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TE KURA HAUORA TANGATA



Interim Evaluation Report

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Massey University Healthy Families NZ Evaluation Team

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The Healthy Families NZ evaluation is commissioned by the Ministry of Health and being undertaken by Massey University. This report is written by the Massey University Evaluation Team. The views expressed in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.

Executive Summary

Introduction

In Budget 2014, the Government allocated \$40 million over four years to support the implementation of Healthy Families NZ. In 2015 the Ministry of Health contracted a three-and-a-half-year evaluation of Healthy Families NZ to Massey University. Healthy Families NZ is a large-scale initiative that brings community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play by taking a dynamic systems approach to preventing chronic disease. It is focussed on creating many health promoting environments across the community that enable people to make good food choices, be physically active, smoke-free and free from alcohol-related harm. This involves working with early childhood education, schools, workplaces, food outlets, sports clubs, marae, businesses, places of worship, local governments, health professionals and more to create healthier environments. Healthy Families NZ is a key part of the Government's approach to helping New Zealanders live healthy, active lives.

The initiative is being carried out in 10 locations, predominantly in areas with higher than average rates of risk factors for preventable chronic diseases and/or high levels of deprivation. The locations are geographically spread and are a mixture of urban and rural areas. The locations in which Healthy Families NZ is being implemented are:

- East Cape¹
- Far North
- Invercargill City
- Lower Hutt City

¹ Includes Opotiki and Gisborne Districts

- Rotorua District
- Whanganui District²
- Manukau Ward
- Manurewa-Papakura Ward
- Spreydon-Heathcote Ward³
- Waitakere Ward.

This Interim Evaluation Report provides a high-level summary and descriptive analysis of the early implementation of the Healthy Families NZ initiative. Overall, the findings suggest there is much which is promising about the Healthy Families NZ approach and that, largely, the initiative has been implemented with integrity to its intention and purpose. Eight cross-cutting themes emerged from the descriptive analysis of the first view case study findings. These themes capture the overarching observations of the early implementation phase of Healthy Families NZ. These themes are:

- building the plane while flying it,
- negotiating boundaries,
- balancing top-down/bottom up decisions and actions,
- working with a hands-on National team,
- getting to grips with systems thinking and acting,
- emphasising leadership,
- enabling Māori ownership and leadership, and

² Also includes Rangitīkei and Ruapehu Districts

³ Note that Healthy Families Spreydon-Heathcote is now referred to as Healthy Families Christchurch as Spreydon-Heathcote ceased to exist as a Local Government ward in October 2016.

- making equity an integral part of the initiative.

Purpose of interim evaluation report

The Interim Evaluation Report provides an in-depth picture of the evolution and implementation of the Healthy Families NZ initiative from inception until March 2016. Emerging themes and lessons from Healthy Families NZ locations are identified to inform ongoing refinement and development of Healthy Families NZ or similar initiatives. A later report will focus more on the outcomes of the initiative.

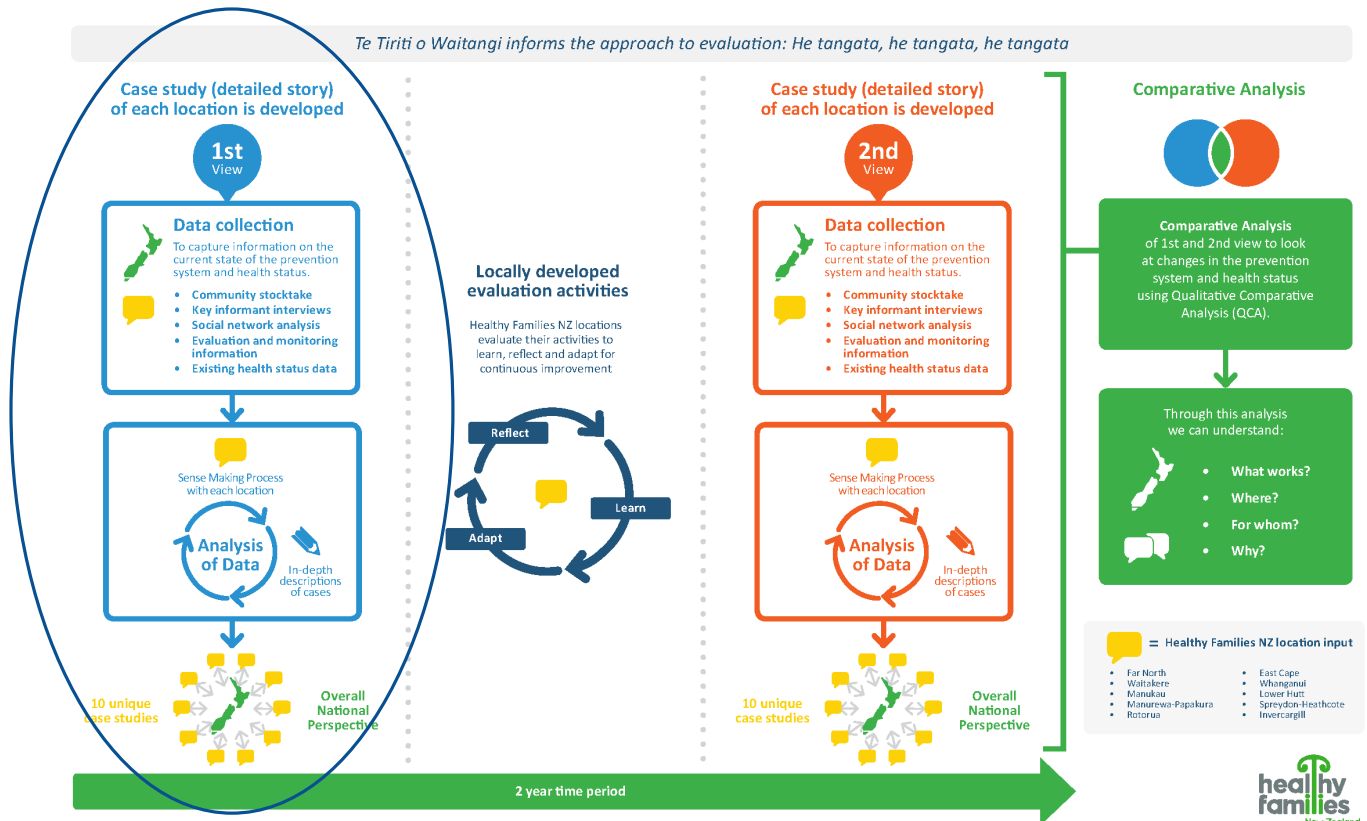
The evaluation design

At the heart of the national evaluation is a case-comparison study which is illustrated in the Evaluation Design diagram below. The 10 Healthy Families NZ locations are different in many ways including people, geography, priorities, opportunities for action and the presence of other initiatives that are also contributing to the prevention of chronic disease. To understand change and outcomes achieved in each location, we are developing a detailed story (case study) of each location, and a National perspective to be compared at two points in time. Information in the Interim Evaluation Report is from the first view in the Evaluation Design where baseline case studies have been developed (shown by the circled first view column). A further summative evaluation report is due mid-2018, following the second round of data collection and analysis.

EVALUATION DESIGN

Is Healthy Families NZ contributing to better health and wellbeing for the people in our communities?

Te Tiriti o Waitangi informs the approach to evaluation: He tangata, he tangata, he tangata



Evaluation findings

The evaluation findings presented in this Interim Evaluation Report provide some context for considering the impact of Healthy Families NZ to date. We analysed findings from the baseline case studies structured around the Building Blocks of a strong prevention system (which underpin the Healthy Families NZ investment) and also the Principles created to guide Healthy Families NZ priorities and action.

Baseline population health data

Data from the Census, New Zealand Health Survey and B4 School Check were used to help provide a picture of the starting point for each Healthy Families NZ location. Understanding the starting point will be important for identifying change that occurs.

The 10 locations vary in population size, with more concentrated populations in urban areas and more spread out, smaller populations in more rural areas. Approximately 900,000 people live within the boundaries of the 10 locations and in many cases locations were selected because they had higher levels of deprivation. Of note is that population structures are different by locations with some having a lower proportion of working age people, and some a higher proportion of children and young people.

The NZ Health Survey data analysed by location showed that in general, both adults and children from Healthy Families NZ locations had worse or similar rates of health behaviours and risk factors compared to total New Zealand in 2011/12 to 2014/15.

Analysis of B4 School Check data by location showed that there has been a small decrease in obesity in New Zealand four-year-old children over the four years from 2011/12 to 2014/15. There has also been a decrease in obesity over this time in one of the locations. Rates of overweight four-year-olds have been stable in total New Zealand children over the four years from 2011/12 to 2014/15. There has been an increase in rates of overweight four-year-old children in two locations.

Building Blocks of a Strong Prevention System

Within each Healthy Families NZ case study, we analysed the experience of successes and challenges against the five Building Blocks of a strong prevention system, which are:

- Workforce: dedicated, reflective and skilled workforce
- Leadership: Building leadership for prevention across the whole community
- Relationships: Building relationships with prevention partners across the system
- Resources: Allocating resources to effect sustainable change
- Knowledge and Data: Capturing and feeding back knowledge and data

Across the Healthy Families NZ locations, and from the perspective of the national Healthy Families NZ team within the Ministry of Health, we found that all Building Blocks were key areas

of focus, with activities around each Building Block continuing to develop and adapt. Across Healthy Families NZ locations, we found differences in the approach to the Building Blocks, in line with the intention of initiative. It is also clear that implementation was sped up to some degree where Healthy Families NZ locations were able to build upon existing relationships or initiatives. Realistically, it takes about a year to establish Healthy Families NZ in a new location.

Principles for System-Wide Change for Good Health

Healthy Families NZ design allows flexibility for each location to choose activities that are relevant to their communities, with decision making guided by a set of principles focussed on systems change. The Principles are:

- Implementation at scale
- Adaptation
- Collaboration for collective impact
- Experimentation
- Equity of outcome
- Leadership
- Line-of-sight⁴

Over the implementation period covered by this report, the Healthy Families NZ workforce and those involved in Leadership Groups have shown an evolving understanding of the Principles and how they can guide their work. We observed locations adapting how they set up Healthy Families NZ and how they developed collaborative relationships. In some cases, locations adopted additional principles relevant to their kaupapa.

⁴The Healthy Families NZ Principles were developed in partnership with the Victorian Government, Australia, as part of the 'Healthy Together Victoria' initiative

Equity and scale were commonly identified as guiding principles for prioritising activities and projects. Co-design of activities with partner organisations was also commonly discussed, related to collective impact.

Cross-cutting themes and lessons

Several cross-cutting themes emerged from our analysis. We developed lessons from each theme which we discuss below. These lessons could also provide insight for other largescale initiatives seeking to make an impact on complex social challenges.

Theme 1. Building the plane while flying it

Large initiatives like Healthy Families NZ will necessarily have a planning and establishment stage. One of the more significant challenges for the locations and the National Healthy Families NZ team was trying to design and plan the initiative at the same time as having strong expectations to show action and progress towards achieving their goals. In practice, the establishment phase lasted about a year. In this time, locations recruited the full workforce, built staff capacity, undertook extensive mapping and stocktaking, built relationships with key stakeholders, planned activities, and established community presence. The National Healthy Families NZ team supported and provided guidance to locations. It was not until the beginning of 2016 that the majority of the locations were in a position to focus strongly on the initiative goals.

Impact of theme: Judgement about progress made at the end of the current contracts in mid-2018 will need to take into account the considerable establishment phase.

Lesson: The establishment phase was necessary to set up the new teams within Lead Provider organisations. When implementing a new, intentionally complex policy initiative, we should expect an iterative and involved establishment phase.

Theme 2. Negotiating boundaries

The intention of Healthy Families NZ to allow for adaptation creates an expectation that priorities for action will shift as the initiative evolves. This expectation means that Healthy Families NZ teams are regularly negotiating the boundaries of their work. This includes evolving perspectives of what the 'prevention system' includes for their community, the partners they work with and even the geographical boundaries within which they work. Having the 'space' and a permissive environment to negotiate boundaries of different kinds in a timely way has been an important feature of the implementation of Healthy Families NZ. Mechanisms that have facilitated this permissive environment include having the Ministry of Health on the Leadership Groups as well as performance monitoring approaches that are narrative and context-rich, rather than requiring standardised measures. Facilitation and negotiation skills of the workforce are also important.

Impact of theme: The Healthy Families NZ teams' ability to negotiate boundaries has facilitated their ability to adapt to local environments and changing contexts.

Lesson: An explicit intention to allow for adaptation is important for enabling local responsiveness. Ensure spaces for negotiation remain.

Theme 3. Balancing top-down / bottom-up decisions and actions

As is usual in policy implementation, tensions existed between top-down direction and community-led action. To an extent, these tensions are seen as inevitable for nationally-contracted, locally-delivered initiatives. Healthy Families NZ involved a new way of contracting, with a systems focus geared towards a more adaptive and less directive approach.

The relationships between the Ministry of Health and the locations have oscillated between being positively and negatively framed by those involved. Overall, however, the relationship between the National Healthy Families NZ team and the locations appears to have been close

and responsive. This style of interaction enables the relationship to continue even when significant challenges arise.

Impact of theme: Tensions between perspectives will occur, however, the initiative includes mechanisms to respond constructively to both opportunities and challenges.

Lesson: Explicitly recognise there will be tensions between top-down and bottom-up perspectives and include mechanisms for responding in a timely manner to both opportunities and challenges.

Theme 4. Role of the National team as part of the initiative

A feature of the initiative has been the role of the National Healthy Families NZ team. They are expected to play an active leadership and coordination role in Healthy Families NZ.

Consequently, the team view themselves as part of the initiative rather than external contract managers. There is an explicit recognition that the National Healthy Families NZ team's relationships, actions and responses will impact local activities and local success. For example, at a national level, the Ministry of Health can influence key systems such as the food industry, workplace/business systems and education, all of which impact at a local level. The National team have also connected Healthy Families NZ to other policy initiatives like the Childhood Obesity Plan.

Impact of theme: The National Healthy Families NZ team members actively support locations by influencing key systems at a national level (through, for example, engaging with other Government departments and key national-level stakeholders). The National Healthy Families NZ team also help facilitate alignment with other nationally-contracted, locally-led initiatives, both Ministry of Health funded and non-Ministry of Health funded.

Lesson: Traditional, hands-off contract management practices may not always be appropriate. Hands-on, active engagement by the funder can enable systems change – through influence on national level activities as well as on local activities.

Theme 5. Getting to grips with systems thinking and acting

A big challenge for the workforce, the Lead Provider organisations, and Leadership Groups was understanding how systems change and implementation at scale (how locations can influence a large proportion of the population) differ from traditional health promotion approaches. We have observed an evolution in how the workforce understands systems thinking. Given the different approach that focussing on systems change requires, some communities were sceptical about the value of the initiative during the establishment phase. This scepticism appeared to come more from health sector organisations than other sectors.

Impact of theme: The systems approach underpinning Healthy Families NZ requires a significant shift in ways of working. Challenges inherent in this shift, and the way the approach is understood, have contributed to the longer establishment phase.

Lesson: Work to increase capacity and capability at all levels to communicate what systems approaches involve and challenge barriers to new ways of working.

Theme 6. Emphasising leadership

Empowering both local and national leadership – including iwi and Māori ownership and leadership – has been a strong intentional focus and area of activity. This is reflected in the National Healthy Families NZ team’s priorities and in the location teams’ reported activities. The representation of a broad range of different sectors on Leadership Groups, including those outside of the health sector, has created opportunities for teams to collaborate with key influencers in priority settings.

Impact of theme: Empowering leadership for prevention creates potential for increased collective impact and population reach, as well as potential for advancing equity issues.

Lesson: Build commitment of community leaders and influencers to create healthy environments and support them to get involved in creating systems change. Recognise that

fostering outward focussed community leadership serves a different function than having leaders in a governance role.

Theme 7. Enabling Māori ownership and leadership

Flexibility within the tendering approach for selecting Lead Providers has enabled iwi in Far North, Whanganui Rangitīkei Ruapehu, and East Cape to take leadership roles. The Lead Provider in Rotorua is also Māori-led. A conscious focus on Māori communities and continuing engagement of leadership is evident in all locations, including those where the providers are not Māori-led.

Impacts: The workforce and Leadership Groups both incorporate considerable Māori participation, and Māori perspectives are actively sought.

Lesson: The design of Healthy Families NZ has allowed local responsiveness, and ensured Māori are prioritised, creating the potential for action on Te Tiriti o Waitangi principles.

Theme 8. Making equity an integral part of the initiative

Equity considerations are part of the initiative as a whole (through the Healthy Families NZ Principles), and a local priority. Allowing flexibility and adaptation has created room for diverse worldviews, including Pacific cultures, religions, youth and, in particular, Māori perspectives. Healthy Families NZ teams have consciously attempted to match workforce and activities to significant communities within locations with already significant health and social inequalities.

Impact: The structure of Healthy Families NZ has created the potential to achieve greater equity within the selected locations.

Lesson: Flexibility to address local equity issues may be supported by explicitly focussing on equity within initiative design, enabling local responsiveness to particular social and ethnic groups who experience health inequalities.

Conclusion

Overall, our findings suggest Healthy Families NZ is a promising approach which has been implemented with integrity to its intention and purpose. The key features of the initiative, as directed by the Building Blocks of the prevention system, have been, for the most part, successfully put in place. The guiding Principles have helped focus on activities that are more likely to achieve systems change. There are also strong indications that local adaptations of the initiative to local cultural and environmental circumstances is occurring. Most locations have now also begun to consolidate their stakeholder relationships, as well as their own purpose, and are collaborating on substantial activities within their communities.

The **next step** in the evaluation of Healthy Families NZ is completing the second round of data collection which will begin in September 2017. This data will inform both the second view case studies and the systematic comparative analysis using QCA. The findings of both the *thematic* comparison and the *outcomes* comparison will be reported in 2018. This next report will address specific evaluation questions relating to *what has worked for whom, where, and why*.

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1. Introduction: Purpose of Interim Evaluation Report

This Interim Evaluation Report is a high-level summary and descriptive analysis of the establishment and early implementation of the Healthy Families NZ initiative. Further detail on the overall evaluation design is provided in Section 3.

A further outcomes evaluation report in mid-2018 will summarise the second view case studies and the results of a Qualitative Comparative Analysis exercise, following the second round of data collection and analysis.

In this Report we:

1. provide an in-depth picture of the evolution and implementation of the Healthy Families NZ initiative from inception up until March 2016.
2. identify themes and lessons emerging from the Healthy Families NZ locations that can inform ongoing refinement and development of Healthy Families NZ.
3. reflect on early implementation of Healthy Families NZ to help inform future developments of Healthy Families NZ, and other significant policy initiatives.

What information contributes to this Interim Evaluation Report?

The analysis presented draws primarily on qualitative themes apparent across case study reports for each Healthy Families NZ location and the National perspective (see Figure 1). These case studies cover the early implementation period from 2015 to early 2016.

In addition, we use information from ongoing data sources to provide indications of the direction of travel since the early implementation period. Ongoing data sources are regular

phone calls with Healthy Families NZ location Managers and the six-monthly Performance Monitoring Reports that locations submit to the Ministry of Health.

Figure 1 below depicts the relationship between parts of the evaluation and how they feed into this Interim Evaluation Report. Starting from the bottom of the figure, Boxes 4 and 5 describe our first view case studies. These case studies are reports we have created for each of the Healthy Families NZ locations based on a variety of data sources, including demographics, health data, key informant interviews, network data and documents (see Section 3, Overview of Evaluation Design, for more detail). We also developed a National perspective case study, covering how Healthy Families NZ evolved. Box 3 shows that we ran sensemaking sessions with Healthy Families NZ locations and the National Healthy Families NZ team to refine the case studies. Sensemaking sessions involved the participants and stakeholders in the interpretation and presentation of the collected data.

