FINAL PROCESS AND IMPACT EVALUATION REPORT 2004–2006

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

REPORT TO THE NATIONAL SCREENING UNIT

JANUARY 2007

Mihi Whakatau

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

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

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

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

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

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Whakakape – Disclaimer

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

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

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

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We would also like to express our gratitude to the Māori, Pacific and other New Zealand women who participated in the focus groups throughout the country. Without their honest comments and sharing of their personal experiences we would not have been able to understand their personal journeys.

NGĀ KŌRERO Ā ROTO – CONTENTS

WHAKARĀPOPOTOTANGA – EXECUTIVE SUMMARY

Introduction

To be fully effective, BreastScreen Aotearoa (BSA) and the National Cervical Screening Programme (NCSP) coverage of Māori and Pacific women must increase. If these programmes are to be effective for Māori and Pacific women, focusing NCSP and BSA health promotion on the women who are not participating in screening is imperative. This observation has provided the basis for the process and impact evaluation conducted between January 2004 and December 2006.

This Final Process and Impact Evaluation Report 2004–2006 is a summary of the process and impact evaluations undertaken with the aim of increasing the coverage and participation of Māori and Pacific women in the BSA and NCSP. Reducing inequalities for these priority groups of women has been the focus of this three-year evaluation and is the fundamental concern of this final report.

Methodology

This report contains the research gathered throughout the three years of the process and impact evaluation. Kahui Tautoko Consulting Ltd utilised a kaupapa Māori approach to a methodology that included a combination of face to face interviews, an email survey and focus groups around the country. The process evaluation information was determined through initial baseline and final surveys conducted on site with the health promotion staff at each provider, and an email survey was carried out in between these two visits to determine any mid term changes. Twenty nine providers were involved in the initial baseline survey, twenty two responded to the midway survey and twenty eight providers were interviewed for the final survey.

The impact evaluation data was gathered through focus groups with Māori, Pacific and other New Zealand women in 2004 and again in 2006. In 2004, 39 focus groups around New Zealand were conducted, one Māori, one Pacific and one for other New Zealand women, in each of the thirteen NCSP regions. These groups aimed to determine general barriers, knowledge and perceptions among these ethnic groups. In 2006, 18 focus groups were conducted, eight Pacific groups (the 7 main Pacific nations plus 1 group of young Pacific women), five Māori and five European, to establish more detailed information about each group and in particular between the 7 main Pacific nations in New Zealand.

Analysis of both the process and impact qualitative information was carried out using N6 Qualitative Research database and quantitative information through Microsoft Excel.

Ethics committee approval was granted for the research in August 2004 by all 13 regional ethics committees with the Wellington Regional Ethics Committee as the lead committee. An Evaluation Advisory Group was established to support Kahui Tautoko Consulting Ltd throughout the three years.

Findings

The findings of the baseline, midway and final surveys show that providers are conscious of the need to target Māori and Pacific women in order to reduce inequalities and increase coverage and participation rates. The evaluation has looked at health promotion activities within both programmes from a range of perspectives, including the models used, methods of needs assessment, planning approaches, delivery of services, evaluation of programmes, regional relationships, and infrastructural and workforce issues. The report contains information sourced from providers in both programmes relating to these aspects.

The report also looked at the impact of these health promotion activities on priority women. The perspectives from a sample of Māori, Pacific and New Zealand European women were gained to determine their knowledge of, attitudes towards and behaviours relating to both programmes.

Overall, it is believed that progress has been made, particularly in the areas of innovative activities to target the hard-to-reach women. However, there are areas for improvement, including aligning with the health promotion cycle, ensuring effective relationships between providers, building the connections between health promotion and other components of the screening pathway, and always ensuring that providers are continuing to focus on priority women. In conclusion, while we recognise the efforts and achievements of health promoters and kaimahi throughout New Zealand, this report aims to provide guidance on best practice within screening to reduce inequalities for Māori and Pacific women.

The analysis and a comprehensive set of conclusions have brought together the findings of both the process and impact components, and have led to a number of recommendations for the National Screening Unit.

