transferability to other settings. The most important issue from our study is the lack of investment in applied health services research of the sort that will be required to produce the evidence for practice that policy makers desire. The current lack of evidence for community health reflects failure of the system to invest in research and evaluation that is adequately resourced and designed for complex community settings.

Aust Health Rev 2007: 31(4): 603–610

Gwyn M Jolley, MSC(PHC), Senior Research Officer
Angela P Lawless, BAppSci(SpeechPathology), GradDipPHC, Senior Research Officer
Fran E Baum, PhD, Director and Professor of Public Health
Catherine J Hurley, BA, BSocAdmin, GradCertPHC(Research and Evaluation), Senior Research Officer
South Australian Community Health Research Unit, Department of Public Health, Flinders University, Adelaide, SA.

Denise Fry, BA(Hons), Walk To School Project Officer
Health Promotion Service, Sydney South West Area Health Service, Sydney, NSW.

Correspondence: Ms Gwyn M Jolley, South Australian Community Health Research Unit, Department of Public Health, Flinders University, G Block FMC Flats, Flinders Drive, Bedford Park, Adelaide, SA 5042. **gwyn.jolley@flinders.edu.au**

What is known about the topic?
Program evaluations are often conducted for community health initiatives, but there has been little information on the quality of the completed evaluations.

What does this paper add?
This paper presents the results of a review of program evaluations conducted in South Australian community health services. Although there were a large number of evaluations completed, most were internal and did not provide useful information for policy and planning decisions.

What are the implications for practitioners?
The authors suggest a need for investment in health services research to improve the quality of program evaluations for decision making.

THIS PAPER DESCRIBES a review of the quality of program evaluations conducted in South Australian community health services and considers how effective these evaluation reports are in terms of producing an evidence base for the work of these services. It also reports on the attitudes of services toward evaluation. Community health in this paper describes the state government-funded primary health care sector that provides comprehensive primary health care services not targeted at a particular population group. Services are mainly non-medical and multidisciplinary, with a range of strategies and an emphasis on health promotion and illness prevention.

Over the last decade there has been an increasing interest in evidence-based medicine (EBM) and the application of evidence-based principles to other areas of health practice and policy making. For example, a MEDLINE search for evidence-based medicine revealed one citation in 1992 but more than 13 000 in 2004.[1] EBM mainly uses systematic reviews of randomised and other controlled trials to assess and synthesise evidence about the effectiveness of interven-

tions. Increasingly, primary health care and health promotion programs are being called upon to produce similar evidence of effectiveness. While much has been written about the (un)suitability of direct translation of EBM methods, given the complexity of primary health care interventions and settings[2,3,4] the pressure to develop an evidence base for primary health care practice and policy continues to grow.

There is value in primary health care policy makers and providers developing evidence on the effectiveness of their practice. Concern has been expressed that the progress of community health is impeded by the lack of documented evidence for practice and programs and a belief that it is not possible to produce robust evidence such as that from randomised controlled trials. This means that community health is often disadvantaged when arguing for funding, particularly when competing with hospitals and acute care services where there is less demand for evidence as a basis for funding.[5]

This is not to say that community health services do not have a strong commitment to research and evaluation. In fact, SA community health service programs routinely include some form of evaluation.[6] Given the small proportion of the health dollar received by community health in Australia nationally ($3.1 billion or 4.8% of total recurrent expenditure in 2002–03),[7] it compares favourably with other parts of the health sector in terms of evaluation practice.[5] To meet the calls for evidence, however, an approach to evaluation that moves beyond evaluation for internal organisational purposes to one which provides useful evidence for the development and improvement of community health practice is needed.

Community health practitioners and policy makers involved in the development and implementation of services and programs in areas as diverse as mental health, child development, violence intervention, physical activity and healthy ageing need a robust evidence base and resources with which to produce this. While the dangers of deciding on the wrong treatment in a clinical context seem obvious, the dangers of implementing the wrong program or policy in response to a community health issue may be equally far reaching. Some apparently well intentioned interventions have had adverse unintended consequences, such as a bicycle education program which actually increased the risk of injury,[8] and an eating disorders prevention program that had short-term success but at 6-months showed a return to baseline levels for eating disorders and an unwelcome increase in dietary restraint.[9] There is also evidence to suggest that health promotion messages are taken differentially by different population groups. For example, since the promotion of folate and voluntary fortification of food, there has been a 30% fall in neural tube defects in Western Australia. However, there has been no reduction in rates in the Aboriginal population, and neural tube defects in Aboriginal infants are almost twice as common compared with non-Aboriginal infants.[10]

Thus it is possible for such programs to have an unintended effect of increasing inequities. It is important that providers can be confident that their programs are beneficial to participants and the wider community, that practitioners have a good understanding of what interventions are effective, and why and what may cause harm. This type of evidence is important to convince decision makers to fund programs, to convince policy makers to extend successful programs and to inform decision making about the opportunity costs involved in choosing one program over another.

Towards an evidence base

The first phase of this work is reported in *Investing in community health — finding the evidence for effectiveness,*[5] which identified three major challenges in establishing an evidence base for community health: the difficulties inherent in attributing program outcomes to a range of interventions; the complexity of the community-based setting; and the danger of ease of measurement driving the intervention. Four means by which community health programs can be judged were examined: economic evaluation, use of routine databases, systematic reviews and performance

1 Mean score for each review question

Question	Mean score (1–5)
Q1.1 Does the evaluation provide a clear description of the program goals/aims/expected outcomes?	3.462
Q1.2 Does the evaluation provide a clear description of the intervention/program and the processes used in it?	3.532
Q1.3 What evidence is presented that shows why the intervention is expected to lead to better health outcomes? (ie, Is the program logic well articulated?)	2.957
Q1.4 Does the evaluation consider issues of equity and produce evidence for the ways in which the intervention is working towards both a) equity of access to services and b) equity in health outcomes?	2.968
Q1.5 Does the evaluation document ways in which the broader implications of a health issue are considered through the intervention? Are attempts made to tackle "up stream" causes of the problem?	2.828
Q1.6 Does the evaluation discuss to what extent and how effectively the intervention involves community participants?	2.978
Q1.7 Does the evaluation discuss to what extent and how effectively the intervention involves other groups and agencies?	2.763
Q1.8 Does the evaluation document unintended aspects of the intervention?	2.548
Q1.9 Does the evaluation report on achievement of program objectives/expected outcomes? Are immediate and intermediate outcomes reported?	3.274
Q1.10 Does the evaluation discuss the likelihood of achieving longer term health outcomes?	2.349
Q1.11 Does the evaluation report on transferability of the intervention?	2.339
Q1.12 Does the evaluation report on sustainability of the outcomes?	2.309
Q2.1 Does the evaluation provide a sound justification for the evaluation method and acknowledgement of limitations of the method chosen?	2.677
Q2.2 Does the evaluation use a representative sampling method for those consulted as part of the evaluation?	2.629
Q2.3 Does the evaluation provide an adequate description of the context of intervention?	3.016
Q2.4 Does the evaluation provide evidence of data quality?	2.715

indicators. Each of these techniques was reviewed to determine the contribution they make to assessing the effectiveness of community health services. The resulting report concluded with a discussion of the way forward to a more systematic approach to assessing the performance of community health services. This paper presents a review of evaluation reporting, not of the interventions themselves.

Methods

From previous experience with the community health sector, the research team were aware that evaluations are inevitably small scale and rely heavily on qualitative methods. Qualitative systematic review methodology is underdeveloped in comparison to statistical meta-analysis and systematic review, and there is no agreed method for assessing the quality of qualitative studies.[11] A review framework was proposed by the research team to assess the quality of reporting on planning, program logic and evaluation in community health services. The framework also needed to take account of the importance of the core values underpinning comprehensive primary health care, especially participation, equity and recognition of the social determinants of health.[5] These core values both define and strengthen primary health care delivery in SA community health

---

2 Sample questions from the review protocol

Q. 1.3 Does the evaluation provide a program logic?

Explaining the logic behind an intervention is important

What evidence is presented that shows why the intervention is expected to lead to better health outcomes?
(ie, Is the program logic well articulated?)

1	2	3	4	5	N/A
not met	minimally met	partially met	largely met	fully met	justify

Comments

Q 2.1. Does the evaluation provide a sound justification for the evaluation method and acknowledgement of limitations of the method chosen?

The evaluation methods used should be described fully with sufficient details for a reviewer to make a judgement about their applicability to the particular evaluation.

1	2	3	4	5	N/A
not met	minimally met	partially met	largely met	fully met	justify

Comments

---

services and contribute to the difference in approach when compared with the medical model of health care.

The review protocol, based on previous work on synthesis of qualitative data[12] and public health interventions[13] was developed in consultation with a reference group comprising the research team, community health practitioners and state government policy officers. There were twelve questions about the description of the intervention and four questions about the evaluation methodology (see Box 1 for a list of question topics). Many of the questions had supplementary questions to guide the reviewer (see Box 2). The full review protocol can be viewed at <http://som.flinders.edu.au/FUSA/SACHRU/Research/reviewtrialv2.doc>

All evaluation reports from the five community/women's health services in the metropolitan region (1999–2002) were identified and collected. Inclusion/exclusion criteria resulted in a set of 93 reports for review. Reports were included only if the evaluation was formally documented and a metropolitan community health service was a key player in the activity/program. Reports also needed to contain, at a minimum, a description of the intervention, a description of the evaluation method and a report of the findings.

The review team consisted of three researchers, a practitioner from each community health service and an interstate consultant with considerable experience in primary health care research and evaluation. Training sessions were held to maximise consistency and to finalise the review protocol questions.

Each report was independently reviewed twice: once by the interstate reviewer and once by a member of the SA review team. The extent to which each report met the descriptor was scored from 1 (not met) to 5 (fully met) (Box 2) and comments were invited for each question. Report and intervention characteristics, scores and comments were entered into SPSS version 11 (SPSS Inc, Chicago, Ill, USA) for collation and analysis.