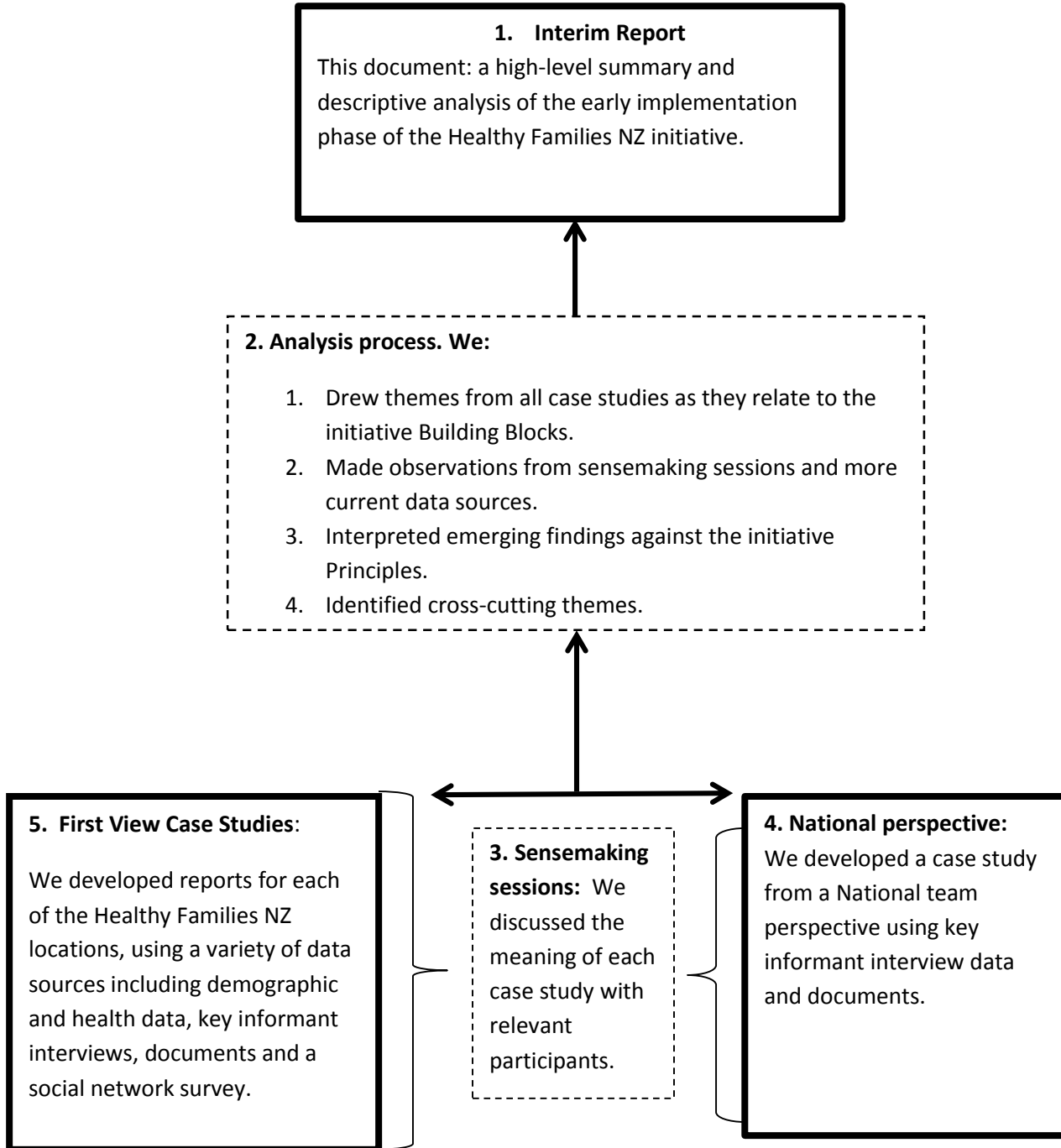
Box 2 describes the process of analysing the data that informs this Interim Evaluation Report.

Analysis involved:

- drawing themes from all case studies and arranging them according to the initiative Building Blocks.
- collating observations from sensemaking sessions and more current data sources to include in later drafts of the case study reports.
- interpreting emerging findings against the initiative guiding Principles.
- identifying cross-cutting themes capturing the dominant issues during the early implementation phase.

A further outcome evaluation report summarising the second view case studies and the results of a Qualitative Comparative Analysis exercise is due mid-2018 following the second round of data collection and analysis.

Figure 1. What contributes to this Interim Evaluation Report?



2. Overview of Healthy Families NZ

In Budget 2014, the Government allocated \$40 million over four years to support the implementation of Healthy Families NZ. In 2015 the Ministry of Health contracted Massey University to carry out a three-and-a-half-year evaluation.

Healthy Families NZ is a large-scale initiative that brings community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play by taking a dynamic systems approach to preventing chronic disease. It is focussed on creating many health promoting environments across the community that enable people to make good food choices, be physically active, smoke-free and free from alcohol-related harm. This involves working with early childhood education, schools, workplaces, food outlets, sports clubs, marae, businesses, places of worship, local governments, health professionals and more to create healthier environments. Healthy Families NZ is a key part of the Government's approach to helping New Zealanders live healthy, active lives.

The initiative is being carried out in 10 locations, predominantly in areas with higher than average rates of risk factors for preventable chronic diseases and/or high levels of deprivation. The locations are geographically spread and are a mixture of urban and rural areas. Healthy Families NZ has the potential to impact over a million New Zealanders living in the following locations:

- East Cape⁵
- Far North
- Invercargill City
- Lower Hutt City

⁵ Includes Opotiki and Gisborne Districts

- Rotorua District
- Whanganui District⁶
- Manukau Ward
- Manurewa-Papakura Ward
- Spreydon-Heathcote Ward⁷
- Waitakere Ward

In each location, a locally-based Lead Provider is responsible for implementing the initiative in their community. This includes establishing a dedicated prevention workforce, and bringing together a partnership of key stakeholders in the community. Partnership members are those organisations or individuals best placed to influence transformational change in their communities. There is a strong focus on enabling leadership across organisations, sectors, and communities to make sustainable healthy changes. Because Healthy Families NZ is about locally driven solutions to local needs, the kinds of initiatives delivered in each location are different.

The tendering process to select Lead Providers sought to identify locally embedded NGOs who were best placed to lead transformational change in their communities. The Lead Providers for Healthy Families NZ comprise iwi organisations, Regional Sports Trusts, and local Councils. Contracts with Lead Providers began from September 2014, for an initial term of four financial years (to June 2018).

The Healthy Families NZ approach

A growing body of evidence (Foresight, 2007; Gluckman, Nishtar, & Armstrong, 2015; McKinsey Global Institute, 2014) has prompted calls for a comprehensive and coordinated approach to chronic disease prevention that is sustained over the longer-term.

⁶ Also includes Rangitikei and Ruapehu Districts

⁷ Note that Healthy Families Spreydon-Heathcote is now referred to as Healthy Families Christchurch as Spreydon-Heathcote ceased to exist as a Local Government ward in October 2016.

Healthy Families NZ builds on existing action underway in the community to create an integrated, community-wide 'prevention system' for good health. The Healthy Families NZ approach was informed by and modelled on Healthy Together Victoria (HTV), an initiative that pioneered the application of systems thinking to the primary prevention of chronic disease in children and adults in Victoria, Australia (Strugnell et al, 2016).

Healthy Families NZ is about encouraging innovation. It is a move away from disconnected, small-scale and time-limited projects and programmes towards a whole-of-community approach that makes sustainable and long-term changes to the systems that influence the health and wellbeing of individuals, families and communities (see Figure 2). The Healthy Families NZ approach is focused on the following Building Blocks of a strong prevention system⁸ (adopted from HTV):

- resourcing and supporting a dedicated, reflective and skilled workforce at a local level to engage, activate and influence at multiple levels of the system.
- building leadership for sustained prevention across the system to drive effective and long-lasting change.
- building relationships with prevention partners across the system, and across sectors and industries, to strengthen positive health outcomes on multiple fronts.
- allocating resources based on best possible investment to effect change and population need, seeding long term change by resourcing local organisations to lead action towards public health.
- capturing and feeding back knowledge and data on progress, impact and effectiveness and calling for new types of research, policy and practice collaborations.

⁸ The Building Blocks were adapted by HTV from the WHO Building Blocks of a Strong Health System, along with other complex systems ideas

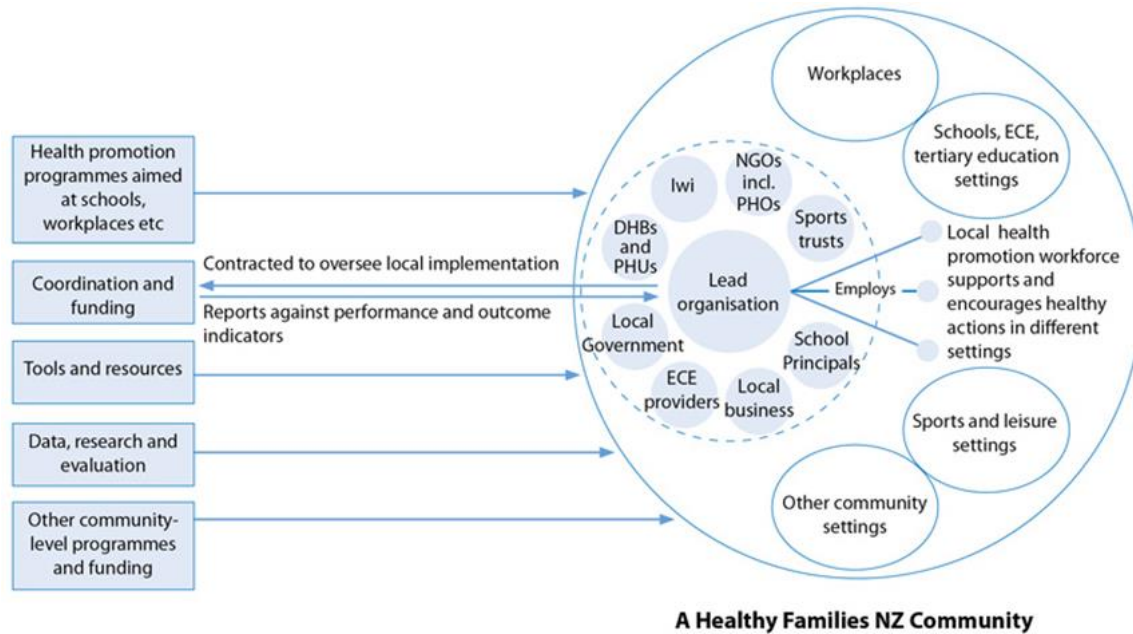
Figure 2. Healthy Families NZ Building Blocks of a strong prevention system



While the design for Healthy Families NZ draws on HTV, Healthy Families NZ has been adapted to reflect the unique context of New Zealand communities, and the special relationship between Māori and the Crown, involving obligations under the Treaty of Waitangi (Te Tiriti o Waitangi).

Figure 3 depicts how a Healthy Families NZ location can be considered, the key settings within that community and the resources and activities that support the implementation of the initiative. This model is taken from the 2013 Cabinet Paper (Office of the Minister of Health, 2013).

Figure 3. Healthy Families NZ Model, from 2013 Cabinet Paper



A new way of commissioning prevention

The Healthy Families NZ approach represents a significant departure from the way the Ministry of Health has traditionally commissioned services aimed at preventing chronic disease. Traditionally, services are funded to address a specific risk factor (for example, tobacco control), and are highly specified with pre-determined outputs (for example, the delivery of a particular programme). Healthy Families NZ is unique in that it focuses on multiple risk factors for chronic disease, and takes a placed-based, whole-of-community approach that enables the initiative to be driven by local leadership and responsive to the local context. A tight-loose-tight, high-trust contracting approach is employed: tight in terms of the specified resource and the outcomes sought, and loose in terms of how the initiative is operationalised ‘on the ground’. This approach required the Ministry of Health to adopt multiple responsibilities beyond that of the traditional funder-provider relationship. These responsibilities are discussed in further detail below.

Service contracts between the Ministry of Health and Lead Providers in each location outlined the implementation of Healthy Families NZ. Providers are expected to:

- maintain an agreed number of Full Time Equivalent (FTE) positions as part of the Healthy Families NZ workforce, participate in workforce development and actively contribute to the evaluation of Healthy Families NZ.
- establish shared governance arrangements to guide local action.
- establish a Prevention Partnership of key stakeholders best placed to influence change in the community.
- develop an Implementation Roadmap.
- work collaboratively with other Lead Providers, the Ministry of Health and other key partners on the ongoing implementation of Healthy Families NZ.

Key features of Healthy Families NZ

Workforce

The core Healthy Families NZ investment is building a systems-thinking prevention workforce in each Healthy Families NZ location. Healthy Families NZ teams are tasked with working collaboratively with local leaders and organisations to drive sustainable healthy change in the places where people live, learn, work and play. This involves working with early childhood education providers, schools, workplaces, food outlets, sports clubs, marae, businesses, places of worship, local governments, health providers and more to create healthier environments.

Each Healthy Families NZ Location was established with a minimum of 4 Full Time Equivalent (FTE) positions. These comprised the following roles:

- A Healthy Families NZ Location Manager/Team Leader, responsible for leadership and coordination of the initiative and management of the team.
- A Settings Coordinator, focussed on supporting systems change in early childhood centres, schools, workplaces and other community settings.

- A Partnerships and Engagement Coordinator, focussed on local level communication, social marketing and community engagement.
- A Health Promoter⁹, responsible for assisting early childhood services, schools and workplaces in the implementation of health promotion frameworks. Larger communities have additional Health Promoters.

Eighty percent of the funding for Healthy Families NZ is invested in this workforce, with the remaining twenty percent allocated towards an Action Budget to support local initiatives.

Governance and Leadership

Shared governance and leadership at a local level is an important aspect of each Healthy Families NZ location. In most locations, Governance Groups have been renamed Leadership Groups to more accurately reflect their purpose and activities. A Lead Provider holds the Healthy Families NZ contract with the Ministry of Health in each location. Lead Providers are responsible for establishing appropriate governance arrangements. This includes engaging leaders that have influence over the systems and environments that Healthy Families NZ is trying to make more health promoting. Members are expected to provide strategic oversight of Healthy Families NZ and actively champion the initiative, utilising their spheres of influence to support change in the community. The group has a key role in signing off the Implementation Roadmap and overseeing the investment of the Action Budget, ensuring all spending is in alignment with the principles of Healthy Families NZ. The Ministry of Health's National Healthy Families NZ team also participates in local Leadership Groups.

Establishment of local 'Prevention Partnerships'

Healthy Families NZ Lead Providers are responsible for bringing together a 'Prevention Partnership' of key stakeholders in the community. Prevention partnerships are intended to:

⁹ Many of the Healthy Families NZ teams chose not to call these positions Health Promoters – instead using titles such as 'Community Activator'

- develop a ‘prevention system’ at a local level that will help coordinate activities within each community.
- support community engagement, leadership and participation in determining local solutions.
- establish, build and support a local health promotion workforce.
- support evidence-based health promotion in early childhood services, schools, workplaces and communities.
- tailor health messages to the circumstances and needs of local communities.
- contribute to building the evidence base for locally-driven health promotion.

The Prevention Partnership Groups provide a mechanism for enabling organisations working within chronic disease prevention to work together to achieve greater collective impact. In practice, the approach to Prevention Partnerships has been different across the locations, with some having less formal networks and collaborations, and others having formalised groups that meet regularly.

Development of dynamic Implementation Roadmaps

Each Healthy Families NZ team was tasked with creating a high-level Implementation Roadmap, oriented around the Prevention System Building Blocks. This method of implementation planning is intended to enable the Healthy Families NZ workforce to take a dynamic and adaptive approach that is responsive to changing circumstances, learnings and opportunities that arise, rather than being limited by a detailed plan that would quickly become outdated.

To inform the development of their Roadmap, each Healthy Families NZ location was asked to undertake a mapping and stocktake activity to identify:

- key demographics and health needs in their area.
- existing programmes and the capacity of the health promotion workforce.








- existing networks.
- the number of key settings such as school, marae and workplaces.
- features of the environment such as food and alcohol retailers.
- key local policies that influence the environment.
- local champions and leaders.

Principles for a whole-of-systems approach to prevention

The design of Healthy Families NZ intentionally provides a large degree of autonomy to Healthy Families NZ locations about what they deliver. A set of principles to guide decision making at every level ensures integrity to a whole-of systems approach to prevention (Table 1). The Healthy Families NZ Principles are key to guiding the allocation of Action Budget spending. The Principles have been adapted from HTV.¹⁰

¹⁰ The Healthy Families NZ Principles were developed in partnership with the Victorian Government, Australia, as part of the 'Healthy Together Victoria' initiative

Table 1. Healthy Families NZ Principles

Implementation at Scale	
	Strategies are delivered at a scale that impacts the health and wellbeing of a large number of the population, in the places where they spend their time – in schools, workplaces and communities.
Collaboration for Collective Impact	
	<p>Long term commitment is required by multiple partners, from different sectors, at multiple levels, to generate greater collective impact on the health of all New Zealanders.</p> <p>Knowledge is co-created and interventions co-produced, supported by a shared measurement system, mutually reinforcing activities, ongoing communication and a 'backbone' support organisation.</p>
Equity	
	Health equity is the attainment of the highest level of health for all people. Healthy Families NZ will have an explicit focus on improving Māori health and reducing inequalities for groups at increased risk of chronic diseases. Māori participation at all levels of the planning and implementation of Healthy Families NZ is critical.
Experimentation	
	Small scale experiments provide insight into the most effective interventions to address chronic disease. These experiments are underpinned by evidence and experience, and are monitored and designed to then be amplified across the system, if they prove effective.
Adaptation	
	Strengthening the prevention system requires constant reflection, learning and adaptation to ensure strategies are timely, relevant and sustainable.
Line of Sight	
	The line of sight provides a transparent view on how investment in policy is translated into measured impacts in communities, ensuring best value from every dollar spent on prevention.
Leadership	
	Leadership is supported at all levels of the prevention effort including senior managers, elected officials, and health champions in our schools, businesses, workplaces, marae, sporting clubs and other settings in the community.

National level support for Healthy Families NZ

The Ministry of Health provides leadership and coordination of Healthy Families NZ at a national level. Some of the key aspects of Healthy Families NZ at a national level include:

- workforce development, support and training.
- support for national-level systems mobilisation and leadership networks.
- coordinating 'networks of practice' across the Healthy Families NZ sites.
- providing tools and information to support local action.
- funding and performance monitoring.
- participating in local governance structures.
- guiding and participating in recruitment processes.
- evaluating the initiative.

The National Healthy Families NZ team, comprising four staff members, was established within the Public Health Group of the Ministry of Health and has overall responsibility of the initiative. The nature of Healthy Families NZ has meant the Ministry has had to adopt additional responsibilities beyond that of the traditional 'arms-length' funder-provider relationship. For example, to de-centralise decision-making and provide greater autonomy and agency at the local level, the Ministry does not sign off on Implementation Roadmaps or Action Budget spending, but instead participates in the governance and leadership group arrangements, and has one vote as part of decision-making processes. Participation at the leadership and governance level also enables the Ministry to have an in-depth understanding of how the initiative is operationalised locally, rather than being solely reliant on six-monthly performance monitoring reports.

Healthy Families NZ Locations and Lead Providers

Figure 4 shows the locations and the Lead Providers. Early on, Healthy Families Manukau and Healthy Families Manurewa-Papakura joined as one location, when Auckland Council were awarded the contract for both Manukau and Manurewa-Papakura, and formed the Tāmaki Healthy Families Alliance. Since the initial Request for Proposal (RFP) process, Healthy Families Spreydon-Heathcote has had a change in Lead Provider from Pacific Trust Canterbury to Sport Canterbury, and a change in title to Healthy Families Christchurch.