Recommendations

It is recommended that the National Screening Unit:

- NOTE and ACCEPT this is the final Process and Impact Evaluation Report of existing health promotion services within the NCSP and BSA programmes, for Māori and Pacific women
- NOTE that 29 health promotion providers participated in the baseline survey, 22 providers responded to the midway email survey, and 28 providers participated in the final survey (refer to section 2.2.1)
- ENCOURAGE and promote the application of other kaupapa Māori models among providers as a basis for their health promotion approach, and in particular, encourage use of the Te Pae Mahutonga model for which NSU has provided guidance (refer to section 3.1.2 - Health promotion models and Section 5.1.2 – Ottawa Charter and kaupapa Māori models)
- NOTE that providers generally use a combination of population-based, one-on-one and holistic approaches for their health promotion services, and that these combinations of approaches should continue to be recognised and encouraged (refer to section 3.1.2 - Health promotion planning approach and section 5.1.2 – population-based vs one-on-one models)
- NOTE that one-on-one holistic health promotion works better for recruiting Māori women to both programmes, because it is more effective at both informing women and supporting women through screening (refer to section 5.1.2 – recruiting women)
- NOTE that for Pacific women a population-based approach works to raise awareness at a broader level, but targeted health promotion is needed in small groups to focus information for the different ethnic groups (refer to section 5.2.1 – recruiting women)
- NOTE that once women are enrolled, they are generally able to be retained in both programmes through a combination of continued awareness from population-based health promotion, having positive experiences from the screening (mammography or smear), plus a robust recall/reminder system that

constantly prompts them to return (refer to section 4.1.3, section 4.2.1 – reasons/influences for participating and section 5.1.2 Population-based vs one-on-one models)

- NOTE that providers have used a number of sources to identify the needs of eligible women, (refer section 3.1.1 and section 5.1.3) including:
- NCSP/BSA screening data
- the opinions and views of key women
- other data (eg, census or deprivation data)
- anecdotal feedback
- community consultation
- formal needs analysis and evaluations

NOTE that the effective use of NCSP and BSA data has been limited by:

- Accuracy of ethnicity data
- Provision of ethnicity data
- training to interpret and monitor ethnicity data.

It is further recommended that this 'training' be incorporated into induction training and kaimahi hui programmes (refer to section 3.1.1 and section 5.6.4)

NOTE the need for providers to improve the formality and documentation associated with their needs assessment processes to support their focus on reducing inequalities and meeting the specific needs of Māori and Pacific women – effective needs assessment needs to occur through a combination of quantitative and qualitative data and broader consultative processes that directly involve other NCSP/BSA providers and external stakeholders (refer to section 3.1.1)

CONSIDER a move to three-year health promotion plans, with annual targets within the health promotion cycle (refer to 5.1.4)

NOTE that there has been an increasing emphasis on formal evaluation of activities, but that this is not 'business as usual' for all providers nationally and there is often no clearly defined link between evaluation and health promotion planning. (Refer to section 3.3 and section 5.4)

NOTE that because providers experience difficulties recruiting and retaining competent health promotion staff (refer to section 3.5), the NSU could consider a number of strategies to alleviate this issue (refer to section 5.6.3), including:

- defining the price per full-time equivalent (FTE) and the number of FTEs to be employed within contracts – consideration should be given to ensuring the price per FTE is within current market rates for salaries for health promoters and includes a set percentage for training
- supplying providers with guidance on, or templates of, draft job descriptions e.g. screening health promoter. This template should remain optional, however could guide providers on screening, cultural and health promotion competencies expected of the position. This could be an interim step until a nationally consistent framework for health promotion competencies is developed.
- implementing a training or professional development programme for skills specific to screening (see below)
- encouraging providers to undertake exchanges or placements of new staff to avoid service disruption and worker isolation, and to ensure new staff are able grasp the requirements of the service more expediently

RETAIN the induction and orientation programme for new kaimahi, but with the inclusion of the following topics - with annual refreshers to update (refer to section 5.6.3):

- BSA and NCSP standards (including audit requirements)
- implementation of the health promotion cycle
- the importance of documentation (i.e. developing a systematic method for utilising and filing of all health promotion planning, activity and evaluation documentation)
- the importance of national and regional relationships
- the use of resources
- cultural issues related to health promotion for Māori and Pacific women
- having a reducing inequalities focus
- how to use the NSU screening data and conduct self-analysis for planning and monitoring purposes
- CONSIDER re-formatting the kaimahi hui and Pacific screening workers conference to a national reducing inequalities conference (suggest three days). This would include all providers who work with priority women, regardless of the ethnicity of the managers and workers. A fourth day could be allocated for a separate hui respectively for Pacific and Māori kaimahi, with the agenda for

these being set by Māori/Pacific kaimahi themselves, while the NSU should lead the screening conference. This would make more effective use of national hui/conference resources, as well as provide an opportunity for the annual updates (refer to section 5.6.3)