At the request of the community health services, short workshops on evaluation at each of the participating community health services were conducted. The purpose of the workshops was to gain an understanding of the current uses of evaluation within services and the factors that promote or act as barriers to practitioners under-

3 Promoters and barriers to evaluation (in order of response frequency)

Promoters	Barriers
Skills and training	Not enough time/resources for evaluation
Culture of evaluation	Lack of evaluation culture
Evaluation process or structure	Not enough expertise within organisation to do evaluation
Evaluation used to make a difference	Evaluation results aren't used
Access to expertise and support	External evaluation too expensive
Appropriate data systems and evaluation tools	Evaluation not seen as relevant/appropriate to work
Consistent framework	Evaluation is perceived as a threat to individual or program
Feedback and follow up	Don't know how to interpret evaluation findings

taking evaluation of their work. Six workshops took place with 127 participants in total. The process included a round table discussion about current uses of evaluation, a listing of individual, organisational and system level evaluation promoters and scoring a list of potential barriers. After identification of the top three barriers for each group, there was discussion about how these barriers might be addressed.

Results and discussion

This was the first time that SA community health program evaluations had been subject to assessment of quality against a common set of criteria. The study revealed a large amount of varied and innovative program activity within community health services, and similarly diverse evaluation practice and reporting styles. It is important to understand that most of these evaluation reports had been written for an internal audience, and thus information that would have been made explicit in documents intended for a wider audience were consequently sometimes omitted from the evaluation report.

The total possible score for each evaluation report was 160. Assuming equal weighting across the 16 questions, scores ranged from 57 (36%) to 145 (91%) with a mean of 89 (56%). This represents the high end of "minimally met". Summary scores for each question are listed in Box 1. Description of the goals and the intervention scored most highly; questions relating to

long-term outcomes, transferability and sustainability scored lowest.

The wide range of total scores and the consistency between reviewers suggests the review tool was robust and scores were not just a reflection of individual interpretation. The two reviewers' scores differed by 2 or more for 4.3%–4.4% of scores across the questions. Sustainability and sampling questions showed most frequent difference between reviewers.

Description of programs

Most reports contained a clear description of the program goal and strategies. Problem definition and information about how the problem came to be identified were less clearly articulated, and low scoring reports typically lacked information about the intervention.

Describing the program logic and linking this to longer term health outcomes was generally poorly done. Given the intended audience for most reports was the health service itself, familiarity with the program and its development was probably assumed by the writers. Few reports tackled or discussed macro-level social or economic determinants of health or underlying causal issues.

Questions regarding three key features of community health practice — equity, community participation and collaboration — were included in the review tool. Reviewers found that these rarely figured in reports, despite the fact that primary health care principles are stated

as underpinning most programs and services. Again, the intended audience for reports may have influenced the way in which these issues were dealt with. For example, equity was not explicitly discussed even when the program was apparently designed with equity issues in mind, or equity issues were implicit in the focus of interventions, for example disadvantaged groups or geographical areas. Reviewers found various understandings of equity across disciplines and programs.

Community participation, while enshrined within service policy and strategic plans, also did not feature highly in the evaluation reports. Program participants were most often described as being involved by virtue of contributing to the evaluation or, to a lesser extent, to the planning stages. Participation was generally measured by attendance. Only a few reports reflected on the quality and effectiveness of community participation. A positive comment was:

> Community-owned project and evaluation, involvement in structure, running and evaluation.

while a more typical comment was:

> Not evident in report — didn't appear to be any community involvement in project beyond the participation in the forum.

Reporting on collaborative partnerships with other groups or agencies was similarly sparsely covered. A few reported comprehensively on the role of partnerships but others simply listed partners and did not describe the process of participation or reflect on the effectiveness of collaboration or report partners' views.

Reviewers were generally positive about reporting of achievement of objectives or immediate outcomes (for example, participants learned new skills around food and nutrition), although there were some concerns about the validity of data and findings. Longer term outcomes, such as actual changes to more healthy eating, were less often considered and seldom linked to established research. Evaluation reports generally did not address issues of the potential for transferability and sustainability of the interventions.

Description of evaluation

Nearly one-third of reports described only one method of data collection, usually participant feedback sheets. Another third reported using three or more methods. Many of the reports contained little or no justification of methods or limitations identified:

> Sole evaluation method was feedback from parents in a questionnaire at the end of the group. No justification for this method or acknowledgement of limitations.

The question of the representativeness of the sample of those responding to the evaluation was generally not well reported. In most cases, where representativeness was covered, it was because the evaluation had included all people involved in the program in the evaluation. This was usually possible where the program was small. In many cases the response rates were not made clear or were left out altogether.

A few evaluations gave details of data analysis or identified more than one source of data. However, many evaluations failed to give sufficient detail in this area, particularly when it came to the analysis and presentation of data:

> Results presented are unclear — not much about collection or analysis of data. Only one source of data is given.

Practitioner perspectives on evaluation

Workshops with community health practitioners identified how evaluation was used within the organisation and the promoters and barriers to undertaking evaluation. Participants reported that evaluation was used for planning and improvement, accountability, validation and promotion of services and programs. Participants believed evaluation was more likely to be undertaken if it had a clear purpose and the findings were seen to be useful. Participants maintained that to establish an evaluation culture, an organisation should articulate the purposes for evaluation, establish a consistent framework, provide resource support and

structures, and access to expert help and guidance. Evaluation tools are needed that are relevant to the participants and the community, are flexible, qualitative and allow for creative methods of data collection and presentation.

The main promoters and barriers to evaluation identified by practitioners within the service are shown in Box 3. All workshops suggested "not enough time/resources" as the main barrier to evaluation. This was followed by "lack of evaluation culture" and "not enough expertise within organisation to do evaluation". Much of the discussion regarding the time/resource barrier centred on the pressure to provide services and administrative and management responsibilities. This meant there was little time for reflection and evaluation.

Conclusion

Our study suggests that community health services in SA do undertake a good deal of evaluation. The evaluation reports reviewed illustrate the enormous amount of innovative work being undertaken, in relation to some of the most complex issues and marginalised people in our society. Evidence from evaluations is used to inform planning processes and decision making and to describe programs and services to funders, bureaucracies and communities. Very few evaluations engaged with more fundamental theory or the underlying rationale for the program, even though some attention to this is usually required at the planning or funding submission stage. Most were internal evaluations, and a very small proportion were undertaken by external evaluators (usually for larger, grant-funded programs). Since the intended audience is mostly internal, it is reasonable to assume that knowledge of the program's rationale is assumed by the report writers. Further, when programs are limited by fixed funding and timeframes, there may seem to be little point in considering broader issues of long-term health outcomes, transferability to other settings, and so on. Typically, these evaluations were of short-term projects with uncertain futures. The writers of these reports were, for the most part, busy practitioners undertaking evaluation and report writing

with very little support in terms of time, resources or professional development.

A number of issues emerge from this study that must be addressed if community health services are to build evidence bases for their practice and programs that are convincing to funders. Firstly, systematic investment must be provided to support quality evaluations and their dissemination. With additional resources and greater expertise, evaluation and research will be able to develop and move from evaluations designed for mainly internal consumption to longer term research and evaluation with a focus on outcomes and program extension. The current investment in evaluation of community-based primary health services is very low when compared with other sectors, for example the General Practice Evaluation Program in the 1990s.

Secondly, practitioners in the workshops felt that their organisations did not have a culture supportive of evaluation despite the number and range of evaluation reports identified through the review process. The large number of evaluation reports was not reflected in subsequent use of findings. This suggests the need for more organisational commitment and support for workers undertaking evaluations. Organisations need to develop "learning cultures" that are demonstrated through organisational structures, processes and policies, for example, appropriate funding and in-kind support provided for evaluation and research activity. This culture would foster practitioners' ability to access and assess evidence and develop their research and evaluation skills and knowledge. Likewise publication and dissemination of evaluations must be facilitated and utilisation emphasised in order to contribute towards the broader evidence base.

Our review indicated that the evaluations were not generally explicit in dealing with the principles and strategies that underpin community health work. In particular, evaluations of equity, community participation and intersectoral collaboration, which are central to a community health approach, were mostly not well documented in the reports. For example, equity requirements were considered to be met if the program was targeted at a disadvantaged group; community

participation was frequently limited to consultation or opportunities to provide feedback; and partnerships were described but not assessed in terms of process or outcomes. Mechanisms need to be developed so that community health services can routinely articulate and evaluate these aspects of their programs.

Implications for research and practice

A number of initiatives designed to enhance the capacity of community health services to undertake quality evaluations are being implemented as a result of this research. An evaluation and reporting template[14] was developed as part of the project in order to encourage consistency across reports and promote greater rigour. To encourage evaluation, tools for assessing partnerships, community participation and equity are being developed.

The most important issue to emerge from our study is the lack of investment in applied health services research of the sort that will be required to produce the evidence base for practice that services and policy makers desire. Most community health evaluation activity is not funded or is inadequately funded. The vast majority of research funding is directed at medical research rather than health systems research, a problem noted internationally, not just within Australia.[15] At times the push for "definitive evidence that programs work" appears daunting for community health practitioners, as producing evidence for their work is methodologically challenging and there are few resources to design and implement appropriate evaluations. Without adequate resourcing of, and commitment to, the development of high quality evaluation, reporting and dissemination, it will not be possible to produce an evidence base for community health programs that is comparable with that being established in the EBM world. The current lack of evidence for community health reflects failure of the system to invest in research and evaluation that is adequately resourced and designed for programs in complex community settings.

Acknowledgements

Competing interests

The authors declare that they have no competing interests.