Figure 4. Healthy Families NZ locations and Lead Providers



3. Overview of Evaluation Design

Overall evaluation approach

The evaluation has two purposes. The first is to support the 10 Healthy Families NZ locations to evaluate, learn from, and continuously adapt their approaches (developmental evaluation).

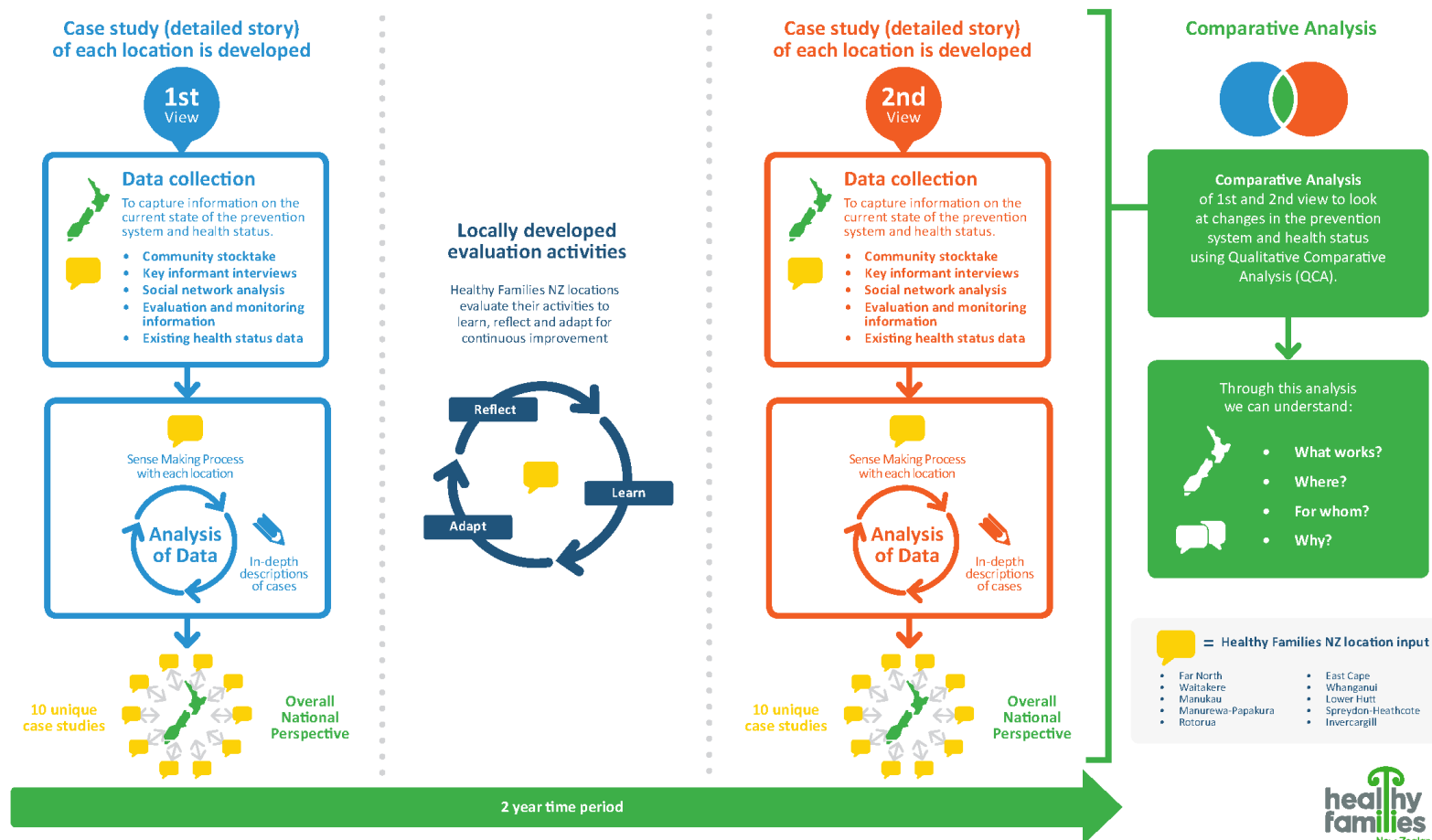
The second purpose is to understand how Healthy Families NZ has been implemented locally and whether it is contributing to the prevention of chronic disease (national evaluation). A description of the overall Healthy Families NZ evaluation design follows (Figure 5).

Figure 5. Evaluation of Healthy Families NZ - Design

EVALUATION DESIGN

Is Healthy Families NZ contributing to better health and wellbeing for the people in our communities?

Te Tiriti o Waitangi informs the approach to evaluation: He tangata, he tangata, he tangata



Local Developmental Evaluation – Supporting ongoing learning and adaptation

Developmental evaluation seeks to inform innovation through evaluation activity (Patton, 2011). The evaluation team provided a set of resources to the Healthy Families NZ locations from mid-2016. These tools support regular collection and review of data to provide rapid feedback on activities. We will also discuss findings from the national evaluation with teams in each location to aid an understanding of the findings, and to feed results back into local-level action.

National Evaluation – Identifying what works, for whom and why

At the heart of the national evaluation is a case-comparison study. The 10 Healthy Families NZ locations are different in many ways including people, geography, priorities, opportunities for action and the presence of other initiatives that are also contributing to the prevention of chronic disease. To understand outcomes achieved in each location, we are developing a detailed story (case study) of each location. The case studies draw upon multiple types of data (see Figure 6).

Figure 6. Summary of Healthy Families NZ Local Case Study Data



Case Study Comparison Approach

As illustrated in Figure 5, comparison across first and second view case studies for each Healthy Families NZ location will show how the initiative has developed over time. A comparative analysis will show the change occurring within each local prevention system.

Comparison between Healthy Families NZ locations will identify combinations of factors that have contributed to outcomes of interest (e.g. reduction in harmful alcohol use or increase in physical activity). The analysis will consider what has worked and in what circumstances.

The evaluation is using two comparison approaches. The first is a qualitative ‘thick’ description – the detailed story of a location and its changes over time. The second approach is a structured comparative method called Qualitative Comparative Analysis (QCA) (Byrne, 2013).

QCA has been increasingly used in recent years as an evaluation approach from a complex adaptive system perspective (Blackman, Wistow, & Byrne, 2013; Verweij & Gerrits, 2013; Warren, Wistow, & Bambra, 2013). We will use QCA to compare the cases over time.

QCA enables us to identify combinations of factors associated with prioritised outcomes across the cases. The factors included in the analysis are referred to as ‘conditions’.

Conditions could be features of the case context (e.g. continuity of staffing and Prevention

Partnership network features), process (e.g. reach into settings), and outcomes (e.g. change in health behaviours). A collaborative process is currently underway to develop these condition indicators.

Te Tiriti o Waitangi

The evaluation is also underpinned by Te Tiriti o Waitangi. We have provided multiple opportunities for diverse stakeholders to engage in the evaluation, including within evaluative judgements around the findings. The evaluation design allows for diversity in perspectives, values, and approaches, to be understood and respected. We specifically explore how Te Tiriti o Waitangi has been operationalised within Healthy Families NZ implementation. Experienced Māori researchers and evaluators are engaged to embed a Māori perspective into the evaluation design, methods and analysis.

Ethics

The Massey University *Code of Ethical Conduct for Research, Teaching and Evaluation involving Human Participants* guides this evaluation. In line with Massey University processes, the project was assessed by peer review to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The evaluators are responsible for the ethical conduct of the research. We have followed standard ethical processes for gaining participants' informed consent.

The method behind this Interim Evaluation Report

The information presented in this Interim Evaluation Report draws primarily on a descriptive analysis across the first view case study reports for each Healthy Families NZ location and the National perspective (see Figure 1).

Data sources

The data contained within the location case studies includes:

- interviews with members of the workforce, Leadership Groups, and selected partners (123 interviews in total).
- service contracts and Performance Monitoring Reports submitted by locations to the Ministry of Health.
- New Zealand Health Survey data for adults and children on smoking, nutrition, physical activity and harmful drinking. Information on mental health, dental caries, self-perceived health and unmet primary care need was also included. Data has been pooled for 2011/12-2014/15 years.
- B4 School Check BMI Data for years 2011/12 to 2014/15.
- 2013 Census data on the proportions of the population by New Zealand Deprivation Index classification, ethnic groups, age and gender.
- Sensemaking reflections. Draft case studies were taken back to each Healthy Families NZ location and the National Healthy Families NZ team within the Ministry of Health to check the accuracy of the information presented, and reflect on the data. Key reflections have been captured and included in updated case studies. In most locations, a majority of the workforce attended sensemaking sessions as well as a member of the leadership group in several locations.

In addition to the data contained in the first view case studies, this Interim Evaluation Report also draws upon phone interviews conducted with Healthy Families NZ location

managers (these occur around every 6 weeks), as well as the July 2016 Performance Monitoring Report submitted to the Ministry of Health.

Analysis

Analysis consists primarily of themes related to successes and challenges identified by key informants over the first view case study period, across the locations and National Healthy Families NZ team. The themes are ordered by the initiative's Building Blocks for a strong prevention system and the Principles for system-wide change for good health.

Systems thinking literature comprises a wide range of concepts and approaches. As the evaluation progresses, we will draw more heavily upon literature in this area, but for this report we apply three key concepts in systems thinking. These are boundaries, interrelationships, and perspectives (Williams & van't Hof, 2016).

Boundaries – complex systems are open, which means there are no hard boundaries defining what is inside or outside a system under study. However, to work with complex systems we do need to be clear about how we do define boundaries so that we have a focus. The act of creating a boundary includes or excludes perspectives, people or actions.

Interrelationships – It is the interaction between elements in a complex system (people, objects, programmes) that leads to outcomes from that system. Understanding interactions helps to identify how and why certain outcomes emerge.

Perspectives – Systems approaches involve identifying different perspectives within and between systems to better understand interrelationships. How we decide to draw boundaries around a complex system, how we view interactions, and the assumptions we bring, influence our own perspective of what an issue is and what a success looks like.

Design Limitations

Overall Design Limitations

There were a number of challenges when deciding on an approach for evaluating Healthy Families NZ. These included:

- differences between each Healthy Families NZ location
- influences from the wider social/political environment that potentially impact on local activities, practices and policies, and
- the time-frames for changes in population-level chronic diseases and their risk factors being outside the contracted evaluation period.

To meet some of these challenges, we selected a comparative case study design.

The limitations of the overall design relate to the inherent challenges of evaluating this kind of initiative which is characterised by a high level of diversity both among and within communities, and nested chains of complex causality. These characteristics make causal attribution difficult.

QCA techniques allow the systematic comparison of cases, with the help of formal tools and with a specific conception of cases. Each case is considered a complex configuration (or set) of conditions linked to an outcome and this configuration is kept intact throughout analysis. Causality is established by comparing cases which are or are not linked with an outcome to see which combinations of conditions are present when an outcome occurs (Rihoux et al., 2013). An example could be effective leadership, where looking across cases with effective leadership, the presence of a stable workforce is consistently seen. By understanding and comparing how cases change or remain stable over time, we can learn something about the conditions that influence change.

Limitations of summary descriptive data presented in the Interim Evaluation Report

This interim report presents descriptive analyses, showing contextual information about the establishment phase of Healthy Families NZ. The NZHS and B4 School Check data are presented to give a picture of the baseline for some important health indicators – although indicators for use in QCA method are still in development. Another limitation is the extent of the key informant interviews that are mostly from participants ‘inside’ or close to the initiative. Although this gives rich data, it emphasises the identified successes and challenges from perspectives inside Healthy Families NZ rather than the wider prevention

systems in each Healthy Families NZ location. This insider perspective is most relevant for understanding implementation.

There is less depth to data collected outside of the first view case study period. Reported observations from after the 2015 to early 2016 time period come from Performance Monitoring Reports submitted by Healthy Families NZ locations to the Ministry of Health, regular phone interviews with Healthy Families NZ Managers, and reflections at sensemaking sessions on first view case studies. The observations should be treated as indications of how things were evolving, and of emerging themes from March to December 2016.

Focusing on emerging themes across Healthy Families NZ locations and the National perspective inevitably removes some detail and presents findings separate from the context of locations. However, as an ethical consideration, it was important to avoid singling out locations to preserve participants' anonymity.

4. Evaluation Findings

The evaluation findings presented here:

- a) provide some context for considering the establishment and preliminary impact of Healthy Families NZ to date.
- b) identify themes across first view case studies grouped by the Building Blocks for a strong prevention system and Healthy Families NZ Principles.
- c) summarise cross-cutting themes identified through comparison across first view Healthy Families NZ location (and National perspective) case studies.

The context for first view descriptive case studies

Establishment Phase

The Ministry of Health ran a two-stage competitive tender process from March to September 2014 to select Lead Providers in the 10 locations. The selected Lead Providers were locally-based organisations including iwi organisations, local government authorities, and regional sports trusts. Healthy Families NZ has an explicit focus on improving Māori health and improving health equity; four of the ten Healthy Families NZ Lead Providers are Māori organisations.

Healthy Families NZ locations were established from late 2014 through 2015. Table 2 gives an outline of activities in the establishment phase of Healthy Families NZ. Much of the data collected for this Interim Report occurred during this establishment phase.

While contracts for Healthy Families NZ locations cover an initial three-and-a-half-year period (from September 2014 to June 2018), substantial activity in terms of meeting initiative goals gained momentum for all locations at the beginning of 2016. Several factors contributed to this:

1. The National Healthy Families NZ team within the Ministry of Health was being established at the same time as teams in the Healthy Families NZ locations. This, as well as the evolving nature of the initiative, meant that several key supports, such as job descriptions and guidance on using the Action Budget, were not provided until

well into 2015. Because of the novelty of the initiative, it also needs to be acknowledged that this has been a big learning curve for the Ministry of Health as well as communities – meaning it took time to determine what supports might be needed and useful.

2. None of the Healthy Families NZ locations had all allocated FTE in place by the end of 2015. For some, recruitment carried on well into 2016, while changes in FTE were a common discussion point in Managers’ monthly phone calls throughout 2016.
3. Initial plans were for existing Ministry of Health-funded settings-based health promotion programmes to be brought together under a single umbrella, similar to the Achievement Programme in HTV. The aim was to provide a common framework for evidence-based action in community settings, and provide data on the reach and impact of settings-based health promotion initiatives across the 10 locations. The Health Promotion Agency was contracted to achieve this. However, in line with the evolving and adaptive nature of Healthy Families NZ, the project was reshaped in late 2015 following consultation across the 10 locations and with key national stakeholders. In response to this feedback, guides to support the workforce in engaging with education and workplace settings were developed. However, some Healthy Families NZ locations began initial planning and workforce recruitment expecting that they would deliver an Achievement Programme and had to rethink some activities. This may reflect a differing understanding between location teams and the National Healthy Families NZ team about the Achievement Programme. Early on, the National team explained that although an Achievement Programme had been referred to in the RFP, that exact type of programme would not be happening.

Table 2. Timeline of activities during establishment of Healthy Families NZ

Dates	Key events	Location workforce/contracts	Ministry workforce/activities
14 March 2014	Minister of Health, Hon Tony Ryall, announced the Registration of Interest process had opened for Healthy Families NZ		Senior Portfolio Manager already on secondment to lead the RFP process. Victorian Department of Health officials visit New Zealand to provide advice and support around further development of the

Dates	Key events	Location workforce/contracts	Ministry workforce/activities
			Healthy Families NZ approach
24 July 2014	RFP for Local Lead Provider contracts closed		
August 2014		Contract signed by Lead Providers: * Pacific Trust Canterbury (Spreydon-Heathcote) *Te Oranganui (Whanganui Rangitikei Ruapehu) *Hutt City Council (Lower Hutt) *Te Arawa Whanau Ora Charitable Trust (Rotorua) *Sport Waitakere (Waitakere)	
September 2014		Contract signed by Lead Providers: *Te Runanga O Te Rarawa (Far North) *Auckland Council (Manukau) *Sport Southland (Invercargill)	Programme Director started Manager and Senior Portfolio Manager visit Victoria to see HTV in action
November 2014		Contract signed by Lead Providers: *Auckland Council (Manurewa Papakura) *Te Aitanga a Hauiti Hauora Charitable Trust (East Cape) Manager started in Invercargill	Portfolio Manager started
December 2014	Principles for Systems Wide Change for Good Health sent to Managers	Manager started in Waitakere	Project Coordinator/Administrator started
January 2015	Final logo and brand chosen by locations	Managers started in East Cape, Whanganui Rangitikei Ruapehu, Rotorua and Spreydon-Heathcote	
February 2015	Healthy Families NZ video co-designed with locations Letter of Agreement signed with HPA	Managers started in Lower Hutt, Manukau and Manurewa-Papakura; interim manager started in Far North	DHBs and Public Health Units provided with 2015/2016 Annual Planning Guidance to include supporting Healthy Families NZ in their planning
March 2015	First Healthy Families NZ national	Two settings coordinators started in East Cape	Victorian Department of Health officials come back to New Zealand to meet

Dates	Key events	Location workforce/contracts	Ministry workforce/ activities
	workforce development hui		with Minister of Health and deliver systems thinking training to Healthy Families NZ Managers and lead provider CEOs. Joint Commitment to Prevention signed between The Victorian Department of Health and Human Services and the New Zealand Ministry of Health.
April 2015	Roadmap template supplied to workforce. Healthy Families NZ National Implementation Roadmap also supplied to workforce for their information.	Partnerships and engagement coordinators started in Rotorua, East Cape, Manukau, Manurewa-Papakura Settings coordinator starts in Rotorua Healthy Families East Cape launch	
May 2015	Final brand guidelines sent out 2nd Healthy Families NZ national workforce development hui - Auckland	Settings coordinators start in Waitakere and Lower Hutt	
June 2015		Partnerships and engagement coordinators start in Whanganui Rangitikei Ruapehu and Waitakere Settings coordinators start in Invercargill and Spreydon-Heathcote	
July 2015	3rd Healthy Families NZ national workforce development hui - Auckland	Partnerships and engagement coordinator starts in Spreydon-Heathcote Healthy Families Invercargill launch	
August 2015	Communications resource for Healthy	Partnerships and engagement coordinators start in Lower Hutt, Invercargill, Far North	

Dates	Key events	Location workforce/contracts	Ministry workforce/activities
	Families NZ sent to managers	Settings coordinators start in Whanganui Rangitikei Ruapehu, Manukau and Manurewa-Papakura Healthy Families Waitakere launch	
September 2015	Healthy Families NZ video released		
October 2015	Healthy Families NZ website goes live		Childhood Obesity Package announced (Healthy Families NZ part of the package, specifically for supporting a coordinated effort in prevention)(Office of the Minister of Health, 2015)
November 2015	4th Healthy Families NZ national workforce development hui	Settings coordinator starts in Far North Healthy Families Rotorua launch	
December 2015			Relationship with the Department of Conservation established, resulting in Healthy Families NZ locations collaborating on the Healthy Nature Healthy People initiative
February 2016	Contract with Toi Te Ora Public Health Unit - Coordination of National Approach to Workplace Wellbeing		
March 2016	Draft Action Budget Decision Support Tool sent to location Managers for feedback		Ministry of Education release communication to encourage schools to adopt 'water only' policies and Healthy Families NZ locations encouraged to support implementation locally

Baseline Health data (NZHS and B4 School Check)

We used three sets of quantitative data in the location-specific, first view case studies to:

- present the local context for the years preceding the implementation of Healthy Families NZ in those locations
- show how populations in those locations compared with the whole population of New Zealand.

Key quantitative data sources included the New Zealand Health Survey (NZHS) and B4 School Check for the four years between 2011/12 and 2014/15 and the 2013 Census.

Comparison to the whole population does not imply that the national rates are necessarily a desirable endpoint.