- NOTE that the model for successful relationships should include (refer to section 5.6.2):

- those who need to have direct involvement in developing plans and strategies (BSA lead providers and subcontractors, NCSP regional screening and subcontractors, and NCSP and BSA independent service providers)
- parties who should be consulted on draft plans and strategies – primary health organisations (PHOs), general practitioners, Māori and Pacific providers in the region, community groups and priority women)

- WORK with the Ministry of Health to influence PHO contracts at a national level to introduce contractual clauses that encourage and reward positive relationships between the PHO and BSA/NCSP services (refer to section 5.2.1)

- NOTE that in the last three years providers have increased their focus on priority women and reducing inequalities, which has been evident through more specific activity outlined in their health promotion plans although this is not a nation-wide trend.(refer to section 3.1.1 and section 5.7.1)

- NOTE that the quality and responsiveness of both programmes depends to some extent on the ability of the NSU to influence all aspects of the screening pathway – this evaluation has identified that the influence is greater over the BSA programme than the NCSP programme. Therefore, the NSU should consider how it can increase their control over key components of the NCSP (e.g. quality and monitoring). (refer to section 5.2.1)

- NOTE that free BSA services are a significant factor increasing access to screening, and that the cost of smears is a barrier for many women. It is further recommended that the NSU work with the Ministry of Health to influence the provision of free smears for priority women (refer to Section 4.2.1 – reasons/influences for participating and Section 4.2.1 - reasons for not participating and barriers to screening

- CONSIDER revising the service specifications for health promotion to give specific recognition to the three functions of: recruitment, health promotion and general practitioner liaison, and developing performance indicators for each function (refer to Section 5.2.2)

- NOTE that some women suggested that more information should be disseminated about the stages of cancer development and the importance of early detection (refer to Section 4.3.1).

1. WHAKATŪWHERATANGĀ – INTRODUCTION

1.1 Background

Māori and Pacific women's coverage and participation rates for both BreastScreen Aotearoa (BSA) and the National Cervical Screening Programme (NCSP) are around half the levels required for the screening programmes to be effective for these populations. For BSA, the current target is for two-yearly screening of 70% of eligible women (NSU 2004a). For the NCSP to be effective the programme needs coverage of 85% of eligible women over a three-year period (NSU 2000).

Consequently, Māori females have twice the breast cancer mortality rate and four times the cervical cancer rate of non-Māori females (Ministry of Health 2006). Similarly, Pacific women have higher-than-average mortality rates for breast cancer (all age groups) and cervical cancer (45–64 years age group) compared with the total New Zealand population (Ministry of Health 2005).

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

Kahui Tautoko Consulting (KTC) were contracted by the NSU in January 2004 to undertake process, impact and formative evaluation work over a three-year period. This combined evaluation specifically aimed to provide information about the BSA and NCSP health promotion services to increase the coverage and participation of Māori and Pacific women in these services.

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

1.2 Structure of this report

Section 1 of this report outlines the scope and provides background information to provide a context to the findings of the evaluation. The methodology and approach behind this evaluation are included in Section 2. Section 3 documents the findings of the three-year process evaluation with the providers, and the findings of the impact evaluation are outlined in Section 4. An analysis of both the process and impact findings are contained in Section 5. Lastly, Section 6 contains conclusions based on the findings and the analysis.

1.3 Evaluation purpose

Process evaluation focuses on programmes that are already in progress and documents activities, tasks and procedures involved in delivering a health promotion service. This type of evaluation explores and then describes what is being delivered, how it is being delivered and to whom (Health Promotion Communication Unit 2006). Process evaluation helps both the evaluators and the managers of a programme to understand how and why a programme achieves its results (Waa et al 1998).

Impact evaluation determines the positive or negative, intended or unintended, intermediate or longer-term outcomes of a programme (Lunt et al 2003) by determining people’s perceptions of the programme and health promotion issues (Waa et al 1998).

1.4 Objectives

As defined by the NSU, the objectives of the process evaluation were to provide information about:

- the range of activities and approaches used by health promoters to reach the target populations, including resources used and developed
- the linkages and processes the health promotion teams have established with other relevant service providers (general practitioners, practice nurses, hospitals and other health promoters)
- any changes the service providers have made to their activities and approaches over time, why these changes were made, what impact the changes have had and the results of the changes.