References

1 Strauss S. What's the E for in EBM? *BMJ* 2004; 328: 535-6.
2 Baum F. The new public health. 2nd edition. Melbourne: Oxford University Press, 2002.
3 Judge K. Testing evaluation to the limits: the cause of English health action zones. *J Health Serv Res Policy* 2000; 5: 3-5.
4 Salisbury C. Healthy living centres. *BMJ* 1999; 319: 1384-5.
5 Baum F. Introduction. In: Baum F, Duffy J, Jolley G, eds. Investing in community health — finding the evidence for effectiveness. Adelaide: South Australian Community Health Research Unit, 2003.
6 Jolley G, Baum F, Hurley C, Fry F. What works? A systematic review of the evidence for the effectiveness of community health in Adelaide. Adelaide: South Australian Community Health Research Unit, 2004.
7 Australian Institute for Health and Welfare. Health Expenditure Australia 2002-03. Canberra: AIHW, 2004. (AIHW cat. no. HWE27.)
8 Carlin J, Taylor P, Nolan T. School based bicycle safety education and bicycle injuries in children: a case-control study. *Inj Prev* 1998; 4: 22-7.
9 Carter J, Stewart A, Dunn V, Fairburn C. Primary prevention of eating disorders: might it do more harm than good? *Int J Eating Disorder* 1997; 22: 167-72.
10 Bower C, Eades S, Payne J, et al. Trends in neural tube defects in Western Australian Indigenous and non-Indigenous populations. *Paediatr Perinat Epidemiol* 2004; 18: 277-80.
11 Mays N, Pope C, Popay J. Systematically reviewing qualitative and quantitative evidence to inform management and policy-making in the health field. *J Health Serv Res Policy* 2005; 10 Suppl 1: 6-20.
12 Popay J, Rogers A, Williams G. Rationale and standards for systematic review of qualitative literature in health services research. *Qual Health Res* 1998; 8: 341-51.
13 Rychetnik L, Frommer M. A proposed schema for evaluating evidence on public health interventions version 3.1. Melbourne: National Public Health Partnership, 2001.
14 South Australian Community Health Research Unit. Are you writing an evaluation report? Evaluation report template. Available at: http://som.flinders.edu.au/FUSA/SACHRU/PDF/EvalReportTemplate.pdf (accessed Sep 2007).
15 Sanders D, Labonte R, Baum F, Chopra M. Making research matter: a civil society perspective on health research. *Bull World Health Organ* 2004; 82: 757-63.

Jolley, G. Lawless, A. and Hurley, C. (2008) Framework and tools for planning and

evaluating community participation, collaborative partnerships and equity in health

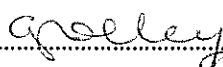promotion. *Health Promotion Journal of Australia*, 2008; 19 (2) 152-157.

Statement of authorship

Framework and tools for planning and evaluating community participation, collaborative partnerships and equity in health promotion.

Gwyn Jolley (Candidate)

Major role in conceptualising and designing the research. Researched and wrote the community participation section of the paper. Coordinated and took part in piloting of framework with practitioners. Coordinated and presented framework at conference workshop. Synthesised findings and led the drafting and revisions of whole paper and acted as corresponding author.

Signed .... *Goolley* .... Date ...25/9/12...

Angela Lawless

My contribution to this paper involved conceptualising and designing the research. Researched and wrote the heath equity section of the paper. Co- presented framework at conference workshop. Commented on and approved final draft of the paper
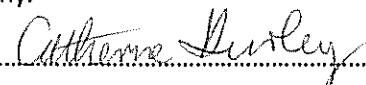
I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... *Lawless* .... Date ...27/9/12...

Catherine Hurley

My contribution to this paper involved designing the partnership tool and researching and writing the partnership section of the paper. I took part in the piloting of the partnership tool with practitioners and presented it at the conference workshop.

I give consent for Gwyn Jolley to present this paper for examination towards the Doctor of Philosophy.

Signed .... *Catherine Hurley* .... Date ...28/9/12...

Framework and tools for planning and evaluating community participation, collaborative partnerships and equity in health promotion

Gwyn Jolley, Angela Lawless and Catherine Hurley

Introduction

This paper reports on the development of a planning and evaluation framework and tools to assess key principles of primary health care: community participation, collaborative partnerships and a focus on equity.

Comprehensiveness of services is a hallmark of primary health care and health promotion and the principles of community participation, partnerships and health equity should underpin all practice, whether it be service delivery or community development.[1,2] Consideration of these key principles guides a structural approach to health that goes beyond individual behaviour change and medical interventions. Despite the fundamental importance of these principles, they seldom feature in evaluation reporting.[3,4] A review of 93 evaluations conducted in South Australian (SA) metropolitan community health services found that, although there is considerable

evaluation activity, there is room for improvement. The research identified a need for practical tools for assessing and evaluating the key components: community participation, collaborative partnerships and equity.

The authors undertook to develop a framework and tools for understanding each of these components and ways to assess how effectively they are applied at the program and practice level. The tools attempt to deal with evaluation challenges by providing practitioners and evaluators with a framework to examine health promotion work. The tools are not intended to examine big picture interventions such as social policy initiatives or regional programs. They have been developed for application to the small-scale, local interventions that characterise much of primary health care and health promotion's work. The tools are intended to capture information from workers, community members and

Abstract

Issue addressed: This paper reports on the development of a planning and evaluation framework and tools to assess key principles of primary health care/health promotion: community participation, collaborative partnerships and a focus on equity. The focus of the tools is on planning and process evaluation with some outcome questions included.

Methods: Following a scan of literature, the framework and tools for each component were developed. The tools were road-tested with colleagues and trialled by workshop participants.

Results: A framework and tools for each of the components and ways to assess how effectively they are applied at the program and practice level was developed. The tools attempt to deal with evaluation challenges by providing primary health care/health promotion practitioners and evaluators with a framework to examine these components of their work.

Conclusions: Planning and evaluation are regarded as routine in good practice. As health promotion practice and programs are shaped by principles such as partnerships, participation and equity, it is important that we also apply an evaluation lens to these components. Sound planning and evaluation allows practitioners to explain how and why these principles are integrated into their work and what is achieved.

Key words: evaluation, community participation, partnerships, equity

Health Promotion Journal of Australia 2008; 19:152-7

So what?

The development of a pragmatic evaluation framework for each of the key principles will assist practitioners to build a sound evidence base, not only about their individual practice or program, but also about an approach to health care which holds considerable promise to meet the health challenges of this century.

other relevant stakeholders. They are best used in combination with other data sources such as minutes, informal feedback, media and reports.

Good evaluation begins with sound planning and assessment as a preparation. Process evaluation is most often used by health promotion practitioners since longer-term outcomes are more complex to assess. Thus, the focus of the tools is on formative and process evaluation but with some outcome questions included.

Each tool consists of series of questions to be used at different stages in the program and is divided into three sections: preparation/planning, process evaluation and impacts/outcome evaluation.

While the background research was set in the South Australian context, the framework and tools are likely to be relevant for primary health care services more generally.

Methods

Electronic searches and scans of English language literature were undertaken to identify existing tools and their theoretical bases that could be adapted for the Australian context. Grey literature, reports and web-based examples of frameworks developed for health promotion or social programs dominated the search results. Each tool was developed following analysis and consensus building from the reviewed literature. An overall evaluation framework including a discussion of the conceptual issues, definitions and program logic was developed. The framework and tools were road-tested with practice colleagues and trialled by workshop participants at the Australian Health Promotion Association Conference in April 2007.[5] More than 50 conference delegates attended this workshop, indicating a strong interest by the field. Following this, the tools were made available as a 'work in progress' (see http://som.flinders.edu.au/sachru). Further refinement to increase the appropriateness and effectiveness of the tools will be undertaken as feedback on their use is obtained from practitioners.

The remainder of this paper describes the framework and tools. Each section begins with a discussion of concepts, as all three principles are contested in terms of meaning. This is followed by an outline of what is needed in order to make the primary health care approach effective, and a discussion of planning and evaluation issues.

Community participation

Community participation in the planning, implementation and evaluation of services is a key component of the primary health care approach.

Definition of community participation

Both the literature and health services use a variety of terms to describe communities and community participation. The term 'community participation' is used here to include participation by patients, clients, consumers, community representatives, community members and citizens. Other terms for community participation include community engagement, community partnerships and community involvement. Community participation has been defined as:

"the involvement of consumers in the development of health services. This can include involvement in policy development, strategic planning, service planning, service delivery and evaluation and monitoring."[6]

Participation can occur at any or all stages of health service decision making and should go beyond the standard satisfaction survey. The 'ladder of participation'[7] describes levels of community participation. The levels are not mutually exclusive and participation may occur at several levels simultaneously. More recently, participation has been suggested as a complementary continuum rather than a ladder, with organisation and community capacity as key factors in facilitating community participation.[8] However, the ladder does provide an opportunity for services to think about their approach to participation, their goals and what is achievable. The desired level of participation will depend on the particular program or service.

Effective community participation

According to the WHO, primary health care will:

"promote maximum community and individual self-reliance and participation on the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develop through appropriate education the abilities of communities to participate."[9]

Community participation is an ethical and democratic right and has also become an expectation of funding bodies. Potential benefits include:

• improved service quality and safety and help towards health service accreditation

• services more responsive to consumer needs

• increased compliance with therapy or treatment

• improved health outcomes.

Each of these has in common the idea that involving consumers in health care decision making leads to changes that will improve health.[10] Evaluation of community participation as a process and outcome is critical to assessing if these benefits have been realised.

Evaluating community participation

Four overarching dimensions of community participation were identified from the literature.[11-13] Firstly, the extent and scope of community participation should be assessed, for example, the number and characteristics of participants, identifying and involving those people with an interest, dealing with barriers to participation and ensuring that processes are inclusive and value diversity. Secondly, the processes of working together should be examined. This includes questions of organisational and community readiness for participation, effective communication, negotiation and conflict management skills and appropriate, effective and efficient procedures. Thirdly, capacity and support, both for staff and community participants should be assessed. This should include skills, knowledge and confidence of staff and participants, recognition and support for participants, and organisational and community capacity for genuine participation. Finally, the impacts of participation should be considered: at what level did participation occur, who had power and control, who benefited and how, what changes were made as a result of the participation?