The analysis of adult responses to the NZHS focused on health behaviours and disease risk factors that relate to Healthy Families NZ such as smoking, vegetable and fruit intake, physical activity and obesity. We also analysed data on the health conditions that Healthy Families NZ seeks to prevent. The analysis of NZHS responses for children focused on health behaviours and risk factors in children such as vegetable and fruit intake, active travel, TV watching, fast food consumption and obesity. The questions about children (aged 14 years and younger) were answered by an adult in the selected household, not by the child.

The B4 School Check is a nationwide programme offering a free health and development check for four-year-old children. Check data were used to show the rates of overweight and obesity among four-year-old children in the Healthy Families NZ locations compared with the whole of New Zealand.

Detailed findings from these data sources, including tables and figures, are included in the supplementary report.

Summary of NZHS adult data

In general, adults from Healthy Families NZ locations in 2011/12 to 2014/15 had worse or similar rates of health behaviours and risk factors compared to the total New Zealand adult population. These include smoking, hazardous drinking, healthy eating, being physically active, and being overweight or obese. This observation was most noticeable for *obesity*, where adults in seven of the ten locations were more likely to be obese than all New Zealand adults; and *smoking*, where adults in five of the ten locations were more likely to be current smokers than all New Zealand adults. The exceptions to this pattern were in *vegetable intake*, where adults from five locations were more likely to eat three servings of vegetables each day than all New Zealand adults; *physical activity*, where adults from three locations were less likely to do little or no physical activity than all New Zealand adults; and *hazardous drinking*, where adults from one location were less likely to drink alcohol in a manner that is hazardous to their health than all New Zealand adults.

Adults from Manukau, Manurewa-Papakura, East Cape, and Whanganui Rangitikei Ruapehu had consistently worse rates of health behaviours and risk factors than all New Zealand, while adults from Spreydon-Heathcote and Invercargill had better rates of vegetable intake and physical activity than all New Zealand.

In general, adults from Healthy Families NZ locations had worse or similar rates of health outcomes than all New Zealand adults in terms of high blood pressure, high cholesterol, ischaemic heart disease, heart failure, stroke, diabetes, mental health and oral health. This was most noticeable for *diabetes*, where adults in three of the ten locations were more likely to have diabetes than all New Zealand adults. However, adults in three of the ten locations were less likely to have poor *oral health* than all New Zealand adults.

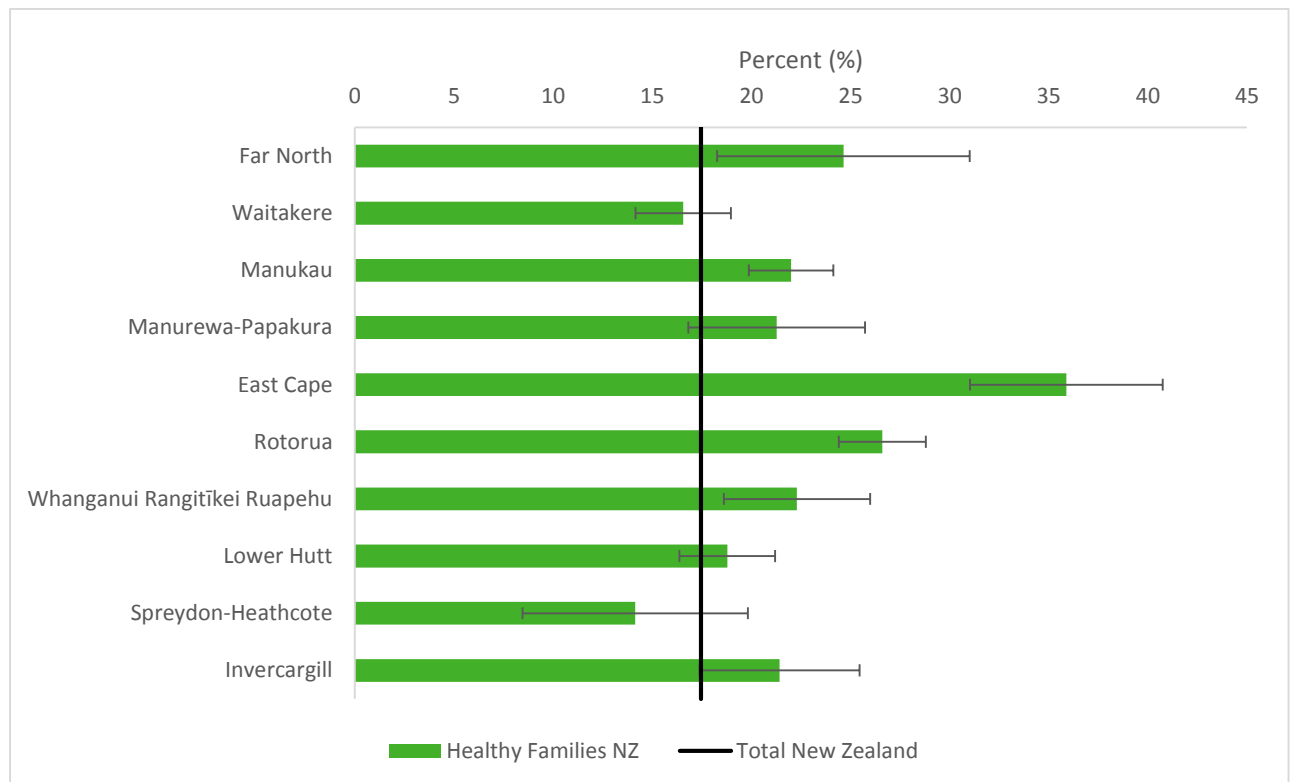
Adults from Far North and Manurewa-Papakura had worse rates of health outcomes than all New Zealand.

In addition, adults from Healthy Families NZ locations had worse or similar rates of self-reported excellent, very good or good health than all New Zealand. While adults from Manukau had better rates for unmet need for primary health care than all New Zealand

adults, adults from Lower Hutt had worse rates of unmet need for primary health care than all New Zealand.

The following figures are examples of NZHS findings for adults in the Healthy Families NZ locations, covering three health behaviour issues of particular interest: smoking, alcohol, healthy eating and physical activity.

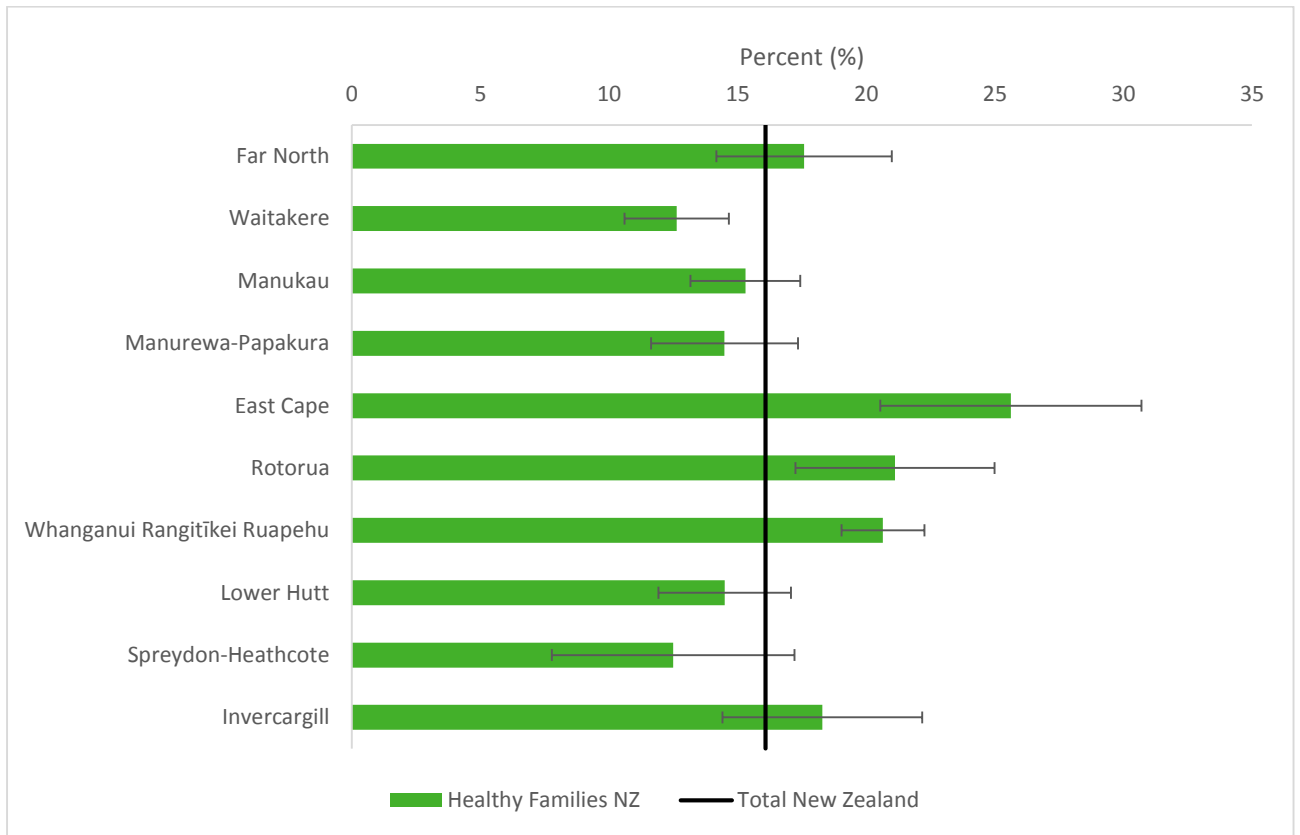
Figure 7. Current smokers, among adults over 15 years, NZHS 2011/12 – 2014/15, unadjusted



Adults from five of the locations are **more** likely to be current smokers than all New Zealand adults, namely Far North, Manukau, East Cape, Rotorua, and Whanganui Rangitīkei Ruapehu.

Adults from the remaining five locations have similar rates of current smoking to total New Zealand adults.

Figure 8. Hazardous Drinkers, among adults over 15 years, NZHS 2011/12 – 2014/15, unadjusted

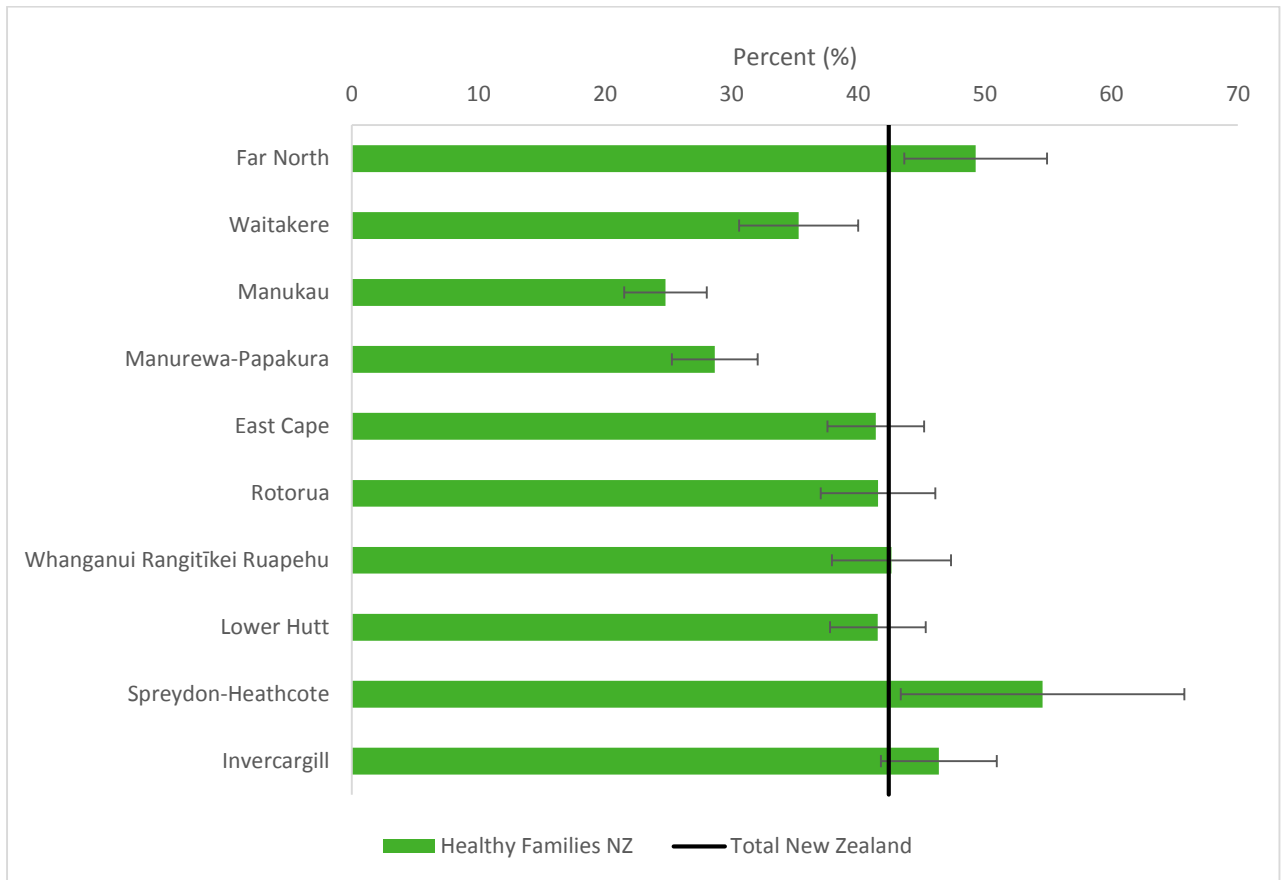


Adults from one of the locations are **less** likely to drink alcohol in a manner that is hazardous to their health than all New Zealand adults, namely Waitakere.

Adults from three of the locations are **more** likely to drink alcohol in a manner that is hazardous to their health than all New Zealand adults, namely East Cape, Rotorua, and Whanganui Rangitīkei Ruapehu.

Adults from the remaining six locations have similar rates of drinking alcohol in a manner that is hazardous to their health to all New Zealand adults.

Figure 9. Adequate vegetable and fruit intake, among adults over 15 years, NZHS 2011/12 – 2014/15, unadjusted

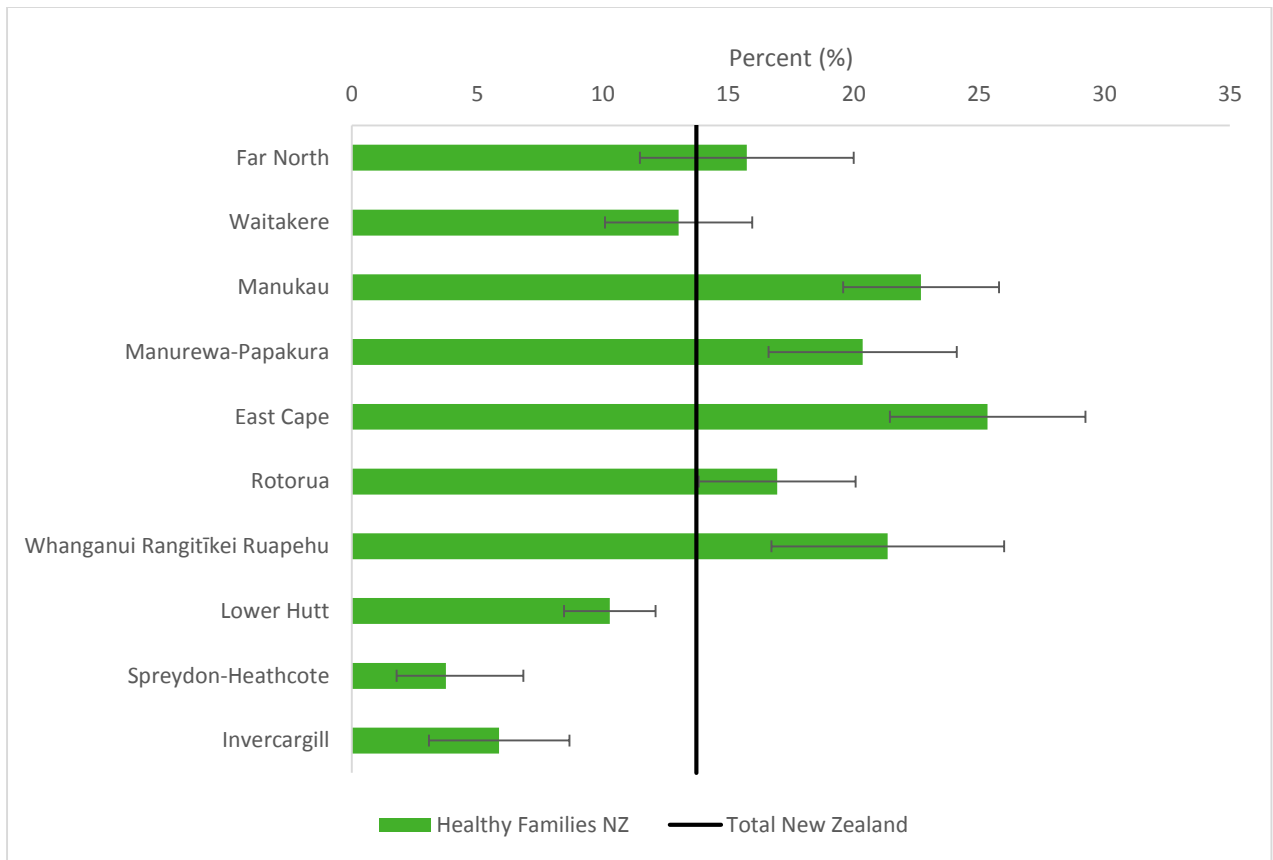


Adults from one of the locations are **more** likely to meet both the vegetable and fruit intake guidelines than all New Zealand adults, namely the Far North.

Adults from three of the locations are **less** likely to meet both the vegetable and fruit intake guidelines than all New Zealand adults, namely Waitakere, Manukau, and Manurewa-Papakura.

Adults from the remaining six locations have similar rates of meeting both the vegetable and fruit intake guidelines to all New Zealand adults.

Figure 10. Little or no physical activity, among adults over 15 years, NZHS 2011/12 – 2014/15, unadjusted



Adults from three of the locations are **less** likely to do little or no physical activity than all New Zealand adults, namely Lower Hutt, Spreydon-Heathcote, and Invercargill.

Adults from four of the locations are **more** likely to do little or no physical activity than all New Zealand adults, namely Manukau, Manurewa-Papakura, East Cape, and Whanganui Rangitikei Ruapehu.

Adults from the remaining three locations have similar rates of doing little or no physical activity to all New Zealand adults.