The objectives of the impact evaluation were to determine the possible effects of the targeted programmes in terms of:

- increasing the target groups’ participation in the screening programmes at both the national and local levels
- ascertaining the extent to which the programmes have contributed to changes in the knowledge, attitudes and behaviour of the target groups.

1.5 Other work related to the evaluation

1.5.1 Literature review

A literature review was undertaken in 2004 to inform all aspects of the evaluation. It commenced in early 2004 and was updated in December 2004 with literature obtained through the baseline process survey. The review identified health promotion strategies based on community development, communications and health education in line with the NSU's Health Promotion Framework. The review sought to identify the aspects of these strategies that made them successful in assisting providers to develop health promotion initiatives to improve Māori and Pacific or other indigenous women's coverage and participation in screening.

For community development strategies, international research and evaluations have concluded that success has occurred where much time has been invested into becoming familiar with the community and establishing the trust of the women being targeted. Success has also occurred where ethnic-appropriate health promoters are utilised, as well as through working with the family unit to provide information and reach women. Success is also achieved where the community has had some input into the development of strategies.

Communication strategies that are combined with community development approaches and appropriately resourced (where the resources 'match' the characteristics of the women being targeted) have proven to be successful. Success has also been achieved using communication approaches that incorporate multiple means of communications and those that are personalised. Communication mechanisms that are already established for specific ethnic groups are key vehicles for communicating screening messages.

Finally, the literature review identified that health education has a higher chance of success if delivered by ethnically appropriate health educators who know and understand the community being targeted.

1.5.2 Review of Māori resources

In 2005, KTC were contracted to review the current NCSP and BSA Māori resources to:

- determine the information needs of Māori women
- identify gaps, appropriateness and the best mode of delivering information to Māori women.

To meet the requirements of this contract, the research was integrated into the literature review, the baseline process survey and the initial impact survey of Māori women for the process and impact evaluation. A review of current resources against known frameworks was also undertaken to support the findings. From this research, KTC made recommendations for the current Māori NCSP and BSA health promotion resources, as well as for the development of new resources.

1.5.3 Formative evaluation

The formative evaluation commenced alongside the process and impact evaluations and involved KTC supporting three providers newly contracted to deliver both breast and cervical screening in the development of their service and health promotion planning. The support included a needs assessment of the providers, supporting the providers in fulfilling the requirements of their contracts, and assisting in the development of new health promotion plans based on Māori models. The Formative Evaluation Report will be presented to the NSU in December 2006.