Partnerships

The Alma Ata declaration states that primary health care "involves in addition to the health sector, all related sectors… and demands the co-ordinated efforts of all those sectors."[14] Collaborative partnerships therefore form a key component of primary health care and health promotion practice and should be included in evaluation.

Definition of partnership

While a widely agreed definition of what makes a partnership is hard to find[15] the following seems appropriate to the primary health care context:

"A group of organisations and individuals who share some interests and are working toward one or more common goals beyond the reach of any one organisation or individual."[16]

A partnership has been described as:

"a joint working arrangement where partners are otherwise independent bodies co-operating to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint program as well as sharing relevant information, risks and rewards."[17]

Collaboration is done for a number of reasons including: application of innovative solutions to often difficult or complex problems, and opportunities for the problem to be viewed by people from various perspectives and innovative solutions offered beyond what an individual person or organisation could achieve.[18,19] Other benefits include increasing knowledge of partners' activities and, in some cases, providing economic efficiencies and avoiding the duplication of effort. Partners can contribute their own resources, in-kind and financial, to allow a program greater depth or reach than might be possible with only one service involved. Different skills may be provided through collaboration along with a greater potential for impact both at the community level and in promotion of the program to a wider audience.

What makes an effective partnership?

Conditions for an effective partnership include trust and effective communication between partners, mutual benefits derived from the collaboration, clearly defined roles and responsibilities and mutually agreed goals.[15,18]

A review of partnership measurement tools by the Communities Scotland group[20] identified the following factors as central to the effectiveness of partnerships:

• presence of a key person/driving force;

• no one individual or agency is dominant, the process is genuinely collaborative;

• common vision and clear sense of purpose shared by all;

• partnership operates in an environment where work is valued, is part of the ethos and no inter-agency rivalry;

• trust is valued and has been given sufficient time to develop; and

• working in partnership is seen as productive and enjoyable.

Evaluating partnership

In the wide range of literature on evaluating partnership, some authors have identified that its complex and context-dependent nature make it very difficult to devise a tool that will fit every partnership in every circumstance. The unpredictable and changing nature of partnerships over time complicates the task of evaluation as a fixed tool may not detect changes in direction and shifts in relationships.[20,21] A review of a partnership assessment tools using the Health Action Zones program in the UK illustrates this.[22] Partnership assessment tools should have three functions:

• reflect on partnership effectiveness;

• benchmark and/or describe current status; and

• target strengths and weaknesses for development/intervention.[22]

Context is all important to the workings of any partnership and must therefore be taken account of in evaluation.[19,22,23] It is tempting to take a goals-based approach and simply measure whether a partnership has achieved what it set out to do but this does not allow the partnership to analyse where it has come from, what the strengths are and how weaknesses can be addressed. Partnerships that have not achieved their

goals or are struggling will require a more introspective and reflective process built into their evaluation.[22]

Conversely, many existing measurement tools focus solely on processes at the expense of outcomes.[15,24] Partnership should not be viewed as an end but rather rigorously examined to determine the benefits of working in partnership outweigh the costs. The measure of a partnership's success should be "beneficial changes at the level of service provision to users and carers or to the wider interface of health and social care."[15]

The following criteria are suggested for evaluating the outcome-related success of a partnership:

- improvement in accessibility of services to users;

- more equitable distribution of services;

- improved efficiency, effectiveness and quality of services along with reduced overlap and duplication;

- improved service experiences for users and carers; and

- improved health status, quality of life and well being at a population level.[15]

There is widespread support for the idea that partnership evaluation should be multi-faceted rather than reliant on a single quantitative tool. Other methods include field notes, observation by an outsider, records of meetings and interviews with participants.[21,25] It is also suggested that evaluation should acknowledge the costs and barriers to effective partnerships in order to address these if possible.[23]

Equity

Achieving health equity requires more than the programs and services within the scope of primary health care and health promotion. However, these programs, with their strong commitment to equity, have done much innovative and useful work in this area which should be documented and disseminated. Evaluation is an important step in this process.
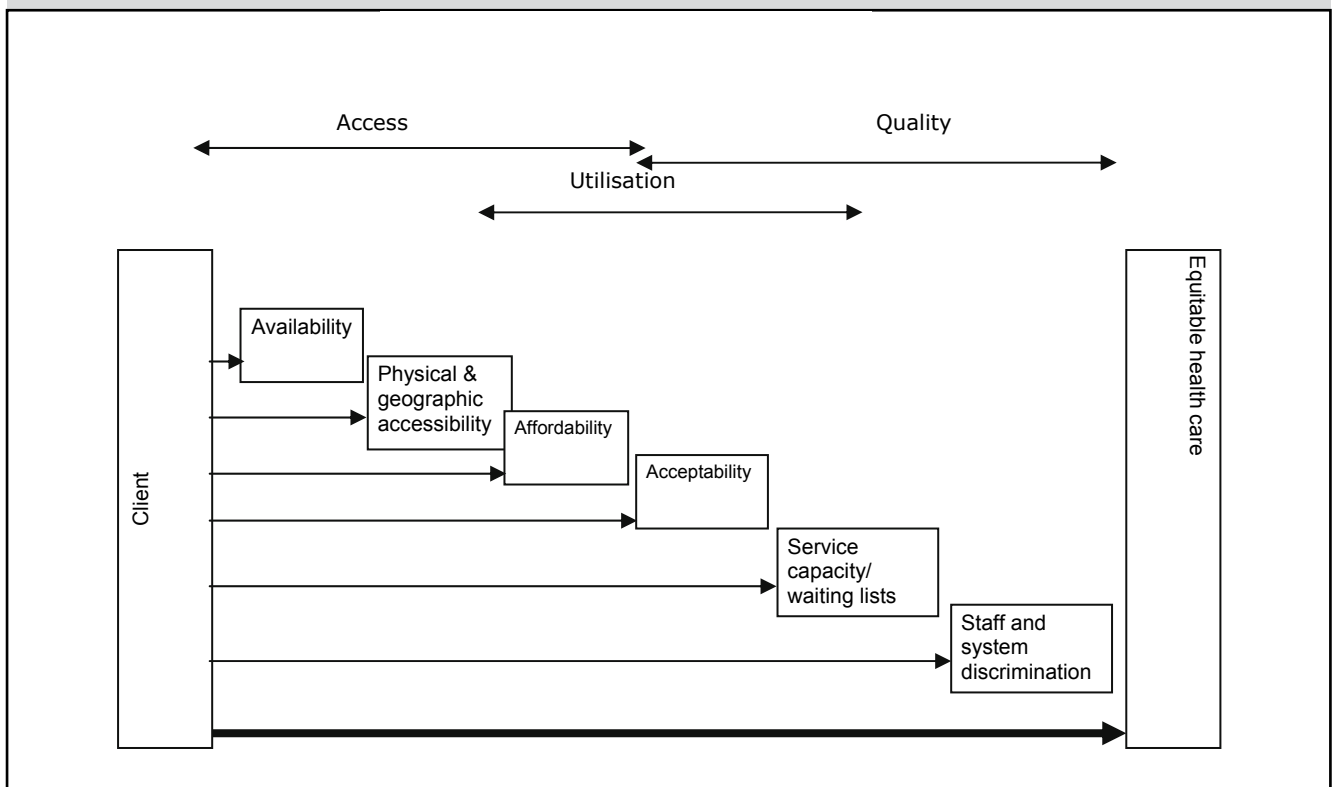
Definition of equity

We have used the terms 'equity' and 'inequity' in this paper. However, inequity and inequality are sometimes used interchangeably and the British convention is to use the term health inequalities.[26] It is important to note that the terms have a moral dimension that is in-keeping with primary health care principles i.e. there is an implied judgement about unfairness or injustice.

A clear understanding of health equity that is congruent with primary health care principles is required. The definitions below provide sound starting points.

"Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided."[27]

Figure 1: Enablers and barriers to equitable health care.

"The term 'inequity' has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. So, in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society."[28]

What makes for effective equity in health services?

The inclusion of health equity as a guiding principle should shape health services, programs and practice. Health promotion programs may have an impact on health equity through action on:

- progression of illness and disability;

- prevention of illness and injury; and

- promotion of positive health and wellbeing.

To be effective, equity work is likely to incorporate a range of strategies including community participation, partnerships, advocacy and capacity building.[29]

Evaluating equity

In order to plan and evaluate initiatives to promote health equity, practitioners must be able to articulate the equity issue and describe the pathway linking their program or practice to improved health equity. Equity in health care has been defined along three dimensions[28] and this provides a useful starting point to explore equity pathways:

- equal access to available care for equal need;

- equal utilisation of available care for equal need; and

- equal quality of care for all.

Figure 1 illustrates some key enablers/barriers to consider when examining practice in this way. For each enabler and barrier a range of questions to aid planning and evaluation can be posed.

Primary health care is concerned with more than providing health services to people. Programs with a community or population focus often aim to have an impact on pathways to health equity that lie mostly outside the traditional health care sector and are aimed at influencing factors which mediate the effect of social and economic disadvantage on health. Others aim at influencing the social and economic conditions that lead to inequitable health outcomes. The themes identified above – accessibility, utilisation and quality – are also useful in applying an equity focus to these activities. If we think about accessibility, utilisation and quality in terms of 'resources for health' rather than 'health care' these principles can be applied to a range of primary health care and health promotion programs. This means that the tool has the potential to be applied to interventions aimed at increasing resources for health.

Conclusion

Evaluation is regarded as a routine part of good practice. It encourages accountability, service and program improvement and contributes to our knowledge of 'what works and why'. As primary health care and health promotion practice and programs are shaped by principles such as the promotion of partnerships, participation and health equity, it is important that we also apply an evaluation lens to these components. Sound planning and evaluation allows practitioners to explain not only why but how these principles are integrated into their work and what is achieved by doing so. It provides information about what works for whom. Programs and practice can be modified and improved on the basis of evaluation findings. Lessons can be drawn for different issues, different people and different contexts.