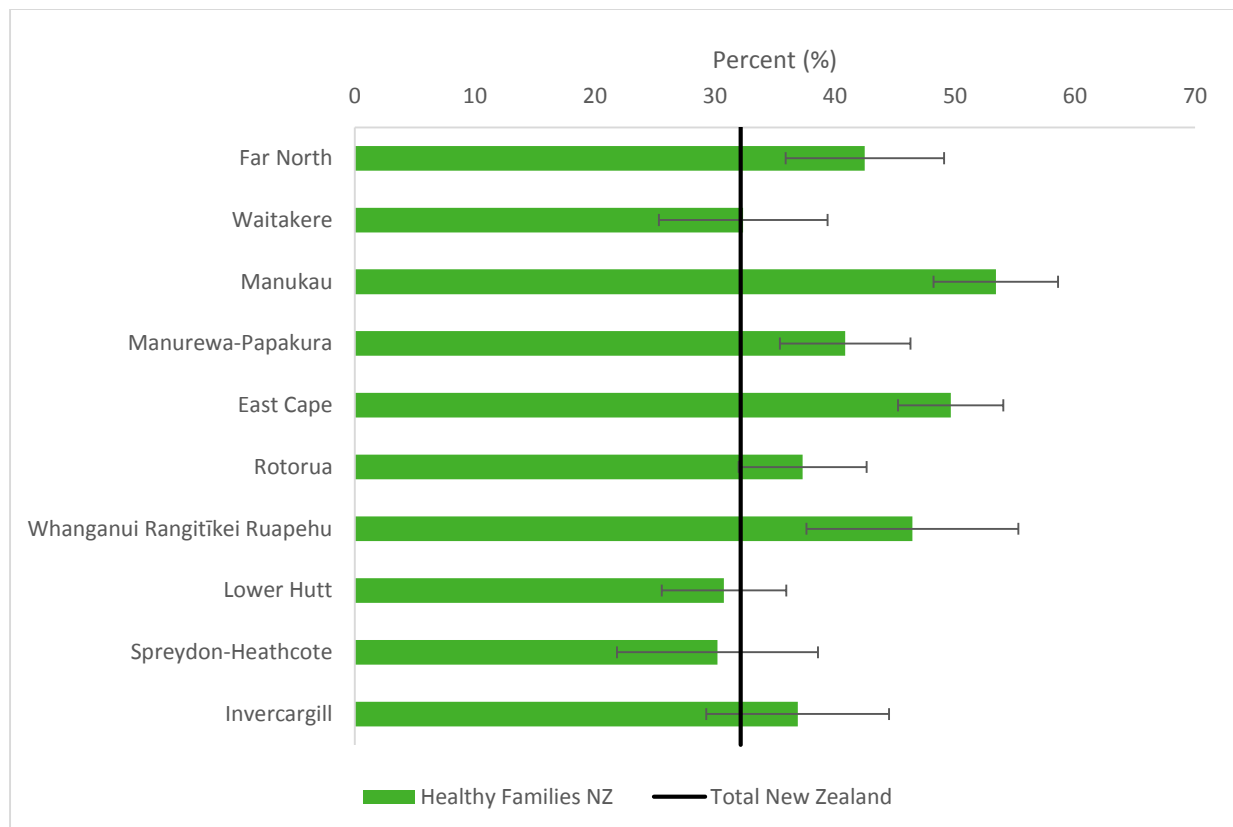
Summary of NZHS child data

In general, children from Healthy Families NZ locations had worse or similar rates of health behaviours and risk factors compared to the total New Zealand child population for healthy eating, TV watching, active travel, and being overweight or obese. This was most noticeable for *TV watching*, where children from five of the ten locations were more likely to watch two or more hours of TV daily; and *obesity*, where children in four of the ten locations were more likely to be obese, and less likely to be a healthy weight, than all New Zealand children (see Figure 11). The only exceptions to this pattern were for *fruit and vegetable intake*, where children from three locations were more likely to eat three servings of vegetables each day than all New Zealand children. Plus, children from one location were also more likely to eat two servings of fruit each day.

Children from Manukau and Manurewa-Papakura had consistently worse rates of health behaviours and risk factors than all New Zealand. Children from Invercargill had better fruit and vegetable intake than all New Zealand.

In addition, children from Healthy Families NZ locations had worse or similar rates of parent-reported excellent, very good or good health than the total New Zealand child population. While children from Manukau and Spreydon-Heathcote had better rates for unmet need for primary health care than all New Zealand, children from Manurewa-Papakura and Lower Hutt had worse rates of unmet need for primary health care than all New Zealand.

Figure 11. Overweight or obese, among children aged 2-14 years, NZHS 2011/12 – 2014/15, unadjusted



Children from five of the locations are **more** likely to be either overweight or obese than all New Zealand children, namely Far North, Manukau, Manurewa-Papakura, East Cape, and Whanganui Rangitīkei Ruapehu.

Children from the remaining five locations have similar rates of being either overweight or obese to all New Zealand children.

Summary of B4 School Check data

For the Healthy Families NZ locations, the number of children completing B4 School Check assessments in the four years covered in this dataset ranged from 2,867 in Spreydon-Heathcote to 10,650 in Manukau.

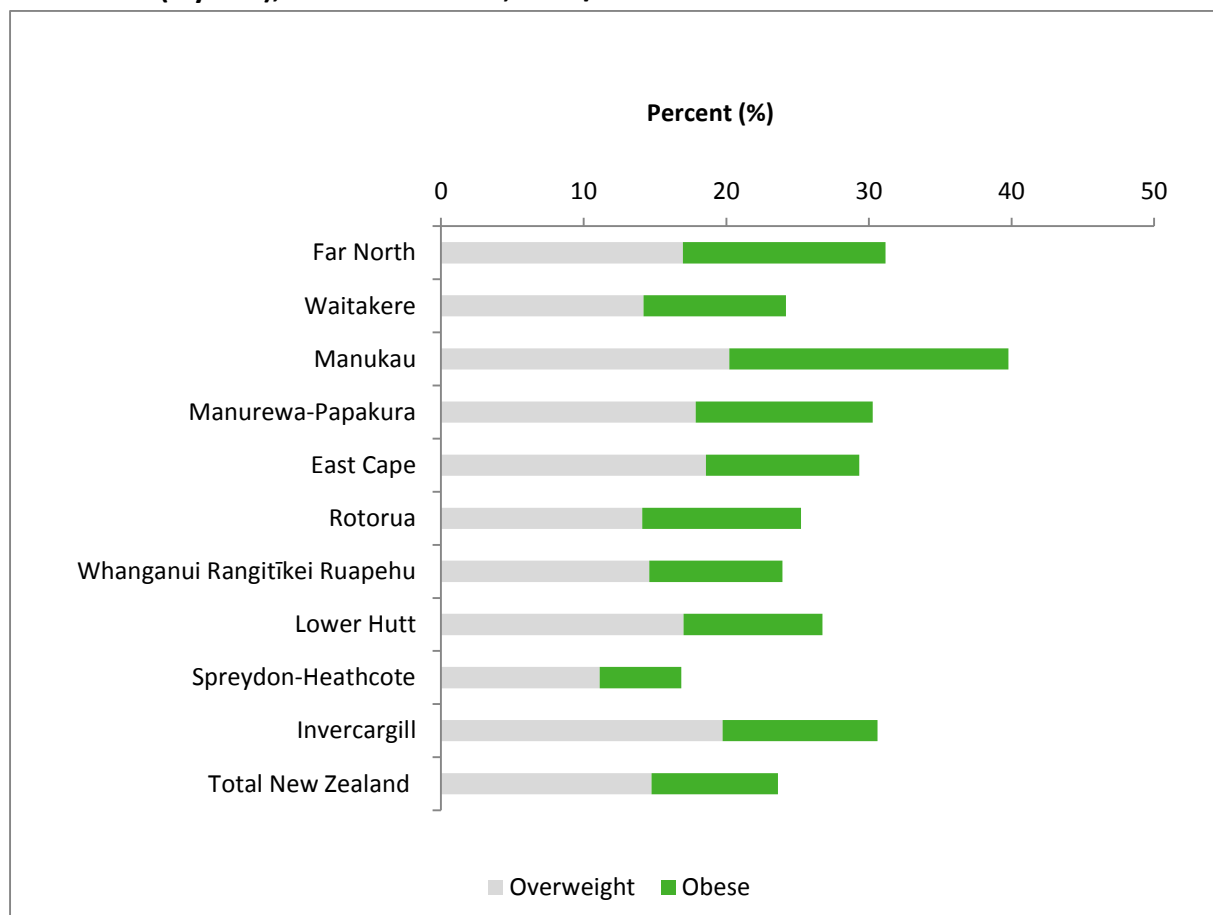
In 2014/15, four-year-old children in four of the Healthy Families NZ locations had higher rates of obesity than the total New Zealand child population (Far North, Manukau, Manurewa-Papakura and Rotorua). Four of the locations had higher rates of overweight four-year-old children than all New Zealand (namely Manukau, Manurewa-Papakura, East Cape and Invercargill). Two of the locations, Manukau and Manurewa-Papakura had higher

rates of both overweight and obese four-year old children than all New Zealand. One of the locations, Spreydon-Heathcote, had lower rates of both overweight and obese four-year-old children than all New Zealand. Figure 12 shows the rates of both overweight and obesity in 4-year-old children in each Healthy Families NZ location compared with the overall New Zealand child population who completed the B4 School Check.

Among the total New Zealand population of four-year-old children, there was a small decrease in obesity over the four years 2011/12 to 2014/15. There was also a decrease in obesity over this time in one of the Healthy Families NZ locations, Manurewa-Papakura. For the remaining nine locations, there was no clear change in rates of obesity over time.

Rates of overweight four-year-olds were stable among the total New Zealand child population over the four years 2011/12 to 2014/15. Among the Healthy Families NZ locations, there was an increase in rates of overweight four-year-old children in two locations, Manukau and Lower Hutt.

Figure 12. Overweight and obese, Healthy Families NZ locations, among children aged 48 – 60 months (4 years), B4 School Check, 2014/15



Further tables and graphs summarising the national-level data are shown in the supplementary report.

Themes organised by the Building Blocks

This section summarises evaluation findings under headings of the Building Blocks of a strong prevention system (see Chapter 2 for more detail about Building Blocks). The Building Blocks are the conceptual foundation of the Healthy Families NZ initiative and guided which mechanisms and resources were put in place.

The Building Blocks used in Healthy Families NZ are:

1. Workforce: dedicated, reflective and skilled workforce.
2. Leadership: building leadership for prevention across the whole community.
3. Relationships: building relationships with prevention partners across the system.
4. Resources: allocating resources to effect sustainable change.
5. Knowledge and Data: capturing and feeding back knowledge and data.

The following discussion of each Building Block contains three sections:

- Emerging themes related to identified successes from the first view case studies.
- Emerging themes related to identified challenges from the first view case studies.
- Observations after the first view case study period (since approximately March 2016).

The themes draw on the range of data available to date including interviews, quantitative data, social network analysis and sensemaking sessions.

Workforce – dedicated, reflective and skilled workforce

Summary of tasks during first view case study period: establishing Healthy Families NZ teams within Lead Provider organisations, recruiting the workforce, and supporting the workforce to think and act using systems frameworks.

Successes – themes from first view case studies:

- Well-skilled and qualified staff have been recruited across locations, according to interview participants within location teams and stakeholders in the wider sector who have worked with those teams
 - Interview responses made clear that ‘skilled’ referred to more than qualifications (there is a wide variety of level of qualifications amongst workforce members). Skilled staff also possessed knowledge of the communities and settings they are working in, connections to existing partner organisations and networks, as well as cultural expertise.
- Healthy Families NZ is a good fit for Lead Providers
 - A majority of interview participants in most locations noted that Healthy Families NZ is a good fit with the Lead Provider. Different Lead Providers appeared to offer different opportunities for the direction of activities depending on the type of organisation, their existing areas of work and relationships.
- A diverse workforce with a large proportion of Māori and Pacific workforce has been recruited
 - A high proportion of the recruited Healthy Families NZ workforce are Māori, and a number of Pacific ethnicities are also present across locations.
 - Team members and stakeholders see diversity amongst the workforce, as important for engaging communities within locations.
- Provision of training and development was well received
 - Places on Ministry of Health funded training programmes (Public Health Leadership Programme and Certificate of Public Health) were available to the Healthy Families NZ workforce.

- Interview participants who attended national workforce hui (which occur biannually) were positive about the ability to meet staff from other Healthy Families NZ locations and focus upon particular aspects of the initiative.
- Leadership training was provided to the workforce by Catapult. This was well received and an on-going training and mentoring relationship has developed in several locations.

Challenges – themes from first view case studies:

- The geographic spread of the workforce creates logistical challenges
 - Where Healthy Families NZ locations have a geographically-spread workforce, this creates challenges for team planning, development and consistency of approach. At the same time, interviewees recognised the practical necessity of having staff embedded across the Healthy Families NZ location areas.
- Most locations experienced delays in workforce recruitment
 - Some of this delay was planned. For example, Lead Providers recruited Managers/Team Leaders first, so that they could then be part of the recruitment process for the remaining positions. The release of the health promoter job description was also staggered to encourage the mapping and stocktaking process to be completed before launching into activity.
 - Some recruitment delays were not planned. They related to difficulties of finding the right people, or delays with HR systems within Lead Providers. Some positions, within some Healthy Families NZ locations, required multiple recruitment rounds to fill.
 - The impact of recruitment delays was to lengthen the establishment phase of Healthy Families NZ in most locations.
- The prescribed mix of roles and job descriptions restricted initial flexibility of staffing
 - The service contracts with Lead Providers stipulated how many FTE would be funded and in what roles. As Healthy Families NZ locations became

established, and the focus of activity areas became clearer, the original mix of positions was refined in a number of locations. The original positions of Manager/ Team Leader, Settings Coordinator and Partnerships and Engagement Coordinator remain in place in all sites, but additional roles such as Kaiwhakahaere have been added. As an example of adaptation and continued reflection, this process could be counted a success. On the other hand, it takes time to change initial staffing establishments, and prescriptions were perceived as restrictive by some interviewees in locations.

- The National Healthy Families NZ team noted that locations were able to make changes to the job descriptions to include information relevant to their local context. Most locations did make some changes to job descriptions, such as replacing the title 'Health Promoter' with 'Community Activator'.
- Integrating Healthy Families NZ teams within Lead Providers required organisational adaptations
 - While the integration of Healthy Families NZ teams within Lead Provider organisations is noted as a success above, in most locations it has not been without challenges.
 - A sensemaking reflection, noted in several locations, was that the style of work and momentum of work for Healthy Families NZ differs from many other services delivered by Lead Providers, particularly where there is a strong focus on programmes delivered to individuals or small groups of people. This creates challenges integrating Healthy Families NZ into wider HR, finance, performance and monitoring systems.
 - Across some locations, there have been ongoing adaptations to structure, such as the level of management within Lead Provider at which the Healthy Families NZ Manager/Team Leader sits. A change in structure suggests the initial placement of some Healthy Families NZ teams within Lead Providers was not optimal. Such changes do also show a process of reflection and adaptation within Lead Providers.

- Providers lacked professional development for applying the systems approach
 - Within first view case studies, there was uncertainty amongst many newly recruited staff about what the systems approach meant.
 - Early training was provided to Managers and Lead Provider Chief Executives on taking a systems thinking approach, and included face-to-face training from people leading HTV. Through national workforce hui, new staff were also exposed to applying a systems approach as they came on board. Although team members saw this training as a good start, some felt the training had not gone into enough depth, while others, due to recruitment timing, missed these early sessions altogether. There was therefore limited national coordination in developing understanding of systems approaches and in applying tools across the workforce. Healthy Families NZ locations were tasked with inducting new staff outside of national hui opportunities. A common reflection at sensemaking on the first view case studies was that more detailed training on systems approaches would be beneficial.

Observations post case study period:

- Additional staff were recruited in many locations as workforce requirements became clearer
 - At the start of the initiative, 73.5 FTE were provided for across all locations. Since then, four locations have not changed their FTE and the other six have recruited further FTE.
 - Additional positions have been funded through underspend in each location, which occurred due to staggered recruitment of the initial workforce.
 - The most common additional positions have been Settings Coordinators. Additional investment in administration support and evaluation/data specialists has also occurred. Kaiwhakahaere positions have also been established.

- The Partnerships and Engagement Coordinator role is a more senior role than job descriptions and salary bands catered for
 - In recruiting Partnerships and Engagement Coordinators, multiple Healthy Families NZ locations have noted that a senior communications professional is required to be effective in this role. Salary bands have been increased where necessary.

Leadership – building leadership for prevention across the whole community

Summary of tasks during first view case study period: establishing Healthy Families NZ Leadership Groups in each location, and identifying and engaging community leaders and influencers.

Successes – themes from first view case studies:

See Appendix 2 for summary of Leadership Group membership in each Healthy Families NZ location.

- The right people with local influence were recruited onto Governance Groups
 - Most location Managers and members of Governance/ Leadership Groups thought they had a good mixture of sectors and organisations participating in the leadership group, at the right level of seniority.
 - Some Healthy Families NZ locations sought additional leadership outside the Leadership Group structure. Examples include Healthy Families Far North where the Taitokerau Iwi Chief Executives Consortium participates, and Healthy Families Manukau and Manurewa-Papakura, which has an Alliance Leadership Team (ALT) comprised of representatives of the four partners in Tāmaki Healthy Families Alliance (Ngā Mana Whenua o Tāmaki Makaurau, Alliance Health Plus PHO, Auckland Council and the Ministry of Health). In these cases, additional mechanisms for engaging leadership more widely across the local prevention system were either in place or being designed.

- Iwi leadership and Māori providers are engaged
 - Healthy Families Far North¹¹ has a relationship with the Taitokerau Iwi Chief Executives Consortium, which was viewed as a positive arrangement. Engagement of wider cross-sector leaders in the Far North had yet to be established at the time of first view case studies.
 - Healthy Families East Cape is established under the Horouta Whānaunga Collective and has a Leadership Group made up mostly of health providers providing representation of eight iwi from across the East Cape.
 - Te Oranganui, Lead Provider for Healthy Families Whanganui Rangitikei Ruapehu, is an iwi mandated organisation.
 - Te Arawa Whānau Ora Collective Trust, a group of seven providers, is the Lead Provider for Healthy Families Rotorua.
 - All Healthy Families NZ Leadership Groups have representation of iwi and/or local Māori health providers. Links with Whānau Ora collectives are also strong in most locations.

- Visible political leadership supported Health Families NZ
 - From a National team perspective, Healthy Families NZ has been supported by the past and present Ministers of Health.
 - Within locations, local government is engaged. Councils are Lead Providers in two locations (one directly and one through a partnership arrangement). Local councillors are involved in some Leadership Groups, while others have senior Council managers involved.

- Workforce leadership extended the reach of Health Families NZ

¹¹ The Taitokerau Iwi Chief Executives Consortium is comprised of Te Runanga o Nui o Aupouri, Te Runanga o Ngai Takoto, Te Runanga o Te Rarawa, Te Rungaga o Whaingaroa, the Ngatiwai Trust Board and Te Runanga o Ngati Whatua.

- Through interviews, numerous examples were provided where individual members of the Healthy Families NZ workforce brought their existing networks and influence into the initiative, and could be seen as leaders within their own communities.

Challenges – themes from first view case studies:

- Understanding of the role of Leadership Groups has evolved
 - The Healthy Families NZ initiative intention for Governance Groups was to help steer the direction of the initiative and provide a mechanism for members to provide leadership within their own organisational and community spheres of influence to activate healthy change. At the time of the first view case studies, it was apparent there was mixed understanding amongst Governance/ Leadership Group members, and the workforce, about the role of leadership and actively championing prevention as opposed to traditional governance oversight of programmes. Most locations have subsequently changed the name of these groups from Governance to Leadership Groups.
- A shared understanding of the Healthy Families NZ initiative and systems change is evolving
 - At the time of first view case study interviews, a number of Leadership Group members, across locations, had only recently become involved with Healthy Families NZ. There was a general understanding of Healthy Families NZ and a systems change approach, but also variable language use and detail that suggests a full understanding is still developing.
- Engaging community leadership is an ongoing task
 - Whilst a number of key partners and leaders were engaged with Healthy Families NZ locations, engaging leaders within settings and communities is an ongoing task.

- Most Leadership Groups have members from diverse sectors. However, recruiting from sectors outside of health has been challenging in many locations.
- Having the Ministry of Health represented on Leadership Groups was perceived as positive. On the other hand, some tension between top-down direction and bottom-up control was evident.
 - A member of the national Healthy Families NZ team at the Ministry of Health participates in each location Leadership Group. As described in Section 2, the intention is to allow decision making at the local level, with authority for signing off Implementation Roadmaps and Action Budget expenditure sitting with the Leadership Group instead of the Ministry of Health. In most locations, there was some discussion of tensions arising from the Ministry of Health sitting at the Leadership Group table. However, having the Ministry of Health at the table was considered positive (see next section). The tension was described as managing expectations of the initiative and decisions on initial focus and direction between the Ministry of Health perspective, and multiple perspectives from local Leadership Group members.
 - Across participant interviews, it was common for examples to be provided where “the Ministry” were considered to be too directive, too dominating in Governance Group discussions, or blocking ideas from Healthy Families NZ workforce or leadership group members. From the Ministry of Health perspective, this was only when they considered the ideas did not reflect sustainable systems based approaches. In some cases, the tension could reflect differing ideas about what a sustainable systems approach is for a particular location.
 - While the Ministry of Health Healthy Families NZ team members saw their role as being just one vote at the table, this was not always the perspective of others within leadership groups. The simultaneous role as funders and contract managers could provide a perception that they had more sway than an equal single vote. While members of Leadership Groups were coming to

understand the Healthy Families NZ initiative, the Ministry of Health representatives were also perceived to have more knowledge of where and how the initiative could develop.