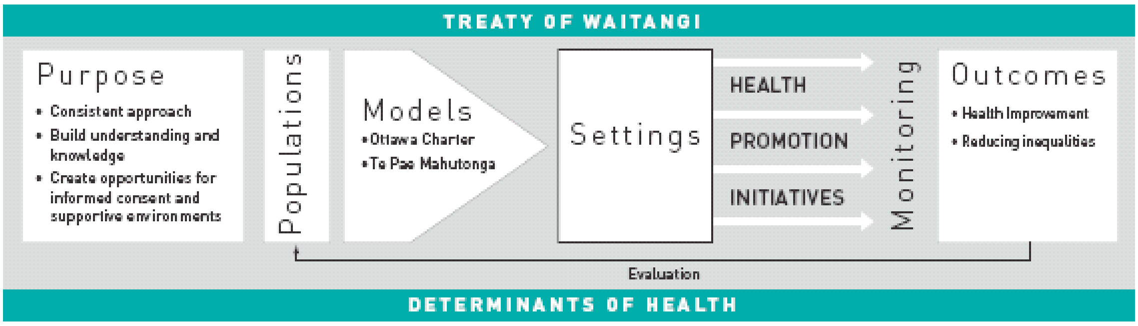
1.6 Screening health promotion

1.6.1 The screening pathway and programme logic

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

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

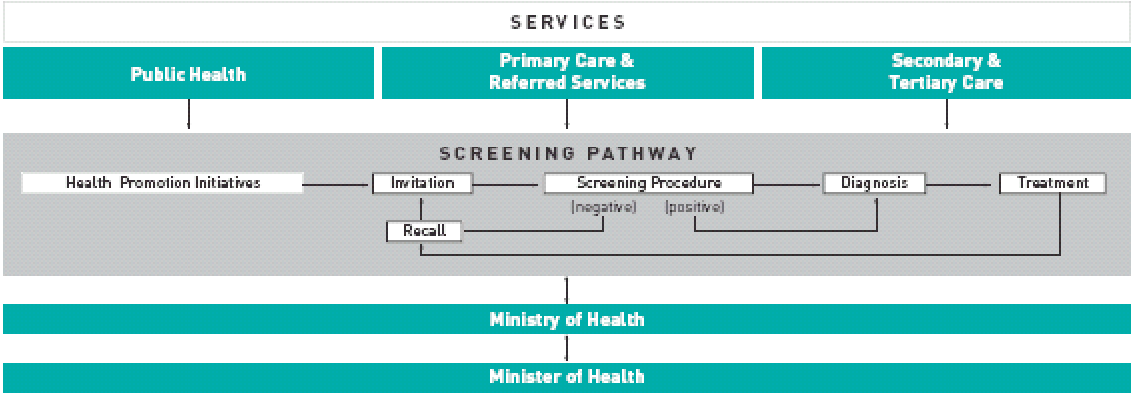
Figure 1: Model of health promotion in screening programmes



Source: National Screening Unit 2004c

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

Figure 2: The Screening Pathway and Roles of Different Services



Source: National Screening Unit 2004c

1.6.2 Definitions

The following definitions have underpinned this evaluation.

<u>Health promotion</u>

The World Health Organisation (WHO) defines health promotion as "the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health" (NSU 2004c). He Tatai i te Ara, Determining the Path: Guidelines for Developing Māori Health Education Resources (Ministry of Health 1996) states that "Health promotion for Māori means having control over their health or encouraging people to determine their own good health and wellbeing".

Further:

- Māori involvement in health promotion means:
- achieving potential
- making decisions
- maximising choices
- being part of the consultative process.

The NSU Health Promotion Framework states that:

- Health promotion planning and strategy development require consideration of the wider determinants of health. In the context of screening these include social and community influences, gender and culture, socio-economic, environmental conditions and lifestyle and behavioural factors. (NSU 2004c)

Screening

The New Zealand National Health Committee has defined screening as:

> *… a health service in which members of a defined population, who either do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be harmed by future tests or treatment to reduce the risk of a disease or its complications*. (National Health Committee 2003)

Screening occurs either within a screening programme or opportunistically. It was designed to improve the health of populations, and traditionally aimed to recruit large numbers of the population to maintain high coverage. However, individual participants need sufficient information to able to make informed choices about whether or not to participate (National Health Committee 2003).

Screening programmes involve planning, funding, delivering and monitoring from a population health perspective. Screening programmes target specific population groups (National Health Committee 2003), which, for the NCSP, is women aged 20–69 years and for BSA is women aged 45–69 years.

Health promotion within screening

> *Health promotion within screening programmes aims to create an environment that is conducive to, and supportive of, informed participation in screening.* (NSU 2004c)

The NSU's Health Promotion Framework recognises the determinants of health and the role of primary care in the screening pathway, and that health promotion also needs to include community development activities in order to sustain long-term behaviour change, particularly in the priority groups (NSU 2004c). To achieve participation, health professionals should provide appropriate and correct information that recognises influential factors to participation programmes – such as access, cost and cultural needs – to ensure the success of screening programmes (NSU 2003).

Priority groups

Priority groups are the direct focus of health promotion activity, and are defined by the NSU as:

- Māori women
- Pacific women
- unscreened women
- under-screened women (NSU 2004c).

1.6.3 Scope of services

National Screening Unit

The NSU is a separate unit within the Public Health Directorate of the Ministry of Health. The NSU has responsibility for planning, national co-ordination, funding and evaluation of the NCSP and BSA (NSU 2004d). Further, the NSU has two strategic outcomes – **health improvements** and **reducing inequalities** (NSU 2003). To reach these two key outcomes a set of core functions of the NSU are set out in the Strategic Plan 2003 – 2008. Three core functions that relate specifically to this health promotion evaluation are that the NSU (NSU 2003):

- provide national leadership and strategic direction for specific screening programmes
- develop and manage effective national health promotion, recruitment and retention strategies for national screening programmes
- facilitate effective communications with all screening programme participants and stakeholders.

Additionally, the NSU has developed its own workforce development strategy and plan of action to guide the development of a competent and capable screening workforce (NSU 2004d).

Health promotion providers

When KTC commenced the process, impact and formative evaluations, there were 29 providers contracted by the NSU to deliver health promotion. Since then the NSU has contracted three new independent service providers (ISPs) (He Waka Tapu, Mana Wahine and Raukura Hauora o Tainui ki Tamaki, included as part of the formative evaluation) and two new BSA lead providers (BSA North and BSA Counties Manukau). The contract for one ISP was terminated in January 2006.