There are many barriers to evaluation practice in primary health care and health promotion settings. Among these are the lack of system level investment in the development of appropriate methodologies and research capacity and the complexity of the evaluation task. Evaluation of the key components discussed here is particularly problematic given they are contested concepts. While there is often implicit recognition of these underpinning principles, evaluation tends to focus on other, more readily evaluated aspects of practice.

The framework and tools presented in this paper offer a resource to assist in the planning and evaluation of health promotion programs and aim to act as prompts to reflective practice. It is hoped that by developing a pragmatic evaluation framework for each of the key principles, practitioners will be able to build a sound evidence base not only about their individual practice or program but about an approach to health care which holds considerable promise to meet the health challenges of this century.

References

1. Baum F. *The New Public Health*. 2nd ed. Melbourne (AUST): Oxford University Press; 2002.

2. Legge D, Wilson G, Butler P, Wright M, McBride T, Attewell R. *Best Practice in Primary Health Care*. Melbourne (AUST): Centre for Development and Innovation in Health, La Trobe University; 1996.

3. Jolley G, Baum F, Hurley C, Fry D. *What Works: A Systematic Review of the Evidence for the Effectiveness of Community Health in Adelaide*. Adelaide (AUST): South Australian Community Health Research Unit, Flinders University; 2004.

4. Jolley G, Lawless A, Baum F, Hurley C, Fry D. Building an evidence base for community health: a review of the quality of program evaluations. *Aust Health Rev*. In press 2007.

5. Jolley G, Lawless A, Hurley C, Biedrzycki K, Ramanathan R. Evalution Toolkits for Equity, Community Participation and Collaborative Partnerships. *Proceeding of the Australian Health Promotion Association Conference 17th National Conference* [homepage on the Internet]; 2007 May 1-4 [cited 2007 June 29]; Adelaide, AUST. Adelaide: South Australian Community Health Research Unit, Flinders University; 20007. Available from: http://www.healthpromotion.org.au/docs/conference_07/Friday/1100_G_JOLLEY.pps

6. Consumer Focus Collaboration. *Feedback, Participation and Consumer Diversity: A Literature Review*. Canberra (AUST): Commonwealth Department of Health and Aged Care; 2000.

7. Arnstein S. A ladder of citizen participation. *American Institute of Planners Journal*. 1969;(5):216-24.

8. Llewellyn-Jones L, Harvey D. The development of a Health Promotion Community Participation Framework. *Australian Journal of Primary Health*. 2005;(11)2:136-46.

9. World Health Organization. *A Global Review Of Primary Health Care: Emerging Messages*. Geneva (CHE): WHO; 2003.

10. South Australian Community Health Research Unit. *Improving Health Services through Consumer Participation. A Resource Guide for Organisations*. Canberra (AUST): Commonwealth Department of Health and Aged Care; 2000.

11. Wilson M, Wilde P. *Benchmarking Community Participation: Developing and Implementing the Active Partners Benchmarks*. York (UK): Joseph Rowntree Foundation; 2003.

12. Burns D, Taylor M. *Auditing Community Participation: An Assessment Handbook. Area Regeneration Series*. 2000; Bristol (UK): The Policy Press; 2000.

13. Communities Scotland [homepage on the Internet]. Edinburgh (SCO): The Scottish Government; 2007 [cited 2008, July 14]. *National Standards for Community Engagement*. Available from: http://www.communitiesscotland.gov.uk/stellent/groups/public/documents/webpages/otcs_008411.pdf

14. World Health Organization. Declaration of Alma-Ata. *International Conference on Primary Health Care*; 1978 September 6-12; Alma-Ata, USSR.

15. Dowling B, Powell M, Glendinning C. Conceptualising successful partnerships. *Health and Social Care in the Community*. 2004;(12):309-17.

16. El Ansari W. *A Study of the Characteristics, Participant Perceptions and Predictors of Effectiveness in Community Partnerships in Health Personnel Education: The Case of South Africa* [unpublished doctoral thesis]. Cardiff (UK): University of Wales; 1999.

17. Audit Commission. *A Fruitful Partnership: Effective Partnership Working*. London (UK): The Commission; 1998.

18. Gray B. *Collaborating: Finding Common Ground for Multi-Party problems*. San Francisco (CA): Jossey Bass; 1989.

19. Lasker R, Weiss E, Miller R. Partnership Synergy: a practical framework for studying and strengthening the collaborative advantage. *Milbank Q*. 2001;(79):179-205.

20. Communities Scotland and the Communities Planning Task Force [Scotland's Community Planning homepage on the Internet] Broxburn (UK): Improvement Services; 2003 [cited 2008, July 14]. *Assessment of Partnership Toolkits, Final Report Volume 1, Approach, Method and Findings*. Available from: http://www.improvementservice.org.uk/index2.php?option=com_docman&task=doc_view&gid=86&Itemid=43

21. Brinkerhoff J. Assessing and improving partnership relationships and outcomes: a proposed framework. *Evaluation and Program Planning* 2002;(25):215-31.

22. Halliday J, Asthana S, Richardson S. Evaluating Partnership: the role of formal assessment tools. *Evaluation*. 2004;(10):285-303.

23. Program Development and Evalution [homepage on the Internet]. Madison (WI): University of Wisconsin Co-operative Extension; 1998 [cited 2008, July 14]. Evaluating Collaboratives: Reaching the Potential. Available from: http://learningstore.uwex.edu/Evaluating-Collaboratives-Reaching-the-Potential-P1032C238.aspx

24. Gillies P. Effectiveness of alliances and partnerships for health promotion. *Health Promot Int*. 1998;13:99-120.

25. Schulz AJ, Israel BA, Lantz P. Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships. *Eval Program Plann*. 2003;(26):249-62.

26. Whitehead M. A typology of actions to tackle social inequalities in health. *J Epidemiol Community Health*. 2007;(61):473-8.

27. Regional Office for Europe. *Social Justice and Equity in Health: Report on WHO Meeting*. Copenhagen (DNK): World Health Organisation; 1986.

28. Whitehead M. The concepts and principles of equity and health. 1991. *Health Promot Int*. 1991;(6):217-28.

29. South East Health. *Four Steps to Equity. A Tool For Health Promotion Practice*. Sydney (AUST): New South Wales Health; 2003.

Authors

Gwyn Jolley, Angela Lawless, Catherine Hurley, South Australian Community Health Research Unit, Flinders University

Correspondence

Ms Gwyn Jolley, SACHRU, Department of Public Health, Flinders University, GPO Box 2100, Adelaide South Australia 5001. Fax: (08) 8374 0230; e-mail: gwyn.jolley@flinders.edu.au

Jolley, G. (2008) Evaluation of an action research project in workforce development and organisational change: Healthy Ageing-Nutrition. *Evaluation Journal of Australasia,* 2008; 8 (1) pp11-19.
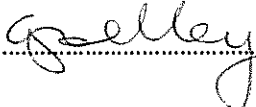
Statement of authorship

Evaluation of an action research project in workforce development and organisational change: Healthy Ageing-Nutrition

Evaluation Journal of Australasia, 2008; 8 (1) pp11-19.

Gwyn Jolley (Candidate)

Conceptualised and designed the evaluation research. Designed data collection tools, conducted data collection, managed, analysed and interpreted the data. Synthesised findings and wrote and revised the manuscript.

Signed .... Date 25/9/12

Evaluation of an action research project in workforce development and organisational change: Healthy Ageing—Nutrition

Gwyneth M Jolley

■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■ ■

Gwyneth M Jolley is a Senior Research Officer at the South Australian Community Health Research Unit at Flinders University in Adelaide. Email: <gwyn.jolley@flinders.edu.au>

This article reports on the evaluation of an action research project designed to support workforce development in the promotion of healthy nutrition for older people. The evaluation methodology was grounded by the action research approach of the project and focused on case studies of the 10 partner organisations. Findings indicate that the Healthy Ageing—Nutrition Project has resulted in a large increase in awareness and knowledge about healthy ageing and nutrition in the case study organisations, and to a lesser extent, in the broader health and aged care sectors. For the case study organisations it seems likely that transformational change has been made through the project's work of building capacity, mediating and facilitating change and providing resources. Support at board and management level, as well as thoughtful development of the workforce, were critical success factors in bringing about organisational change. The main challenge was identified as time and resources needed. Follow-up evaluation of the health outcomes from nutritional assessment, screening and intervention should also be implemented in order to provide further evidence of the value of this effort.

Introduction

This article reports on the evaluation of an action research project designed to support workforce development in the promotion of healthy nutrition for older people. Action research is described as a cycle of action and reflection by practitioners to improve their practice. However, there are a multitude of definitions, approaches and uses, with no consensus on core characteristics (Hart 1996). Most commentators identify two key aims of action research: to change and improve practice and to increase knowledge and understanding (Elliott 1991; Greenwood 1994; Gregory 1994; Malterud 1995). Hart (1996) describes two main benefits of action research for workforce development. First, action research develops professional knowledge that is more appropriate to practice by developing practitioners' capacity for discrimination and judgement in complex human situations. Second, it underpins professionalism and leads to empowerment by employing methods and procedures based on theoretical research and knowledge for improving practice; establishing sound rationale for what professionals are doing and building confidence and resolution to change things. Adopting a thinking, critical attitude towards practice and testing findings, the professional becomes a catalyst for change (Gregory 1994).

Action research: role in workforce development and organisational change

Action research is part of a workforce development approach that may transform the 'professional culture into one that supports collaborative reflection about practice and takes the experiences and perceptions of clients into account in the process' (Elliott cited in Hart 1996, p. 5). It is therefore highly relevant for multidisciplinary, multisectoral and participatory approaches to service delivery. Practice wisdom is particularly important in a field like primary health care where evidence-based practice (as defined by the randomised controlled trial) is difficult to demonstrate. It brings together theory and practice and so helps to make research relevant and useful to policy and practice. This, in turn, increases the likelihood of uptake of research findings in the workplace. Practitioners involved in action research can act as 'catalysts of change' and contribute to reorientation of services to a primary health care approach.