Observations post case study period:

- Locations transitioned from Governance Groups to Leadership Groups
 - In recognition of the leadership role expected of Governance Groups, most Healthy Families NZ locations have reviewed the Terms of Reference for these groups and changed the group's title to "Leadership Group". Healthy Families Far North are developing a regional leadership forum to complement the Taitokerau Iwi Chief Executives Consortium. Some locations have also adjusted their meeting format to increase discussion time amongst group members and to reflect on opportunities to utilise members' spheres of influence to activate local systems change.
 - Most locations have also gone through processes to change the representation of their leadership groups to target appropriate seniority of members across health and non-health sectors.

Relationships – building relationships with prevention partners across the system

Summary of tasks during first view case study period: building upon and establishing collaborative relationships and networks and developing a Prevention Partnership.

Successes – themes from first view case studies:

- Strong iwi relationships have been developed, particularly in those locations that are Māori led
 - Most locations indicated a high level of support from iwi. Four of the ten locations are Māori led, while two others have iwi as part of a Lead Provider collective.

- Relationships with the Ministry of Health were viewed as different to normal and mostly positive
 - Members of the National Healthy Families NZ team have a closer working relationship with Healthy Families NZ locations than was considered the normal 'arm's length' funder-provider relationship.
 - Most participants thought having a close working relationship with the national Healthy Families NZ team was a good thing. It allowed for challenging conversations to be had openly and regularly, which provided an opportunity for greater understanding of perspectives on both sides of the relationship.
- Locations that did not have competition for Healthy Families NZ contracts appeared to have fewer barriers to engagement
 - Responses to the Registration of Interest and subsequent Request for Proposal and tender selection process for Healthy Families NZ contracts varied across locations. Collaboration amongst providers in some locations meant that a single tender was put forward. In other locations, multiple tenders were submitted from different organisations.
 - Within first view case study interviews, and subsequent sensemaking sessions, locations that had multiple tenders for the Healthy Families NZ contract reported more difficulty engaging with organisations involved with rival tender bids. A success was for those locations where there was no competition for Healthy Families NZ contracts; they appear to have been more advanced in collaborative relationships during early establishment period.
- Good progress has been made on expanding networks of partner organisations and community leaders
 - A key focus of activity over the first view case study time period was making connections with organisations, community leaders and influencers, and

other health and social service initiatives. Healthy Families NZ workers who had been in position for some time at least, suggested that progress was being made on making such connections.

- Across locations there were numerous examples of the Healthy Families NZ workforce engaging organisations that have conventionally been on the outside of health promotion community networks. These include the local Chambers of Commerce, business owners, and leaders within the education sector.
- A Social Network Survey was conducted within eight of the ten Healthy Families NZ locations in 2016.¹² Tables 4 and 5 below show results for seven Healthy Families NZ locations¹³ to questions whether the communication frequency or closeness of working relationship had changed over the previous six months within their location.
- The results show that no location had a majority of responses indicating frequency of communication had decreased, with most having only a small number of 'decreased' responses. Four of the locations' most frequent response was 'increased' frequency of communication.
- Six Healthy Families NZ locations had 'closer' working relationships as the most common response.
- A notable exception to the increasing frequency of communication and closer working relationships was Healthy Families Spreydon-Heathcote, which had been having difficulty with leadership from the Lead Provider over a period in 2015 and 2016 and, related to this, with wider engagement.

¹² Organisations identified as within the 'Prevention Partnership' of each location were sent a link to a web-survey on communication and working relationships with other organisations in the survey.

¹³ Healthy Families East Cape responses are not shown due to less than five responses, while no survey was able to be conducted for Healthy Families Manukau, Manurewa-Papakura at the time the survey went into the field.

Table 4. Change in communication frequency within Healthy Families NZ locations in previous six months

Location	Increased	Decreased	Stayed the same
Far North	10	1	1
Waitakere	6	0	4
Rotorua	5	2	8
Whanganui Rangitikei Ruapehu	10	0	8
Lower Hutt	9	1	5
Spreydon-Heathcote	6	6	10
Invercargill	16	2	16

Table 5. Change in working together relationship within Healthy Families NZ locations in previous six months

Location	Closer	Stayed the same	Further apart
Far North	9	2	1
Waitakere	8	2	0
Rotorua	8	5	3
Whanganui Rangitikei Ruapehu	11	6	0
Lower Hutt	10	5	0
Spreydon-Heathcote	7	10	5
Invercargill	19	12	2

Note: Further detail on the Social Network Survey can be found in Appendix 3.

- Past public health programmes provided a starting point for Healthy Families NZ
 - Interviewees often discussed past public health programmes in the four health target areas, in particular, the nutrition and physical activity focussed Healthy Eating – Healthy Action Strategy (2003-2010). In some locations networks and resources developed under that strategy were still in place and could be built upon by Healthy Families NZ.
 - This success has a related challenge: Experiences with past public health programmes influenced perceptions of Healthy Families NZ. Numerous interview participants recalled experiences where programmes had ended early. This caused damage to communities and the public health workforce in the past. The impacts of these past experiences on the establishment of

new relationships ranged from cautious engagement with Healthy Families NZ, through to more obstructive scepticism.

- Perceptions of Lead Providers' strengths and limitations acted as enablers or barriers to relationships
 - Lead providers all had existing networks and relationships upon which Healthy Families NZ could build.
 - This success had a related challenge: There were multiple examples of Lead Providers in one sector, such as Regional Sports Trusts, having trouble engaging with organisations in another sector, such as health promotion. This difficulty was due to a lack of existing relationships and trust.

Challenges – themes from first view case studies:

- Translating engagement with iwi and Māori led provider organisations into partnership actions has been challenging
 - For those locations not iwi or Māori led, workers recognised that an ongoing process was required to turn engagement and support into productive relationships on activities.
- A lack of guidance on Prevention Partnerships development resulted in uncertainty
 - Establishing a Prevention Partnership is included in the Healthy Families NZ service contracts, however the specifics of the partnership groups was expected to vary according to the needs of different locations. At the time of first view case studies, several locations were unsure of how they would proceed with the Prevention Partnership. Having said this, a couple of locations were clear about the Prevention Partnership in their location.
- Exclusion of District Health Boards as Healthy Families NZ Lead Providers created tension
 - According to the tendering documents, the preference was to utilise the capability of the NGO sector. District Health Boards and Public Health Units (PHUs) were therefore not permitted to respond to the Healthy Families NZ

tender process. Some DHBs and PHUs have shown strong support, however in some Healthy Families NZ locations there appears to have been reluctance from units within DHBs and PHUs to engage with Healthy Families NZ teams. One perception of this reluctance was due to the initial exclusion from the tendering process, as opposed to previous initiatives like HEHA, where DHBs had played a lead role in implementation.

- Large geographic areas created practical challenges for engaging partners
 - A practical barrier to engaging with potential partners was noted by people working in large geographic areas. Considerations were travel time and how this impacts on frequency of contact.
 - All Healthy Families NZ locations also had to make practical decisions on when to engage with partners outside of their contracted geographic boundaries.
- The competitive contracting environment created tensions in some locations
 - Participants noted that the competitive contracting environment could create barriers to organisations collaborating on projects and within networks with the local 'prevention system'.
- Different contract goals and expectations among organisations could create barriers to collaboration at both local and national levels
 - Other organisations' more defined contract specifications and programme priorities could constrain their engagement with Healthy Families NZ activities. This issue was identified through interviews, but more strongly articulated by location teams during several sensemaking sessions.
 - A related theme was that Healthy Families NZ has a different pace of working than some partner organisations due to the different style of programmes and initiatives being implemented. This created a challenge to find the spaces where the momentum of each organisation allows collaboration.

- Lack of alignment of contracts with the Ministry of Health could create work for Lead Providers
 - Organisations could have multiple contracts with the Ministry of Health. Expectations and reporting requirements for Healthy Families NZ did not always align with these other contracts. For example, other contracts use Results Based Accountability (RBA¹⁴) for monitoring and reporting (Healthy Families NZ does not).
 - Another theme identified in several locations was the impact of multiple programme contracts for physical activity, nutrition, tobacco control and alcohol harm minimisation within a location. The systems change focus of Healthy Families NZ identified potential to better align these activities, which could involve aligning the contracted programme expectations.
 - The National Healthy Families NZ team within the Ministry of Health considered they had an important role to play in working within the Ministry of Health to increase alignment between Healthy Families NZ and other public health contracts. They had been working to align contracts across the Ministry of Health, and initiated a formal project across the Public Health Group to increase the connections across portfolios.
- Tensions in some locations following the Healthy Families NZ tender process made collaboration harder
 - We noted under success themes that locations with no competition for Healthy Families NZ contracts had a head start in collaborative relationships. However, in locations where there were multiple tenders, interviewees reported some unsuccessful organisations were reluctant to engage with the initiative.

¹⁴ <http://www.health.govt.nz/about-ministry/what-we-do/streamlined-contracting/results-based-accountability>

- The long establishment phase of Healthy Families NZ in some locations negatively impacted on perceptions of the initiative and willingness to engage with it
 - A cross-cutting theme emerging from the identified challenges was that Healthy Families NZ had a long establishment phase after contracts were awarded. The establishment phase of recruiting staff, mapping and stocktaking the prevention system, building relationships and developing communication tools appeared to generate negative impressions that locations were not doing much. This impression needed to be addressed in engaging organisations.
- Scepticism of a 'new' systems way of working impacted perceptions of Healthy Families NZ
 - Healthy Families NZ was identified as a 'new' way of working in public health and health promotion. Multiple interview participants suggested the branding of 'new' was met with scepticism from some who viewed Healthy Families NZ as a rebranding of existing health promotion approaches.
 - The 'new' in the narrative also implied 'better', which challenged some of the organisations Healthy Families NZ were seeking to work collaboratively with.
- People working in the initiative found communicating the Healthy Families NZ approach and purpose challenging in the beginning
 - Clearly communicating what Healthy Families NZ intended to achieve, and what a systems-based approach looks like in practice, was an early challenge. In the early stages, location teams could not refer to any examples of Healthy Families NZ work to help explain their approach.
 - Mainly due to the initiative's name, there has been widespread misunderstanding that Healthy Families NZ is about individual behaviour change or programme delivery to families. The disconnect between the name and the purpose of the initiative has in some cases made communication more challenging for location teams.

- During the case study period, the brand guidelines and collateral such as the Healthy Families NZ video and website were developed. These appear to have been positively received.
- Tensions about engaging with food and alcohol industries emerged for workforce and Leadership Group members
 - In several locations, tension was expressed by some workforce and Leadership Group members about engaging with private sector food and alcohol industry organisations. Some questioned whether engagement should occur (particularly with alcohol industry), while others considered change might occur through engagement.
- Participants noted tension between the top-down priorities of the Ministry of Health, and the bottom-up community driven approach
 - At the time of first view case studies, Healthy Families NZ locations were conducting a stocktaking and mapping exercise of their 'prevention system'. The stocktaking and mapping exercise itself acted as a prompt for engagement and identifying opportunities for action relevant to locations. At the same time, the National Healthy Families NZ team were pushing for additional activities they thought were good opportunities for locations. For example, supporting the 'water only' policies in schools when this was announced by the Ministry of Education. Multiple participants across locations noted this tension between top-down Ministry direction and bottom-up identification of activities.

Observations post case study period:

- The workforce described positive perceptions of relationships in their locations and said engagement continued to strengthen
 - From regular phone interviews with Healthy Families NZ location Managers and the sensemaking sessions on the first view case study, there appears to

be a general perception that the number of relationships continue to grow and existing relationships are strengthening.

- Across most locations, members of the workforce described an increasing number of approaches from other organisations to be involved in the work. They reflected that during the earlier establishment phase they were asking organisations to collaborate, but this has now turned around to people often approaching Healthy Families NZ teams.
- It's become easier to communicate the purpose and systems approach of Healthy Families NZ with more experience
 - The workforce described being more comfortable in communicating the Healthy Families NZ initiative aims and systems change approach. More examples of action were developing to aid this communication.
- The workforce reflected that they have moved from the establishment phase to greater action
 - Sensemaking sessions on the first view case studies in locations occurred between October and December 2016, about a year after the majority of case study interviews were conducted. A common response from location staff members, after reading the first view case studies, was to note how long ago they seemed and how much has changed.
- Collaboration focused on specific projects was often easier than establishing unfocused collaborative relationships
 - While some locations had established collaborative networks that aid engagement of leadership across sectors, most locations talked about strengthening collaborative relationships based around particular projects or activities. Strengthening relationships through project focused work suggests that relationships could be stronger after locations move out of the establishment phase of implementation.

Resources – Allocating resources to effect sustainable change

Summary of tasks during first view case study period: developing resources to support the work of Healthy Families NZ locations and using location Action Budgets.

Successes – themes from first view case studies:

- A suite of communication tools were developed in consultation with Healthy Families NZ locations during 2015. Brand guidelines were released in May, Communication resources for location Managers in August, a video to support engagement in September 2015, and a national website in October.
- An Education Settings Guide and a Workplace Setting Guide developed by the Health Promotion Agency for Healthy Families NZ workforce was released in December 2015.
- During the first view case study period, only a couple of activities supported by the Action Budget had been approved by location Leadership Groups. There was not enough experience with the Action Budget to comment on its effectiveness.

Challenges – themes from first view case studies:

- A lack of guidance to support location activities hampered development
 - In interviews, location team members expressed some concern that each Healthy Families NZ location were developing their own approach to their work. It was felt that greater guidance and resources for activities such as stocktake and mapping, workforce development, communication, and engaging settings were needed. Having said this, participants also acknowledged that there is a tension between standardised resources to support locations' work, and allowing each location to develop in ways relevant to their communities and priorities.
- The workforce had difficulty getting Action Budget items approved by location Leadership Groups

- There was initially little guidance provided to locations on what types of actions were appropriate for support through the Action Budget. Consequently, it took some time before location teams could develop their work enough to decide how best to spend the Action Budget. Interview participants across several locations discussed ideas for using the Action Budget that had not been approved by the location Governance Group.
- Confusion about bringing existing settings-based programmes under one umbrella (similar to the Achievement Programme in HTV)
 - As stated earlier, the Health Promotion Agency (HPA) was contracted by the Ministry of Health to undertake this work. Following consultation with the 10 Healthy Families NZ locations and a range of key stakeholders including those delivering key settings-based programmes, the Ministry decided that bringing programmes under a single umbrella would not be feasible. As an alternative, the Ministry developed guides to support the workforce in engaging with education and workplace settings. In itself, this decision is an example of the adaptive nature of Healthy Families NZ. The challenge for locations was that because they did not have a settings-based Achievement Programme to deliver, there was some initial confusion about how to approach different settings, and what resources would be required.
- The Healthy Families NZ initiative was perceived to be under-resourced
 - Whilst a significant investment, many interview participants identified areas where they thought Healthy Families NZ was under-resourced. One of these areas was the National Healthy Families NZ team within the Ministry of Health who were expected to have a high level of engagement with locations, produce resources for locations, provide national workforce development, and support the initiative by influencing systems at a national level and aligning investment in prevention. Some comments were also made about the small size of the Action Budget compared to the spend on workforce. As articulated by one participant, this perception was informed by comparing the money that had previously been available for local purchasing of services

and projects under the HEHA Strategy, which had a significantly larger budget.

Observations post case study period:

- More resources, tools and guidance became available for locations to use after the establishment phase. For example, the Action Budget decision support tool (March 2016), and the Healthy Families NZ Principles for Engaging with the Private Sector (May 2016). Locations have shared resources as they have developed them, particularly through the Managers' network of practice.
- Reflecting back on the first view case studies, people in many locations felt staff time was a critical resource. Often, their work did not need additional resources from the Action Budget.
- However, more examples of how the Action Budget could be used were developing across locations.

Knowledge and Data – capturing and feeding back

Summary of tasks during first view case study period: understanding the local context for action through stocktaking and mapping programmes, organisations, networks, health needs, community strengths and opportunities.

Successes – themes from first view case studies:

- Locations appreciated flexibility in the approach to the stocktaking and mapping exercise
 - Each location approached the stocktake and mapping exercise differently. This allowed locations to apply their perspectives and values to the exercise. For example, Healthy Families Whanganui Rangitikei Ruapehu wanted to avoid a deficit framing of health inequalities, while Healthy Families Manukau and Manurewa-Papakura used a community insights approach.

- Across all locations, the results of the stocktake and mapping appeared to inform activities. In particular, they fed into the development of Roadmaps for each location.
 - People in several locations reported that the act of collecting information was a helpful focus for initial engagement with partner organisations. Presenting findings of the stocktake and mapping was also reported as a useful engagement tool.

Challenges – themes from first view case studies:

- Lack of guidance to direct the purpose and focus of stocktaking and mapping was difficult for some locations
 - Most locations thought the stocktake and mapping exercise was a significant amount of work, at a time when few staff were in place.
 - For the National Healthy Families NZ team, providing guidance on the scope of the mapping and stocktake was difficult because of the limited planning time available to them. The timing of the stocktake exercise was awkward because it had to be done early for locations to understand their prevention system and it also had to link with the evaluation process which was still in development.
 - Locations looked widely for data in the stocktake and mapping exercises. On reflection, people in several locations said they did not use all the data they had gathered. More guidance on the purpose of the stocktaking and mapping exercise could have focused the activity.
- Location specific data wasn't always easy to find
 - In several cases, Healthy Families NZ location geographic boundaries do not easily map against Territorial Local Authority or Statistics New Zealand or District Health Board boundaries. This made accessing data specific to their geographic location difficult.
- People were uncertain about the focus of monitoring and evaluation, how to define success, and what needed to be reported

- People wanted to ensure the work within locations was captured to inform monitoring and evaluation. However, during the first view case study period, little guidance was available on what monitoring and evaluation would entail as this was still under development.
- People were uncertain about how to attribute any health changes to Healthy Families NZ and the appropriateness of attribution in collaborative working
 - Within collaborative approaches to working, and with a complex systems perspective, there was confusion about how to attribute success. People worried about the potential impact on maintaining collaborative relationships if Healthy Families NZ was seen to be taking credit for success.

Observations post case study period:

- On reflection during sensemaking sessions, many staff saw the stocktaking and mapping exercise as difficult, but overall worthwhile. Notwithstanding this, greater guidance and national support to access location specific data were identified as possible improvements.
- The question of how to attribute success to Healthy Families NZ within a collaborative systems approach is still regularly asked. A focus on contribution rather than attribution is being articulated through the evaluation framework.

Other identified themes outside of Building Blocks for a Strong Prevention System

The following themes did not fit specifically under single Building Blocks, but were identified from the case studies as important for implementing Healthy Families NZ.

Communication

As noted above, people found it challenging to explain Healthy Families NZ and a systems change approach during the first view case study period. The name 'Healthy *Families* NZ' was problematic, as 'families' implied a focus on individual families rather than change within community settings and wider system change. The name also confused the distinction between Healthy Families NZ and Whānau Ora.

Lead Providers

Working towards being a health promoting workplace is a requirement in service contracts with Lead Providers. The Healthy Families NZ teams in some locations noted a positive impact on the culture and way of working within their Lead Provider organisation.

The interaction of local action and national policies

There is a perception that local action will only achieve so much in the absence of supportive national policies and regulation. On the other hand, some interviewees noted that local initiatives could build support to influence national policy action.

Social Determinants of Health

Some interview participants questioned why the focus of Healthy Families NZ was not on the wider social determinants of health drivers of chronic disease. To achieve action on the four target health areas, action on wider social determinants of health is also needed (e.g. housing, income, employment, access to health care). Location team members maintained an awareness of the interlinking health and wellbeing issues (including mental health and deprivation) that influenced the four target areas. There appear to have been some differing understandings within the communities surrounding Healthy Families NZ locations about why the four target areas had been chosen.

How the guiding Principles have been reflected in implementation

Along with the Building Blocks, the guiding Principles are an important element of the Healthy Families NZ approach as they are intended to guide decision making and action at all levels, and help to ensure integrity to a sustainable, systems-based approach to prevention. Through the case study development, it was clear the Principles were considered an integral part of the initiative by those involved, although there were differences in how the Principles were understood. The discussion below is less on these different understandings, and more on how the Principles have been reflected in the implementation of the initiative.

The Healthy Families NZ Principles

Implementation at Scale

Definition: Strategies being delivered at a scale that impact the health and wellbeing of large numbers of the population in the places where they spend their time – in schools, workplaces and communities.

- The examples of actions since 2016 (Appendix 4) shows that there are initiatives underway in settings across all the locations that have the potential for reaching large numbers of the population. Many are building upon existing initiatives, and some new initiatives have also been developed. Settings with example activities included in Appendix 4 include: marae, education, workplaces, events, sports clubs, and churches.
- In support of this focus on settings, in most locations, responsibility for specific settings have been allocated to certain staff members. There was also a growing recognition within the workforce that their role is to be facilitators and influencers, fostering relationships and connecting organisations so that opportunities for others to lead healthy change can be identified and supported.
- There is evidence that boundaries are being extended. Although each location has a defined geographic boundary for their activities, all locations viewed their geographic

reach as wider than this. For example, all locations reported operating outside their specified geographical boundaries when dealing with communities or other organisations who operated within different geographical boundaries – such as iwi and DHBs.

- Boundaries were also being extended in how the initiative was conceptualised – this was seen in the shift towards influencing systems change, and extending population reach, rather than the workforce delivering discrete programmes. A common phrase heard in key informant interviews was that Healthy Families NZ was not “traditional health promotion”.
- The focus on a systems approach was seen differently from different stakeholder perspectives. Healthy Families NZ is unusual for its multi-risk factor, multi-setting, whole of community focus and its degree of local responsiveness. Historically in New Zealand there have been initiatives that, while not being explicitly focussed on systems, take a similar multi-level, multi-factorial approach, albeit with a narrower focus in terms of risk factors and less flexibility in terms of the implementation approach. Examples over the past 15 years include the Intersectoral Community Action for Health (ICAH) projects and the Healthy Eating Healthy Action (HEHA) policy initiative. Equally, current initiatives focused on settings often include an underpinning systems approach. Whether Healthy Families NZ was seen as ‘old wine in new bottles’ or a new approach and opportunity seems to have impacted on the enthusiasm with which some partner organisations have engaged.
- Focusing on the four key risk factors for chronic disease at once meant that Healthy Families NZ had a broader scope than many organisations delivering health promotion programmes tended to have. This broader focus has enabled the workforce to collaborate with a wider range of partners and to encourage a comprehensive approach to health and wellbeing.
- That said, the four target health areas—reducing smoking, increasing rates of physical activity, improving nutrition and reducing alcohol related harm—have placed boundaries around ‘legitimate’ activities for Healthy Families NZ staff. However, one ‘tag line’ for the initiative is, “All of us leading healthy change in the places we live, learn, work and

play”. A number of key informants considered the tag line extended boundaries to include wider social and economic determinants of health, and other health service areas such as mental health and oral health.

- The National Healthy Families NZ team has been creating opportunities for national opportunities that can be taken up by the locations. For example, being actively involved in the development of an online workplace wellbeing initiative that will be available to businesses nationwide.
- There is clear recognition of, and consequently a strong focus on, the role that activating community leadership plays in creating change at scale.
- Trust within relationships was viewed as either a facilitator or barrier to moving to scale.

Collaboration for Collective Impact

Definition: Long term commitment is required by multiple partners, from different sectors, at multiple levels, to generate greater collective impact on the health of all New Zealanders.

Knowledge is co-created and interventions co-produced, supported by a shared measurement system, mutually reinforcing activities, on-going communication and a ‘backbone’ support organisation.

- We found significant commitment to achieving collective impact from multiple sectors through engagement in leadership initiated through Healthy Families NZ.
- A lack of alignment of contracts nationally was recognised as a barrier to collective impact. The National Healthy Families NZ team identified the need to increase alignment in public health contracts and are actively working across the Ministry of Health to improve alignment of investment and service commissioning approaches. The competitive contracting environment also created some barriers to relationships, as did the different cultures and pace of working for organisations who were subject to different contracting mechanisms.
- Collaborative projects have been supported across locations with use of co-design approaches.

- There was an increasing recognition from within the workforce of their role as facilitators towards achieving greater collective impact.
- Shared measurement and understanding of success is a challenge. There were stories of some potential partner organisations being reluctant to engage, concerned that their work would be claimed as a Healthy Families NZ success. In a similar way, a number of comments from Healthy Families NZ staff noted the tension between defining success as belonging to Healthy Families NZ, whilst working collaboratively. The workforce at times encountered the perspective that they were “intruding on others local turf”. Competitive contracts, contractual priorities and who gets credit for success impacted cooperation between organisations.
- Over time, communicating achievements and successes has become more of a priority for most of the locations. However, key informants spoke of tension between media attention and stories that highlight Healthy Families NZ role in activities, and the role that the teams have in being facilitators of change and promoting the activities and leadership of others.
- Working with what already exists locally increases collective impact. In some Healthy Families NZ location areas, the response to the RFP was driven by an existing collective structure. These existing collaborations seem to have been useful in mobilising leadership within these structures. An example is Rotorua, where an existing Whānau Ora collective has been used to develop Healthy Families Rotorua and appears to have sped up initial implementation. In contrast, other locations had lingering tensions in organisational relationships where the tender process had been more competitive.

Adaptation

Definition: Strengthening the prevention system requires constant reflection, learning and adaption to ensure strategies are timely, relevant and sustainable.

Adaptation of the initiative was apparent at three levels. First, the initiative as a whole has adapted to changing information and the New Zealand context. Second, the initiative has adapted to fit the local context (for example additional principles in Healthy Families East

Cape). Third, small ongoing adaptations and refinements of activities were implemented to achieve impact.

- The contracts and reporting requirements of Healthy Families NZ are less prescriptive than conventional contracts, and allow adaptation and flexibility. Underspent resource was directed back into the initiative where it was deemed appropriate by the locations, with approval from the Ministry of Health.
- The guiding Principles and Building Blocks were adapted from HTV to better suit the New Zealand context. Other reflections and adaptations from Healthy Together Victoria involved mix of workforce funded.
- Challenges arose with the Lead Provider in Christchurch. Instead of the initiative in Christchurch being completely undone, a robust negotiation occurred between the Ministry of Health and a new provider. This resulted in all of the Christchurch Healthy Families NZ team shifting to the new provider, retaining the 'institutional' knowledge that had been built up.
- As time went on, the nature of the workforce evolved, with changes in job titles and the mix of roles across the locations.
- The flexibility in Healthy Families NZ has enabled Māori led locations to adapt their approach to suit their populations. For example, Healthy Families Whanganui Rangitīkei Ruapehu felt that their organisational values and principles of operating were more useful to guide day to day work than the Healthy Families NZ Principles. Healthy Families East Cape has added two Principles (Whakapapa and Mātauranga) encapsulating more of a Māori worldview. Healthy Families Far North was considering doing the same. Healthy Families Far North and Whanganui Rangitīkei Ruapehu also have a strong focus on traditional tribal rohe rather than narrower geographical areas.
- Activities for staff in locations were not tightly specified within service contracts on purpose, which meant there was a process required to define operational space. Through the stocktaking and mapping exercise, locations began to identify areas that were well covered with existing programmes and other areas where there was an opportunity to fill a gap or coordinate activities. As relationships developed and

activities progressed, this process of defining operational space appears to be an ongoing negotiation.

- Locations were using reflective practices and tools within their work to learn from and adapt their activities. They were still working out ways to better integrate and systematise these practices. The implementation of developmental evaluation processes across the locations was on-going. This was impacted by a delay in when evaluation training was delivered to the locations.
- There were different perspectives on ability to adapt. One perspective is the flexibility of Healthy Families NZ is an important feature for working collaboratively, when others may be more constrained. Another perspective identifies some tension in establishing collaborative relationships due to differing dynamics of organisations with different delivery models.

Experimentation

Definition: Small scale experiments provide insight into the most effective interventions to address chronic disease. These experiments are underpinned by evidence and experience, and monitored and designed to be amplified across the system if they prove effective.

- Experimentation, linked to adaptation, is evident in many activities undertaken across locations. These are not formal controlled and tightly evaluated experiments, but a mind-set of trialling an approach together with people. This could include, for example, a co-design process with an individual school, reflecting on this, iterating and adapting for further roll-out.
- There was common discussion about the idea of 'safe to fail' experiments, and some evidence of different understandings of the Ministry of Health guidance among locations of what 'safe to fail' experimentation meant. Local team members questioned, 'safe' for whom? Some did not consider that it would be safe for them to propose ideas that failed, thus affecting their reputation and their community's willingness to engage in future.

Leadership

Definition: Leadership is supported at all levels of the prevention effort including senior managers, elected officials, and health champions in our schools, businesses, workplaces, sporting clubs and other settings in the community.

- There is clear evidence that leadership has been prioritised at both the local and national level.
- Understandings of leadership have evolved. Related to this is the transformation of traditional governance oversight into active leadership within spheres of influence. Evidence includes the evolution from Governance Groups to Strategic Leadership Groups, in most locations, and the range of senior organisational participation from local leadership across the country.
- Workforce development in leadership has been prioritised, with Managers and some staff being supported to apply and undertake Ministry of Health funded public health leadership training. Leadership training has also been incorporated as part of the National Healthy Families NZ hui.
- The intention to support and grow leadership was strong both nationally and locally. This intention of supporting leadership created an atmosphere where there was a constant, and robust, negotiation between top-down and bottom-up priorities, actions, and decision-making.
- Significant iwi leadership is apparent within a number of the locations. For example, Healthy Families Far North's relationship with the Taitokerau Iwi Chief Executives Consortium. There is also participation of iwi and Māori organisations and leaders within the leadership groups of other locations.
- Interview participants recognised the need for high-level policy development to support local-level efforts to create change. Local leaders were very aware of the need for and value of national-level policy leadership on the issues they were addressing locally.

Equity

Definition: Health equity is the attainment of the highest level of health for all people.

Healthy Families NZ will have an explicit focus on improving Māori health and reducing inequalities for groups at increased risk of chronic diseases. Māori participation at all levels of the planning and implementation of Healthy Families NZ is critical.

- The locations within Healthy Families NZ initiative were selected in large part because of equity considerations.
- The workforce recruited is diverse with substantial numbers of Māori and Pacific ethnicities amongst staff employed. There have also been attempts to match staff with significant populations within locations, such as recruiting South Asian staff in Healthy Families Manukau, Manurewa-Papakura.
- A tension exists between the initiative focus on the four priority health areas and the need to address the underlying determinants of health. In some locations, the need to focus on determinants such as water quality, housing and employment were perceived as barriers to substantial progress. For example, in East Cape and the Far North, there is tension around promoting 'water only' when water quality in general is not good.
- The adaptive nature and flexibility of the initiative has allowed for models and frameworks expressing a Māori world view and values to be applied to the initiative.
- A systems approach of prioritising interrelationships is viewed as more consistent with Māori world views than more programmatic and output-focussed government funded approaches. Those Healthy Families NZ locations located within iwi and Māori organisations have given particular thought to the relationships between Whānau Ora and Healthy Families NZ.
- There is significant iwi leadership and ownership through the Lead Providers in some locations as well as through engagement with appropriate groups from other locations.
- Through the stocktaking and mapping activity, locations have attempted to identify areas of multiple equity challenges as well as particular communities that they need to engage with.

- All locations expressed equity was a high priority for them.
- The consideration of equity was different for those locations which were iwi and Māori-led than those that were not. Māori led locations expressed equity considerations as “it is just the way we do things”. Other locations were aware of needing to more actively bring a Māori and an equity lens to their work.

Line of sight

Definition: Transparency in how investment in policy is translated into measured impacts in communities – ensuring best value from every dollar spent on prevention.

- Location team members had ongoing questions and uncertainty about how to monitor and evaluate activities within locations, and how to attribute change to Healthy Families NZ.

Overarching themes

From the previous descriptive analysis against Building Blocks of a strong prevention system and guiding Principles for system-wide change, eight cross-cutting themes have been developed. These capture the overarching observations of the early implementation phase of Healthy Families NZ. We draw lessons from each theme to inform the on-going work of Healthy Families NZ locations and the National Healthy Families NZ team. These lessons could also provide insight for other large-scale initiatives seeking to make an impact on complex social challenges in New Zealand.

These themes are:

- building the plane while flying it
- negotiating boundaries
- balancing top-down/bottom up decisions and actions
- working with a hands-on National team
- getting to grips with systems thinking and acting
- emphasising leadership
- enabling Māori ownership and leadership
- making equity an integral part of the initiative.

Theme 1. Building the plane while flying it

Large initiatives like Healthy Families NZ will necessarily have a planning and establishment stage. One of the more significant challenges for both locations and the National Healthy Families NZ team was trying to design and plan the initiative at the same time as having strong expectations to show action and progress towards achieving their goals. In practice, the establishment phase lasted about a year. In this time, locations recruited the full workforce, built staff capacity, undertook extensive mapping and stocktaking, built relationships with key stakeholders, planned activities, and established community

presence. The National Healthy Families NZ team supported and provided guidance to locations. It was not until the beginning of 2016 that the majority of the locations were in a position to focus strongly on the initiative goals.

Impact of theme: Judgement about progress made at the end of the current contracts in mid-2018 will need to take into account the considerable establishment phase.

Lesson: The establishment phase was necessary to set up the new teams within Lead Provider organisations. When implementing a new, intentionally complex policy initiative, we should expect an iterative and involved establishment phase.

Theme 2. Negotiating boundaries

The intention of Healthy Families NZ to allow for adaptation creates an expectation that priorities for action will shift as the initiative evolves. This expectation means that Healthy Families NZ teams are regularly negotiating the boundaries of their work. This includes evolving perspectives of what the 'prevention system' includes for their community, the partners they work with and even the geographical boundaries within which they work. Having the 'space' and a permissive environment to negotiate boundaries of different kinds in a timely way has been an important feature of the implementation of Healthy Families NZ. Mechanisms that have facilitated this permissive environment include having the Ministry of Health on the Leadership Groups as well as performance monitoring approaches that are narrative and context-rich, rather than requiring standardised measures. Facilitation and negotiation skills of the workforce are also important.

Impact of theme: The Healthy Families NZ teams' ability to negotiate boundaries has facilitated their ability to adapt to local environments and changing contexts.

Lesson: An explicit intention to allow for adaptation is important for enabling local responsiveness. Ensure spaces for negotiation remain.

Theme 3. Balancing top-down / bottom-up decisions and actions

As is usual in policy implementation, tensions existed between top-down direction and community-led action. To an extent, these tensions are seen as inevitable for nationally-contracted, locally-delivered initiatives. Healthy Families NZ involved a new way of contracting, with a systems focus geared towards a more adaptive and less directive approach.

The relationships between the Ministry of Health and the locations have oscillated between being positively and negatively framed by those involved. Overall, however, the relationship between the National Healthy Families NZ team and the locations appears to have been close and responsive. This style of interaction enables the relationship to continue even when significant challenges arise.

Impact of theme: Tensions between perspectives will occur, however, the initiative includes mechanisms to respond constructively to both opportunities and challenges.

Lesson: Explicitly recognise there will be tensions between top-down and bottom-up perspectives and include mechanisms for responding in a timely manner to both opportunities and challenges.

Theme 4. The role of National team as part of the initiative

A feature of the initiative has been the role of the National Healthy Families NZ team. They are expected to play an active leadership and coordination role in Healthy Families NZ. Consequently, the National Healthy Families NZ team view themselves as part of the initiative rather than external contract managers. There is an explicit recognition that the National Healthy Families NZ team's relationships, actions and responses will impact local activities and local success. For example, at a national level, the Ministry of Health can influence key systems such as the food industry, workplace/business systems and education, all of which impact at a local level. The National team have also connected Healthy Families NZ to other policy initiatives like the Childhood Obesity Plan.

Impact of theme: The National Healthy Families NZ team members actively support locations by influencing key systems at a national level (through, for example, engaging with other Government departments and key national-level stakeholders). The National Healthy Families NZ team also help facilitate alignment with other nationally-contracted, locally-led initiatives, both Ministry of Health funded and non-Ministry of Health funded.

Lesson: Traditional, hands-off contract management practices may not always be appropriate. Hands-on, active engagement by the funder can enable systems change – through influence on national level activities as well as on local activities.

Theme 5. Getting to grips with systems thinking and acting

A big challenge for the workforce, the Lead Provider organisations, and Leadership Groups was understanding how systems change and implementation at scale (how locations can influence a large proportion of the population) differ from traditional health promotion approaches. We have observed an evolution in how the workforce understands systems thinking. Given the different approach that focussing on systems change requires, some communities were sceptical about the value of the initiative during the establishment phase. This scepticism appeared to come more from health sector organisations than other sectors.

Impact of theme: The systems approach underpinning Healthy Families NZ requires a significant shift in ways of working. Challenges inherent in this shift, and the way the approach is understood, have contributed to the longer establishment phase.

Lesson: Work to increase capacity and capability at all levels to communicate what systems approaches involve and challenge barriers to new ways of working.

Theme 6. Emphasising leadership

Empowering both local and national leadership – including iwi and Māori ownership and leadership – has been a strong intentional focus and area of activity. This is reflected in the National Healthy Families NZ team’s priorities and in the location teams’ reported activities,

as well as in the Leadership Group members' growing understanding that their roles were to focus on leadership rather than governance. The representation of a broad range of different sectors on Leadership Groups, including those outside of the health sector, has created opportunities for teams to collaborate with key influencers in priority settings.

Impact of theme: Empowering leadership for prevention creates potential for increased collective impact and population reach, as well as potential for advancing equity issues.

Lesson: Build commitment of community leaders and influencers to create healthy environments and support them to get involved in creating systems change. Recognise that fostering outward focussed community leadership serves a different function than having leaders in a governance role.

Theme 7. Enabling Māori ownership and leadership

Flexibility within the tendering approach for selecting Lead Providers has enabled iwi in Far North, Whanganui Rangitīkei Ruapehu, and East Cape to take leadership roles. The Lead Provider in Rotorua is also Māori-led. A conscious focus on Māori communities and continuing engagement of leadership is evident in all locations, including those where the providers are not Māori-led.

Impacts: The workforce and Leadership Groups both incorporate considerable Māori participation, and Māori perspectives are actively sought.

Lesson: The design of Healthy Families NZ has allowed local responsiveness, and ensured Māori are prioritised, creating the potential for action on Te Tiriti o Waitangi principles.

Theme 8. Making equity an integral part of the initiative

Equity considerations are part of the initiative as a whole (through the Healthy Families NZ Principles), and a local priority. Allowing flexibility and adaptation has created room for diverse worldviews, including Pacific cultures, religions, youth and, in particular, Māori perspectives. Healthy Families NZ teams have consciously attempted to match workforce and activities to significant communities within locations with already significant health and social inequalities.