A review of workforce development models (Jolley & Masters 2003) demonstrated the importance of organisational, community and environmental support. This support might be realised as 'champions' within an organisation, supportive policies and practices, and the availability of on-site workforce development opportunities. Workforce development needs to be planned, comprehensive and integrated with the goals of the organisation. In a primary health care context the notion of 'workforce' may be extended to include the wider community of stakeholders. A partnership approach to workforce development facilitates exchange of skills and knowledge but this requires trust and good working relationships in order to be successful.

The Healthy Ageing—Nutrition Project

In order to test the feasibility of a partnership in workforce development, a project was conducted in South Australia focusing on the nutritional health of older people. The workforce in this area is diverse and expertise in nutritional care is limited. Unlike other states, where nutrition professionals have a dedicated role in provision of care to older people in a range of settings this has not been the case in South Australia. Thus, any advances in this area would have to be made using a broad workforce development approach. The project ran from March 2004 to March 2006. As a collaborative action research project the aim was to develop workforce capacity in the management of ageing and nutrition issues through increased awareness and use of an early intervention strategy to improve the nutritional health status of older people in South Australia. There were four objectives:

1　to increase awareness and knowledge of the food and nutritional needs of older people among carers and professional groups (known here as 'the workforce')

2　to increase knowledge and skills of the workforce in early identification of nutritional risk by the use of simple assessment and screening tools

3　to increase the use of appropriate nutrition early intervention strategies

4　to increase intersectoral collaboration in addressing food and nutrition needs among organizations and groups who support healthy ageing.

Strategies focused on working with 10 key organisations in the aged care services sector. Partner organisations were mostly self-selected, with encouragement and some targeting by the project manager. They comprised a wide range of providers of services to older people, including home and community-based care; institutional care; meal service provision; general practice; rehabilitation and recuperation; and a group of dietitians working in aged care.

The action research approach meant that the project took a facilitator role and the organisations became partners in developing action plans (using an action planner) specific to their own needs and experiences. The project manager met with each organisation to discuss progress towards agreed goals and to provide encouragement, resources and support. A 'Moving into Action' forum brought together the partner organisations to share information and the development of their action plans.

External evaluation

The South Australian Community Health Research Unit, Flinders University, was contracted to undertake external evaluation for the Healthy Ageing—Nutrition Project. Reflection and evaluation of action was embedded in the action research methodology utilised by the project and this was reflected in the evaluation. The evaluation focused on:

▪ progress towards meeting the Healthy Ageing—Nutrition Project objectives

▪ strength of the action research approach to workforce development in progressing Healthy Ageing—Nutrition Project objectives

▪ reach of the project, in terms of workforce participation, coordination and collaboration.

Evaluation methods

The evaluation plan was developed in consultation with the project management team. The evaluation focused on case studies of the 10 partner organisations and facilitated reflection by the project stakeholders. Data collection and analysis included:

▪ Three interviews with the project manager to document progress, identify what was working well, the challenges and unexpected events, what might need to be changed/done

differently in light of the experience so far, and broader lessons. Interviews were partially transcribed for import to NVivo for analysis. The analysis documented emerging themes and the findings from each interview were used to guide subsequent interviews in order to explore achievements and challenges more thoroughly.

▣ Two rounds of interviews with participating organisations, by phone or in person. Most interviews took between 30–45 minutes. Since the 'dietitians group' was more of a loose federation rather than an organisation, three respondents were interviewed to give a range of viewpoints. This meant that 12 sets of interview data were recorded. The first round of interviews asked respondents to rate the quality of the project management and activities, about their expectations and support needs, and to describe their achievements and changes to date. The second round confirmed any further activities within the organisation, any other changes and asked about the perceived level of achievement of the project's goal and objectives. Analysis of the organisational data against the action plans, project objectives and project documentation was then undertaken in order to produce case studies of organisational change.

▣ A focus group with the Project Advisory Group asked about the role and function, project management, benefits and challenges in bringing about organisational change using an action research approach, achievements and ideas for future development. As a number of advisory group members were unable to attend on the day, follow-up phone interviews were conducted with another four respondents. Reponses from the focus group and the interviews were collated and analysed by question.

▣ The action plans for each participating organisation were reviewed at the mid-point and at the completion of the project. Other project documentation reviewed included interim reports to the funder, copies of presentations to interested groups, planning documents and minutes, and records of activity with 'non-case study' organisations who had an interest in the project.

An interim report was presented to the project management group in July 2005. Following further data collection, analysis and synthesis, a draft report was presented in December 2005. Each of the partner organisations was invited to provide corrections of fact and other comments on their own case study, and following discussion and feedback from the evaluation management team the final report was produced. Findings were also presented at a final forum attended by most of the partner organisations.

Strengths and limitations of the evaluation

The evaluation methodology was grounded by the action research approach of the project. Evaluation was planned for and designed early in the life of the project and maintained a balance between internal and external evaluation. The evaluator, project management team and project manager were part of a consultative process through the evaluation planning, data collection tool design and reporting. This consultative approach maximises the relevance of the evaluation and leads to opportunities for feedback to stakeholders as understanding develops from the evaluation process (van Eyk, Baum & Blandford 2001). The data collection was from a variety of sources and used a number of different methods in order to triangulate findings and increase validity (Farmer et al. 2006).

The main limitation of the method is that changes in awareness, knowledge and skills were not directly measured and quantified in a pre- and post-project design. This would have been both costly and time-consuming, and inappropriate for the project action research approach and the diversity of organisations involved. However, changes within organisations were assessed and some generalisable lessons can be drawn from these case studies.

Findings

A case study example is shown in Figure 1. Case studies were written as a description of the journey undertaken by each organisation and consisted of a brief description of the organisation, a summary of activities planned, achievements, perceived enablers and barriers to change and expectations for the future.

Findings from the various data sources are summarised below.

Progress towards objectives

Objective 1: Awareness and knowledge

▣ eight organisations reported increased awareness of nutritional risk among older people

▣ literature review completed by one organisation

▣ dietetic contribution to aged care accreditation standards

▣ translation of nutrition guidelines into Italian, Greek and Maltese

▣ six dietetic student placements

▣ joint funding applications

▣ conferences papers and presentations

Objective 2: Early identification

▣ seven organisations produced or shared information and resources materials about nutritional risk

▣ increased training in nutritional risk and screening

FIGURE 1: METROPOLITAN DOMICILIARY CARE

Metropolitan Domiciliary Care (MDC) provides home-based care and support to frail aged clients in the Adelaide metropolitan area. There is a workforce of approximately 800 multidisciplinary service providers and 20 000 clients at any one time. Coordinated care programs focus on rehabilitation and may include respite care, personal care, equipment and therapy. Shortly before the start of the project, MDC underwent a major change in structure from separate regional services to an incorporated metropolitan-wide organisation.

PREPARING FOR THE JOURNEY

As a large organisation and the auspice for the project, MDC had a clear role and commitment to achievement in the project. Two areas were flagged for attention: assessment at intake and assessment in the Day Rehabilitation Centre. This kept the project manageable at a time of major organisational change. Within the new structure, MDC hoped to achieve a process of initial needs assessment using the screening tool, then referral with nutrition as one consideration, and evaluation of nutrition outcomes for its clients. Prior to the project, MDC was using a telephone assessment process for newly referred clients. This intake process aimed to assess needs and key issues to be followed up by the case manager. There was no specific focus on nutritional risk although this could be identified as a result of loss of mobility, social isolation, etc.

JOURNEY ACTION PLAN

MDC identified four main goals:

1. identify nutritional risk at intake
2. raise awareness in case managers of nutritional risk
3. raise awareness in Day Rehabilitation Centre staff of nutritional risk, simple screening and intervention activities
4. share information across the workforce about nutritional risk, simple screening and intervention activities.

ON THE ROAD

The project contributed a number of articles for MDC's research newsletter, describing the project and updating readers on progress. A flow chart was developed for use by the Metropolitan Access Team to identify and respond to nutritional risk in new clients and a referral letter to inform other clinicians of the outcome. Information sessions raised awareness among case managers of nutritional risk, simple screening and intervention activities. Day Rehabilitation Centre staff also attended information sessions and an information board was set up. Across the wider workforce, information was provided through newsletters and the project website.

ARRIVING: SUMMARY OF ACHIEVEMENTS

- nutritional risk assessment at intake has been implemented and monitoring has been established
- geriatrician screening of all new clients and followed up by nursing staff has been implemented
- Day Rehabilitation Centre staff have a raised awareness of nutritional risk, simple screening and intervention activities
- workforce information strategies have been established
- links with GPs and other nutritional support systems have been strengthened.

REFLECTIONS ON THE JOURNEY: ENABLERS OF CHANGE

- MDC founded the project and acted as the auspice and so was committed to the success of the project and the importance of nutrition
- CEO and management support for project
- expressed need by MDC to look at nutrition for clients in community settings
- some pre-project interest and preliminary work in nutrition and physical activity as determinants of clients remaining in the community
- project provided facilitation, resources and guidance in the change process.

REFLECTIONS ON THE JOURNEY: BARRIERS TO CHANGE

- undergoing organisational change and the difficulties of introducing more change at this time
- adoption and implementation of new forms and new intake process across the system is challenging.

The structural change that the organisation has undergone has had the effect of delaying the evaluation of outcomes, but nutrition has remained as an important focus. The changes are expected to be sustainable and the organisation is planning for this by upskilling staff in nutrition, talking with other organisations about nutrition in the community and developing an increased capacity to address nutrition issues. The new procedures are established and a focus on nutrition as part of primary health care will remain after involvement in the current project ends.

- seven organisations had implemented a nutritional risk screening procedure

Objective 3: Early intervention

- one organisation had implemented a referral/intervention strategy

Objective 4: Intersectoral collaboration

- links forged across organisations and issues

- beginning involvement of Aboriginal and Torres Strait Islander workers

All the organisations remained actively involved with the project and met their achievements within expectations. According to the project manager, this continued commitment was facilitated by a willingness to negotiate by both parties, and by maintaining relationships with people in the organisation in a position to make changes and by the action research process. For some organisations, the action research complemented established quality improvement practices and encouraged organisations to see how they fitted into the bigger picture and to develop benchmarks for addressing nutrition issues. Organisations were helped to make their action plans concrete and manageable. This led to early small successes and led to larger changes.

Another enabler of change was described as the supportive environment created by the project. For example, effective communication strategies and consistent marketing encouraged organisations and other stakeholders to want to be engaged.

Large organisations and those with a large volunteer workforce proved more challenging in terms of action for change, as their planning processes often took longer to shift. However, new structures or procedures were more likely to be sustained as part of the strategic planning in the organisations. Smaller organisations tended to more easily adopt change when they could see how it would benefit their clients.

The project has forged links with a number of related projects and issues, including physical activity, falls prevention and medication. The concept of healthy ageing has been broadened by joint presentations to services and groups and the project has demonstrated the close links between these issues. An example is the assessment of nutritional risk as part of the falls prevention chart used in some hospitals and aged care settings.

Five organisations reported that there was change at organisational level including policy, increased skills and capacity in nutrition, strengthened links and a multidisciplinary approach. All but one organisational respondent believed that at least some of the achievements would be sustained. Some respondents qualified their response by noting that a funded person would be needed to maintain links, distribute up-to-date information and generally keep ageing and nutrition on the agenda.

Action research approach

Taking a broad and flexible approach has enabled organisations to have a choice in how they respond to the project and the changes that they have planned. Action research has encouraged people to feel part of the project and valued for their contribution. Organisations had a variety of responses to the invitation to develop action plans. Some already had ideas and wanted to jump to action without any reflection. Others found it hard to see opportunities for change and to move beyond the immediate problems they faced. Generally, change seems to be easier in smaller organisations that have more control over their own function and less bureaucracy. For example, in one large, bureaucratic organisation, planning was 'locked down' and one person within the organisation was unable to drive change. In a smaller organisation with little structure or planning experience, one person can implement change but it is more opportunistic than considered, and seems unlikely to be sustainable:

> *They are the two extreme examples but in every organisation, I think it is the combination of the change-ready environment and somebody who is willing to take it on and move it forward. (Project manager)*

How organisations developed and used the action planner also varied. To some extent this was determined by the culture and experience of the organisation, that is, whether they were familiar with quality improvement processes. A small number of organisations with a clear business and management framework in place decided to use their own quality improvement processes. Most organisations preferred to let the project manager complete the action planner following discussion and consultation about what changes would be significant and realistic. For the first few months, the action planner was a fluid document. Once consensus was reached, the planning tool became the formal documentation of the changes that the organisation had agreed to put in place.

In the early and mid stages of the project, there was a high demand for support and most organisations were in frequent contact with the project. The project manager worked proactively and reactively with organisations depending on where they were in the change process. Some organisations needed considerable guidance and input of ideas and this created a tension in the action research approach. The project manager reflected on whether these organisations were being pushed too far and too soon. Evidence from the organisations points to a good relationship with the project manager and an effective balance between motivation and direction. Other organisations were more experienced in strategic planning and quality improvement and with these the support offered was more reactive in response to requests.

Almost all advisory group members were positive about the action research approach of the project. The strengths were seen to be that each organisation was respected as having different needs and different ways to implement the project. An additional benefit noted was that workers 'at the coal face' had been upskilled. The drawbacks of action research were stated as the potential for organisations to drift off target or slow down in their action plans and the difficulty of engaging people who don't accept the need for change.

The forum, advisory group and many other opportunities to share information meant that the organisational development was able to occur collectively as well as the project working with individual organisations. Action plans were individual but they shared common objectives.

Project reach

Information about the project has been distributed in newsletters and articles to the organisations' workforces, covering approximately 9 600 individuals plus national Dietitians Association of Australia readership (approximately 200 in South Australia). The project website averaged 65 hits per day rising to 300 when new information was posted. Other organisations have disseminated information in different ways, such as at staff meetings and presentations. In addition to the active case study organisations, 31 other groups and organisations have been involved with the project.

Enablers and barriers to change within the project

Most advisory group members stated that bringing organisations and people together was the most important enabling factor of the project. For example, the forum had demonstrated there was a critical mass of interest in the topic and set up the other achievements. The wide definition of 'workforce' to include carers was also noted as an enabler. Interview data from organisations suggested that facilitation and support from the project and support from the organisation's board of directors/ management were the strongest enablers to taking action. Barriers identified from both sets of data were mostly related to reluctance to change or 'change fatigue' or to the extra workload entailed in participation. Respondents pointed out that organisations were not funded to participate, and staff time and other resources had to come from their own budgets.

The advisory group members also commented on enablers and barriers to change in the broader environment. Four respondents talked about the changes in the South Australian state health system but it was unclear at that stage whether these reforms would be positive or negative in terms of the aims of the project. Lack of further funding opportunities was seen as a barrier by three people and the ageing population would add to the problems.

Discussion and implications

Achievement of objectives

Awareness and knowledge of the food and nutritional needs of older people

The evaluation did not measure increases in awareness and knowledge directly. Given the methodology, this would have been unrealistic since the organisations were starting from markedly different levels of awareness and knowledge. However, all 10 organisations reported increased awareness and knowledge within their workforce as a result of the project. They reported, moreover, that nutrition is now on the agenda for aged care providers, meals services and carers, and, to some extent for governments. Strategies used by organisations to increase awareness and knowledge include information and training sessions for workers, volunteers and carers; development of nutritionally and culturally appropriate menu plans; information-sharing forums; and newsletters, websites and publications. The project forum, website, student placements and other activities have also contributed to increased awareness and knowledge. The impact on organisations outside the project is less clear. Work is underway to add nutrition issues to the accreditation standards for residential aged care. Websites and other resources, such as the translated food and nutrition guides, will have a broader audience, as will conference papers, reports and other dissemination strategies. Seven organisations have shared information or resources with others; this is also likely to lead to increased awareness. While awareness and knowledge is likely to be sustained within the current workforce, without a driver it is unlikely that information and resources will be kept up-to-date and accessible to a wide range of organisations.

Early identification: knowledge and skills of the workforce

Seven of the case study organisations have changed their nutritional assessment practices and introduced screening tools. This has been accompanied by policy development in the organisation and training for workers. Three of these have processes underway to audit use of screening and at least one more is planning for this. Of the other three organisations, two do not provide direct services: one has made available a screening tool for carers and the other has distributed a flow chart for general practitioners. For organisations outside the project there is some potential for increasing nutritional assessment and use of screening tools. Services that have a culture of benchmarking their activities may pick up on new practices they see in similar organisations to their own. The networking and links that already existed, or that have been strengthened by involvement in the project, may form a conduit for transfer of new skills and practices in screening. Organisations that have taken on the use of screening tools are likely to continue with this as long as some benefit is seen

to outweigh costs. Evaluation that can identify costs and benefits is therefore needed. Wide dissemination of the findings from this project and future evaluations of outcomes from changed practice, will increase the likelihood that current organisations will sustain the changes and that others will take up nutritional screening.

Use of appropriate early intervention strategies

This objective is most likely to occur as a follow-up to Objectives 1 and 2 and therefore it is no surprise that it is the least well achieved according to the evaluation evidence reported here. For most organisations, it is a matter of timing; screening is just becoming embedded and the increased need for early intervention strategies will become apparent once nutritional assessment is a standard part of practice. Two organisations have already set in place referral mechanisms or dietary changes. There is some concern about the capacity of dietetic and other professional services to respond to the anticipated increased demand brought about by regular screening. As yet, no organisation has been able to evaluate the outcomes of screening and early intervention strategies; this will be an important next step.

Intersectoral collaboration in addressing food and nutrition needs

Seven organisations reported new or strengthened links with other organisations as a result of the project. This sometimes meant working with services and groups that were not part of an organisation's traditional network. For some smaller or isolated organisations, the project had the effect of 'bringing them into the loop'. This is illustrated by the exchange of information, resources, speakers and ideas through the website, at the forum and at other events. The connection made between nutrition, falls prevention and medication has been of particular value for many practitioners. The Aboriginal/Torres Strait Islander forum also brought together a number of health issues in a holistic way and introduced Aboriginal/Torres Strait Islander workers to mainstream services that they could access for clients. This objective appears to be the one most at risk if there is no continuation of the project. It is probable that many of the links made are by individuals rather than by formal organisational links. Individual links are likely to be lost when people move on to a different position.

Action research approach

The strengths of this approach can be summed up as:
- a sense of ownership and inclusiveness by advisory group and participating organisations
- flexibility to respond to different organisational needs
- engagement of organisational and other stakeholders
- an opportunity to reflect in a supportive and trusted environment

- organisations have been able to adapt the planning tool to their own situation
- an ability of the project to make adjustments in response to reflecting on actions.

The challenges of action research include:
- the need to re-establish support when developmental changes occur
- the need for balance between leading and supporting organisations in action for change
- potential for organisations to go 'off track' or slow down on actions.