Impact: The structure of Healthy Families NZ has created the potential to achieve greater equity within the selected locations.

Lesson: Flexibility to address local equity issues may be supported by explicit focus on equity within initiative design, enabling local responsiveness to particular social and ethnic groups who experience health inequalities.

5. Summary conclusions

Overall, our findings suggest Healthy Families NZ is a promising approach which has been implemented with integrity to its intention and purpose. The key features of the initiative, as directed by the Building Blocks of the prevention system, have been, for the most part, successfully put in place. The guiding Principles have helped focus on activities that are more likely to achieve systems change. Part of the journey has involved an evolution in the location teams' understanding of what systems change is. This understanding informs their actions and their ability to communicate about the initiative more widely and effectively.

Two significant on-going processes of the initiative include the requirement for local adaptation and the role of the National Healthy Families NZ team in influencing their own areas of practice. So far, the findings show there has been an emphasis on local adaptation, which has resulted in the location teams being able to tailor the initiative to local cultural and environmental circumstances. This is evidenced by the variation in how location teams are organised and also by the diversity of activities undertaken. The National Healthy Families NZ team also has an ongoing and close relationship with locations that contributes to local adaptation. Furthermore, the National Healthy Families NZ team themselves have actively engaged with their own areas of system influence by working for the greater alignment of relevant national policies and initiatives.

The findings also suggest that it was important to consider the organisational contexts within which the initiative was being implemented. A significant strategy in the planning of the initiative was to open up the tendering process so any locally embedded NGOs could apply to be Lead Providers, regardless of whether they were part of the health sector or not. Thus, it was intended at the outset to choose the organisation best placed to lead a

transformational change effort within their community. Consequently, there are a high proportion of Māori Lead Providers and other non-health sector organisations involved. The impact of expanding health promotion action to prevent chronic disease outside of traditional health organisations will be explored further as the evaluation progresses.

Key reflections on recent activities

Since the data for the first view case studies was collected (November 2015 to March 2016), the recruitment of the workforce within Lead Provider organisations has been successful overall. There have been and remain some challenges, but largely the workforce is well supported and engaged. The evolution, and deepening understanding of systems change, within the Leadership Groups have given them greater focus and purpose. Shifting the mind-set of influential community leaders from enacting a governance function to enacting outward-looking systems change has taken time. However, examples are emerging of how this change in function can be fostered and implemented. It is also clear that there has been a leap in the numbers of activities Healthy Families NZ teams are involved in across the locations starting from early 2016. Most locations have now consolidated their stakeholder relationships, as well as their own purpose, and are collaborating on substantial activities within their communities.

Next Steps

The **next step** in the evaluation of Healthy Families NZ is completing the second round of data collection which will begin in September 2017. This data will inform both the second view case studies and the systematic comparative analysis using QCA. The findings of both the *thematic* comparison and the *outcomes* comparison will be reported in 2018. This next report will address specific evaluation questions relating to *what has worked for whom, where, and why?*

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Appendices

Appendix 1. Data sources for evaluation case studies

Data sources that inform the first view Location case studies and the National perspective.

Quantitative data sources

A range of existing quantitative data from survey and routine administrative datasets were used to develop the descriptive case studies and QCA outcome indicators. Data sources were selected for national coverage and their ability to be geographically disaggregated. Key data sources include the New Zealand Health Survey (NZHS) and B4 School Check.

Census 2013

Data for selected demographic themes (including population size and structure, ethnicity, household composition, employment, education, deprivation and household economic status), was extracted from the 2013 New Zealand Census for location to provide a socio-demographic profile. Data was collected at electoral ward or territorial authority level, depending on location, and where necessary aggregated. All data was freely available on the Statistics New Zealand website with the exception of “Household Crowding” – based on the Canadian National Occupancy Standard (CNOS) – for which a data request was made. A composite socio-economic indicator – The New Zealand Index of Deprivation (NZDep2013) – was extracted at small area (meshblock) level for all meshblocks within each Healthy Families NZ area (Atkinson, Salmond, & Crampton, 2014).

New Zealand Health Survey

The NZHS is a robust population survey of New Zealand adults (15 years plus) and children (0-14 years) with a response rate of over 80%. The survey covers health behaviours, health conditions, and health service use. Over 13,000 adults and 4,500 children are interviewed annually. Since 2011, the NZHS has been a continuous survey with a yearly publication of results. Each year data is available for a core set of indicators, along with one or more special topics that are rotated every few years.

The evaluation used annually collected survey data on relevant health behaviours such as smoking, hazardous drinking, fruit and vegetable consumption, physical activity and inactivity (including TV watching in children). It also used obesity and overweight data based on body mass index, and tooth removal due to decay.

B4 School Check

The B4 School Check is a national programme offering a free health and development check for 4-year-olds. It covers over 90% of the eligible population. The evaluation used the data collected on body mass index, to measure overweight and obesity.

Community Stocktake

All 10 Healthy Families NZ locations undertook a stocktake and mapping exercise to understand the existing local prevention system and settings in their communities. This information was used to identify areas for activity and contribute to local evaluation activities. Each locality used a different process for collecting and analysing information. For the national evaluation, community stocktake information was collected using a standardised format for each location. An Excel template asked for information relating to networks, organisations involved in local 'prevention system', key community stakeholders/ 'movers and shakers', number of settings (schools, workplaces, marae, sports clubs, places of worship) and health related programmes within settings, local information and evidence available, health related programmes/projects and initiatives and policies.

Social Network Analysis (SNA)

A social network analysis was conducted using survey data from eight Healthy Families NZ locations. Network data will be used to consider how networks that make up the 'prevention system' in the 10 Healthy Families NZ locations have changed from first view to second view.

Qualitative data sources

Document Review

Relevant documents were reviewed and analysed to inform the case studies. These documents include Implementation Roadmaps, Performance Monitoring Reports, contracts, policy documents and other support materials.

Further document review, including Cabinet papers and other plans and reports, contributed to the National perspective case study.

Key Informant Interviews in each location

Semi-structured interviews were undertaken with key informants who are pivotal to the implementation of the initiative in each location. Interview schedules were tailored to whether a key informant is part of the Healthy Families NZ location team, in a Leadership Group role or from a more distant organisation. A snowballing technique was used to determine the key people to be interviewed including community leaders and Healthy Families NZ workforce.

First view interviews were done in late 2015 and early 2016. A similar number will be conducted and again for second view case studies. Informed consent was obtained from all key informants. The interviews were carried out by the evaluation team, recorded digitally and transcribed verbatim. Participants were invited to review transcripts.

The National perspective provides important information on interactions between national level influences and those at the local level. Data sources include key informant interviews with staff implementing Healthy Families NZ within the Ministry of Health and other central government actors contributing to the initiative.

Sensemaking with the Healthy Families NZ location teams and National team to improve the draft case studies

Sensemaking is a process for literally 'making sense' of information by drawing on different perspectives. The draft case studies for each location and the National perspective were given to the location and national workforce to reflect upon prior to a participating in a

sensemaking workshop. The process, facilitated by the evaluation team, was and will be used to enhance an understanding of context for the data included in the case studies; assist with interpretation of what is considered more or less important; and to correct errors.

Regular phone interviews with Healthy Families NZ Location Managers

To aid tracking of change between first view and second view case studies, Healthy Families NZ Managers are interviewed regularly (approximately every 6 weeks). Interviews are structured to consider: changes in Leadership Group membership, changes in workforce, what has been taking place, the perceived significance of what has been taking place, and any changes in the approach or activities planned based on recent experiences. Questions are informed by the framework of What, So What, What Next (Eoyang & Holladay, 2013).

Appendix 2. Leadership Group membership

Table 1 below shows the Leadership Group membership for each Healthy Families NZ location. Organisations are classified by type, to show the spread of leadership across different sectors in each location.

Table 1. Leadership Group membership

Location	Organisation	Sector
Far North	Direct Governance and leadership provided by Iwi Chief Executives' Consortium	
	Additional leadership group includes:	
	Far North District Council	Local Government
	Northland DHB	Health
	Ministry of Education	Education
	Ministry for Social Development	Social services
	Sport Northland	Sport
	Iwi CE	Iwi
	Northland Chamber of Commerce	Business
	Ministry of Health	Government
Waitakere	Sport Waitakere	Sport
	Waitemata DHB	Health
	HealthWest	Health
	The Fono	Social Services & Health
	Unitec Faculty of Social and Health Services	Education
	Te Whānau o Waipareira Trust	Urban Māori Authority
	Royal Road Primary School	Education
	Ngati Whatua	Iwi
	Hapai Te Hauora Tapui	Māori Health & Social Service
	ZEAL	Youth
	Fresh Choice and SuperValue Supermarket	Business
	Ministry of Health	Government
Manukau, Manurewa-Papakura	Health Alliance Plus (x2)	Health
	Auckland Council (x3)	Local Government
	Ngā Mana Whenua o Tāmaki Makaurau	Iwi
	Ministry of Health	Government
Rotorua	Te Arawa Whānau Ora Collective	Māori Health & Social Service
	Kowhai Health Associates	Health
	Lakes DHB	Health
	Bay of Plenty DHB	Health
	Rotorua Lakes Council	Local Government
	Ministry of Education	Education
	Korowai Aroha Health Centre	Health
	Te Hauora ā iwi o Te Arawa	Māori Health & Social Services
	Ministry of Health	Government
East Cape	Te Aitanga a Hauiti Hauora	Māori Health & Social Services

	Turanga Health, representing the Turanganui-a-Kiwa district. Ngati Porou Hauora Te Runanganui o Ngati Porou Te Runanga o Te Whānau a Apanui Ngai Tai Iwi Tribal Authority Te Ao Hou Trust Bay of Plenty DHB, representing both Bay of Plenty and Tairāwhiti DHBs Ministry of Health	Māori Health & Social Services Māori Health & Social Services Māori Health & Social Services Māori Health & Social Services Health Government
Whanganui	Whanganui DHB	Health
Rangitikei	Te Oranganui	Māori Health & Social Services
Ruapehu	Sport Whanganui Rangitikei District Council New World Ohakune Ministry of Health	Sport Local Government Business Government
Lower Hutt	Hutt City Council Sport Wellington Te Awakairangi Health Network Pacific Health Service Network Takiri Mai te Ata Trust Hutt Valley DHB Ministry of Health	Local Government Sport Health Pacific Health Māori Health & Social Services, and iwi representative Health Government
Christchurch	Governance Group disestablished 31 Aug 2016. New Governance Group yet to be formed at the time of this report	
Invercargill	Sport Southland Invercargill City Council Invercargill Licensing Trust Waihōpai Rūnaka Southern DHB James Hargest College Ministry of Health	Sport Local Government Licensing Trust Iwi Health Education Government

Appendix 3. Social Network Survey Technical Notes

An online social network survey was conducted across eight of the Healthy Families NZ locations over 2016 (see Table 2 for dates of surveys). A specific survey was developed for each Healthy Families NZ location that included a list of organisations provided by each Healthy Families NZ location. At least one person for each of these organisations was invited to complete the survey. Respondents were asked to reply based on their existing knowledge of their organisation.

The social network survey asked respondents to first select the networks their organisation participates in from the provided list. The networks included were again provided by each Healthy Families NZ location. Then respondents were asked to identify which organisation from a list their organisation worked with. Two questions were asked about each organisation selected. First, a question was asked about frequency of communication. Second, a question was asked about level of collaboration (working together) between organisations. For both the communication and working together question, an additional question asked whether there had been change in the frequency or degree of collaboration within the last six months.

The communication frequency scale is derived from Buchthal and Maddock (Buchthal & Maddock, 2015). The working relationship scale is derived from both the VicHealth Partnership Analysis Tool (VicHealth, 2011) and Buchthal and Maddock (2015).

Table 2. Social Network Survey Dates for Healthy Families NZ locations

Location	Whanganui Rangitikei Ruapehu	Waitakere	Christchurch	Far North	Lower Hutt	Invercargill	Rotorua
Survey period	June/ July 2016	June/ July 2016	July/ August 2016	August/ September 2016	June/ July 2016	June/ July 2016	June/ July 2016

Response rates for each Healthy Families NZ location social network survey are shown in Table 3. Response rates are reasonable for a web survey.

Table 3. Organisation response rates for Social Network Survey by Healthy Families NZ locations

Organisation response details

	Organisations invited	Organisations completed	%
East Cape	13	5	38
Far North	29	9	31
Invercargill	36	24	67
Lower Hutt	38	16	42
Rotorua	26	15	58
Spreydon-Heathcote	68	32	47
Waitakere	31	13	42
Whanganui-Rangitikei-Ruapehu	38	19	50
Total	279	133	48

For Healthy Families NZ first view case study reports and this interim evaluation report, only descriptive analysis of results have been conducted focusing on connections with Healthy Families NZ locations.

Appendix 4. Examples of Healthy Families NZ activities from 2016

Across the 10 Healthy Families NZ locations, a large number of activities are being undertaken with the aim of contributing to a strengthened prevention system, improved nutrition, increased physical activity and a reduction in harm from alcohol and smoking. Within the timeframe of the first view case studies, location teams were focusing on establishment of Healthy Families NZ, so a limited number of activities had begun.

An increase in activities is evident across the 10 locations from early 2016. Here, some descriptive examples of activities are provided to give a sense of the type of activities being undertaken across Healthy Families NZ locations. The activity examples provided do not represent the breadth of activities that are underway, nor do they suggest potential outcomes that may arise. A considered identification and analysis of activities will be a feature of the 2018 evaluation report.

Water-only schools

Most Healthy Families NZ locations had collaborated with key partners on Water-Only Schools, an initiative launched jointly by the Ministries of Education and Health in 2016.

A number of resources have been developed. For example, Healthy Families Rotorua has developed in partnership with schools a *water only assessment tool* and Healthy Families Waitakere a *healthy vendor guide* that aligns with their DHB's Food and Beverage Guidelines.

Through Healthy Families NZ, the 'water only' initiative has expanded to work outside of the education setting in some regions to sports clubs, marae, and community events. In some areas (e.g. Whanganui Rangitīkei Ruapehu, Lower Hutt), following engagement with Healthy Families NZ teams, local councils are now looking to increase access to safe drinking water in public spaces.

Healthy Families Far North are involved in discussions concerning some communities' poor access to safe drinking water supplies, which need to be addressed before they could promote water in schools.

Workplace wellbeing

A national workplace wellbeing initiative has been in development over 2016, involving Healthy Families NZ locations, the Ministry of Health, the Health Promotion Agency and Public Health Units amongst others. This initiative developed online workplace health tools that can be delivered at scale. The Ministry of Health funded Toi Te Ora Public Health Service to lead this work and to make WorkWell available to Public Health Units and other interested organisations nationwide. Representatives from the Healthy Families NZ workforce were involved in the co-design process and piloting of the online tool. Several Healthy Families NZ locations are involved with partners in establishing the WorkWell programme in their communities.

In addition, Healthy Families NZ locations have worked with employers in their communities to support workplace wellbeing. For example, Healthy Families Rotorua are working with the Chamber of Commerce to create a Health and Wellness Award in the Westpac Rotorua Business Excellence Awards.

Food in schools

Another activity for many Healthy Families NZ location is adding further support to the work occurring with food in schools and ECE. For example, Healthy Families Rotorua have developed a Health Promoting Environment guide for Kohanga Reo by reworking an existing health promoting environment resource with a Māori worldview. Another example is Healthy Families Waitakere promoting the Auckland University School of Population Health's School - FERST (School Food Environment Review and Support Tool) online tool in their schools. School – FERST enables schools to self-review the healthiness of food and beverages they have available and supports them in improving their food environment.

Healthy Families Invercargill, in collaboration with the Heart Foundation and Rotary, developed a Healthy Lunch resource to be put into new entrant packs.

Healthy Families East Cape is using Kai Atua within the Atua Matua Health Framework as a guiding reference to engage Māori communities. They have been working with seven kura and plan to roll it out to further schools.

Sports club settings

Locations have identified key sports clubs to collaborate with on health promotion activities and systems approaches to promote healthy food and beverages, physical activity and reducing alcohol related harm.

Healthy Families Rotorua are working with sports clubs to be more whānau friendly through the liquor licensing process.

Healthy Families Invercargill are working with Rugby Southland and other partners to develop an *Our Club* package. The *Our Club* process will work with clubs to identify their values, and then identify a range of ways to support those values through, for example, healthy food and drink options available, reducing harmful alcohol consumption and promoting family friendly zones.

Healthy Families Waitakere have worked with their team internally in Sport Waitakere to include some criteria to their excellence awards that show a commitment to alcohol-related harm reduction.

Reducing sugar sweetened beverages

Work to reduce the consumption of sugar sweetened beverages (SSBs) has been reported in Healthy Families Manukau, Manurewa-Papakura and Rotorua locations. Healthy Families Manukau, Manurewa-Papakura's work with Auckland Council has led to removal of SSBs from all vending machines at the 21 Council-run leisure centres in Auckland, removing 340 kilograms of refined sugar from the centres each year.

Healthy Families Manukau, Manurewa-Papakura are piloting a SSB policy in a rugby league club with the intent to scale this up to other rugby league clubs in their location. They are also working with their Council to reduce SSBs in Council operated facilities.

Healthy Families Rotorua has worked with partners including Rotorua Lakes Council to remove SSBs from vending machines in the Rotorua Aquatic Centre (RAC), the largest Council owned venue.

Marae/ Māori Settings

Healthy Families East Cape are using the Atua Matua health framework to facilitate engagement of the multiple iwi in their location and allow for their individual iwi uniqueness. A marae model of practice called 'Ko Runga, Ko Muri, Ko Muri' has been co-designed with marae that aims to lead sustainable change from a Māori worldview to promote healthy food and beverages.

Healthy Families Whanganui Rangitīkei Ruapehu have developed Smokefree Marae and Tikanga Waipiro toolkits to support engagement with Marae committees and Runanga.

Healthy Families Manukau, Manurewa-Papakura are working with the Manurewa Marae to co-design a local smokefree policy.

Smokefree Council policies

Supporting work to create smokefree environments is an ongoing area of activity. Healthy Families Lower Hutt helped lead the smokefree outdoor public places policy which was passed by the Hutt City Council on 24 May 2016, including smokefree for most council owned outdoor spaces. Healthy Families Lower Hutt is coordinating several aspects of the policy implementation and engaging with workplaces to review and update their smokefree policies.

Healthy Families Manukau, Manurewa-Papakura have been running community insight workshops focusing on Māori women's smoking behaviours to support the Council smokefree policy review. Other smokefree work includes looking at how to support families in culturally appropriate ways, how to influence local council policies, and a focus on events and workplaces.

Healthy Families Whanganui Rangitīkei Ruapehu co-presented with partners on smokefree recommendations to the Whanganui District Council, who were considering a proposal to revoke the smokefree bylaw. After robust discussion Council decided to review and strengthen the policy.

Food systems

Strengthening local food systems to provide healthy food is a focus in several Healthy Families NZ locations. For example, Healthy Families Far North have developed a food system framework after running a food system workshops with local kaumatua and the Health Promotion Agency.

Healthy Families Waitakere have co-designed a food system prototype, called Ranui Food Lab, in collaboration with Sport Waitakere and Unitec.

Healthy Families Christchurch partnered with the Food Resilience Network to organise a school gardening hui in February 2016 which led to five schools committing to community based food production.

Healthy Families Christchurch, Healthy Families Waitakere, and Healthy Families Invercargill are working with event vendors to support vendors to sell healthier food options.

In partnership with Rotorua Lakes Council and Toi Te Ora Public Health Service, Healthy Families Rotorua established the Rotorua local food network, working on projects that aim to improve nutrition knowledge, cooking and gardening skills, reduce food waste, increase the accessibility of healthy food and create employment and business opportunities centred on healthy food.

Healthy Manukau, Manurewa-Papakura are using a social lab process to understand the Otara food environment. They were piloting community co-designed affordable food bags in late 2016.