These opportunities and challenges of action research seem to be have been well balanced in the project and most respondents were very positive about this approach for workforce development. Particularly in these times of seemingly constant change, managers, workers and volunteers all valued the way the project was able to accommodate different needs and allow organisations to respond in their own way to the achievement of common objectives. At the same time, the project resulted in concrete change in the competency of the workforce to assess and respond to nutritional risk in older people.
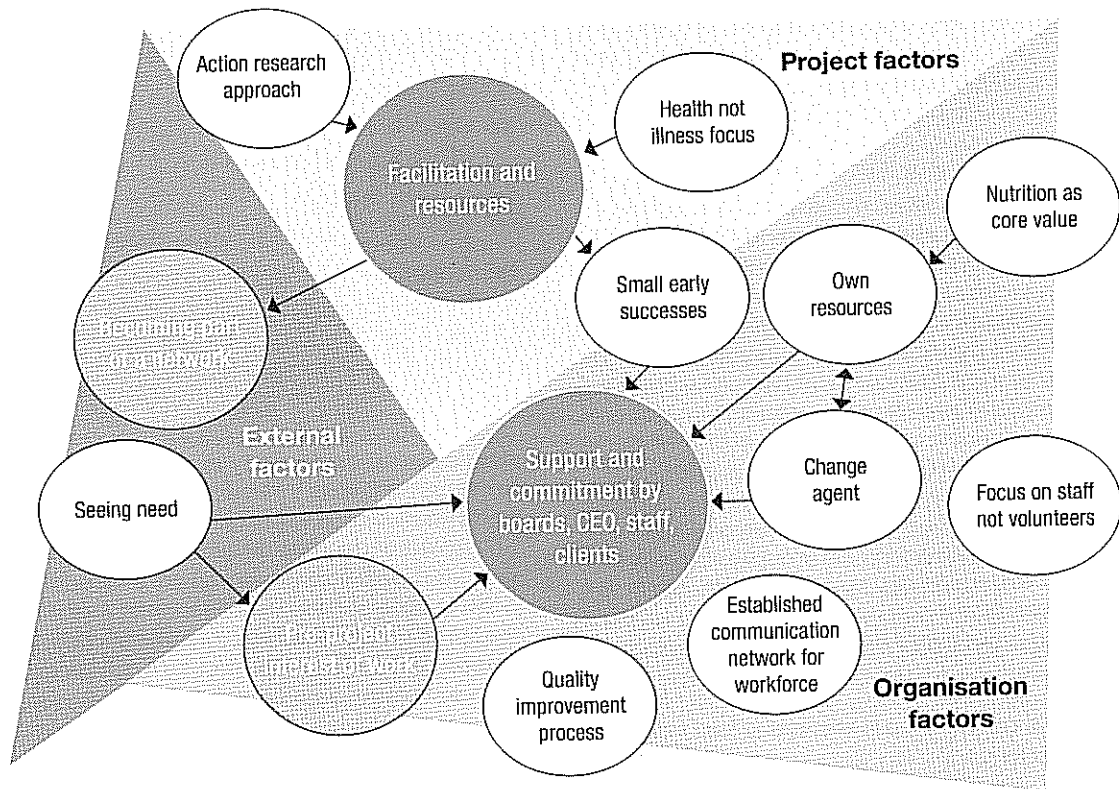
Achieving change

A number of enablers and challenges to achieving organisational change can be identified from the multiple data sources to this evaluation. These are illustrated in Figures 2 and 3. Enabling factors include the facilitation and resources provided by the project and the support and commitment by boards, management, staff and clients in relation to change. The main challenge is the time and resources required from the organisation, particularly when there are competing priorities and resistance to (yet more) change.
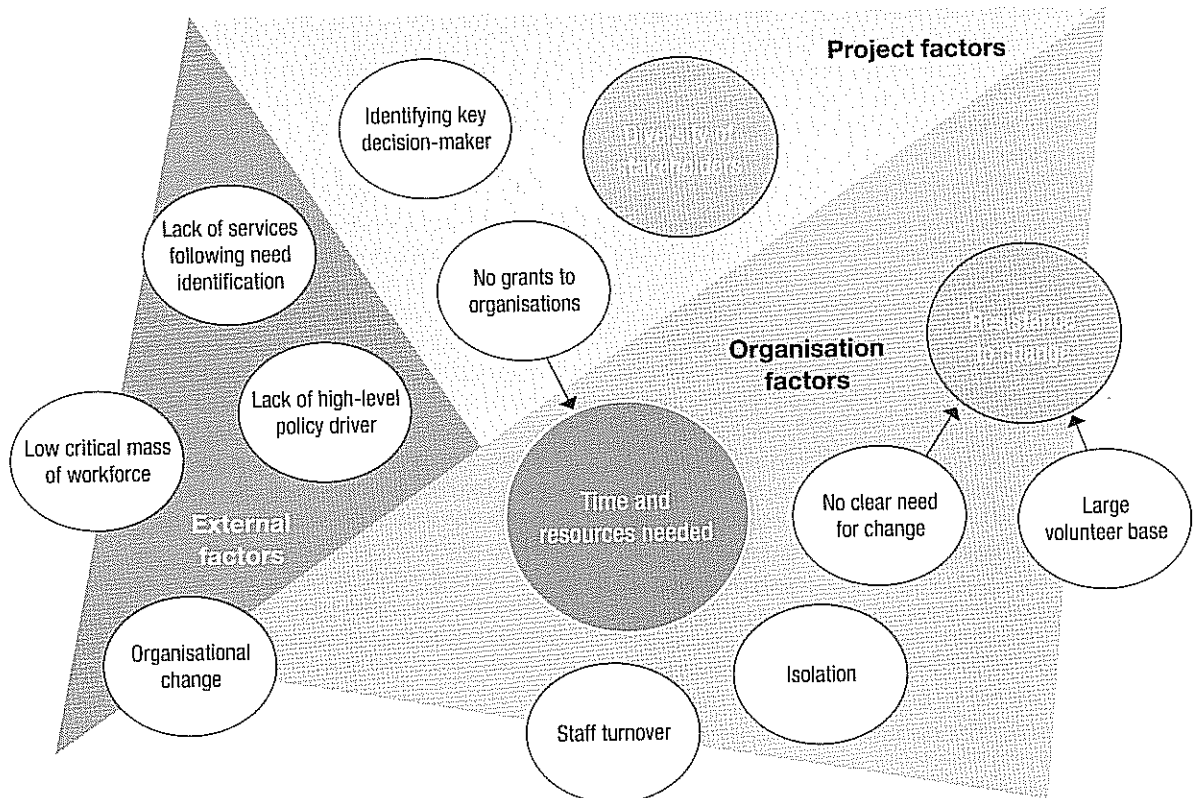
Sustaining change

In the absence of ongoing project funding it seems likely that some changes will be sustainable, particularly in larger organisations that have embedded nutritional screening into their intake assessment policy. A 'change champion' in the organisation is important in getting change onto the agenda but if change has been driven by one individual there is a risk that this will be lost if the person moves to another organisation. On the other hand, individuals moving to new positions take their knowledge and skills with them so this could be a way to increase the project reach.

Ongoing funding would be useful in maintaining the momentum with participating organisations. Few have the resources to update the information and resources that have been an important part of the project and, as described above, when individual workers move positions their networks may be lost to the organisation. Further development of the nutrition and ageing agenda needs a commitment from policymakers and funders to support an

FIGURE 2: ORGANISATIONAL CHANGE—ENABLERS

FIGURE 3: ORGANISATIONAL CHANGE—CHALLENGES

individual or an organisation to act as a driver in bringing about and sustaining change.

Conclusion

The Healthy Ageing—Nutrition Project has resulted in a large increase in awareness and knowledge about healthy ageing and nutrition in the 10 case study organisations, and to a lesser extent, in the broader health and aged care sectors. Nutritional screening and assessment has been introduced in all the service provider organisations and protocols for intervention following screening are being developed by most organisations. There is some concern about the capacity of the system and the workforce to respond with appropriate interventions following screening activity.

For the 10 case study organisations it seems likely that transformational change has been made through the project's work of building capacity, mediating and facilitating change and providing resources. Support at board and management level as well as thoughtful development of the workforce were critical success factors in bringing about organisational change. This helped to overcome the main challenge, which was identified as time and resources needed. Another achievement is the extent of collaborative partnerships that have been established or strengthened around exchange of information and resources, referrals and access to services. The action research approach has contributed to a sense of ownership by organisations and allowed each to develop in its own way, guided by the project. The opportunity for each organisation to establish its own action plan and monitor progress was a key factor in keeping organisations motivated.

The project has achieved an increased focus for ageing and nutrition in South Australia. However, it is unclear if and how this will continue to grow in the absence of dedicated funding for an organisation or individual to take on the driving role. Another concern is about the capacity within South Australia to maintain ageing and nutrition as an important issue, with only a small interest group compared to other states. For the future it will be important to build on the achievements so far and continue to keep ageing and nutrition high on the agenda of governments and service providers. Follow-up evaluation of the health outcomes from nutritional assessment, screening and intervention should also be implemented in order to provide further evidence of the value of this effort.

References

Elliott, J 1991, *Action research for educational change*, Oxford University Press, Buckingham, England.

Farmer, T, Robinson, K, Elliot, S & Eyles, J 2006, 'Developing and implementing a triangulation protocol for qualitative health research', *Qualitative Health Research*, vol. 16, no. 3, pp. 377–394.

Greenwood, J 1994, 'Action research: a few details, a caution and something new', *Journal of Advanced Nursing*, vol. 20, no. 1, pp. 13–18.

Gregory, M 1994, 'Accrediting work-based learning: action learning—model for empowerment', *Journal of Management Development*, vol. 13, no. 4, pp. 41–52.

Hart, E 1996, 'Action research as a professionalizing strategy: issues and dilemmas', *Journal of Advanced Nursing*, vol. 23, no. 3, pp. 454–461.

Jolley, G & Masters, S 2003, *Public health nutrition: identifying models and effective approaches to workforce development*, South Australian Community Health Research Unit, Adelaide.

Malterud, K 1995, 'Action research: a strategy for evaluation of medical interventions', *Family Practice*, vol. 12, no. 4, pp. 476–481.

van Eyk, H Baum, F & Blandford, J 2001, 'Evaluating healthcare reform: the challenge of evaluating changing policy environments', *Evaluation*, vol. 7, no. 4, pp. 487–503.