Of the original 29 providers included in this process evaluation:

- 10 were regional screening services solely providing NCSP (there are now 12 NCSP regional services)
- 6 were BSA lead providers, two of which also provide NCSP as regional screening services
- 13 were ISPs (10 Māori, 2 Pacific, 1 provides services to Māori, Pacific, Asian and new immigrant women) – three provide NCSP health promotion only, nine deliver BSA health promotion and one provides both NCSP and BSA health promotion.

A table in the Appendix lists the health promotion providers and their services included in this evaluation. These providers are contracted to provide health promotion to priority women to encourage their participation in both the NCSP and BSA programmes.

Only health promotion intended to improve coverage and participation among Māori and Pacific women is included in this evaluation.

The NSU funds each of the providers to provide health promotion for Māori women, Pacific women, or both. Of the 28 providers who participated in the final process evaluation visits, 16 (all the regional screening services and BSA lead providers) are contracted to deliver health promotion to both Māori and Pacific women, while the two Pacific ISPs deliver to Pacific women. Nine Māori ISPs are contracted to deliver to Māori women, although both the Pacific ISPs and the Māori ISPs are inclusive of other women. The remaining ISP previously only provided screening services to Asian and new immigrant women, and they now also provide services to Māori and Pacific women.

The following subsections define our understanding of the intended roles, scopes of services and inter-relationships of the different types of health promotion providers. The aim is to provide a context for our findings on the actual roles and inter-relationships that are in place.

BSA lead providers

These organisations are contracted by the NSU to provide the following services to breast screening in their designated region:

- health promotion
- mammography
- assessment.

BSA lead providers are subject to the NSU Policy and Quality Standards (NPQS). They are expected to have a relationship with ISPs in their region to facilitate the regional planning and delivery of breast-screening services. BSA lead providers also have relationships with providers of treatment services (due to reconfiguration there are now eight lead providers) and their mobile units, which deliver services to both urban and rural communities.

NCSP Regional Screening services

These organisations are contracted by the NSU to provide the following services to cervical screening in their designated regions:

- health promotion
- smear-taking services
- register functions.

NCSP regional screening services are subject to the NCSP Interim Operational Policy and Quality Standards. This requires them to liaise with and co-ordinate between women and providers of the NCSP (health promotion, smear-takers, laboratories, colposcopy and treatment services).

The NSU Strategic Plan (2003) states that, across the country, for the NCSP there are:

- 21 District Health Boards (DHBs) contracted by the NSU to provide colposcopy services (13 of these provide NCSP regional services, which include health promotion, smear-taking to priority women and provider co-ordination, and eight provide data entry and laboratory results on to the NCSP register)
- 12 laboratories providing cytology services for the NCSP
- 5300 smear-takers, including general practitioners (GPs) and nurses.

Independent service providers

The NSU contracts independent service providers (ISPs) to allow choices for Māori and Pacific women, particularly for those who might not access mainstream providers. The ISPs provide some or all of the following services to designated priority groups of women (Māori or Pacific):

- health promotion
- support to services
- smear-taking.

ISPs are also subject to the BSA and NCSP standards, depending on which programme they are working under. ISPs are expected to work with other providers in the region to facilitate the planning and delivery of screening services.

‘Support to services’ is defined in NSU contracts with ISPs as “support for women and accompanying support people to attend screening, assessment and treatment (BSA) and screening and colposcopy services (NCSP), including transport to venues”.

2. TIKANGA – METHODOLOGY

2.1 Our overall approach

Māori and Pacific women are at the centre of this evaluation. KTC utilised a Kaupapa Māori approach to all phases of the planning, research, analysis and reporting and these women, their whānau and their values assume key roles in a process designed to assess how well health promotion services are working for them.

As defined by Smith (1996), a kaupapa Māori approach recognises the legitimacy and validity of being Māori, ensuring the survival of te reo Māori and culture, and that self determination is essential to Māori cultural wellbeing. Further, kaupapa Maori must be about challenging injustice, revealing inequalities and seeking transformation (Pihama, 2001).

From KTC's perspective, a kaupapa Māori approach for this evaluation means a commitment to wahine Māori and their whānau, acknowledgement of the significance that Māori values, principles, te reo and tikanga Māori have for them, and understanding of the cultural processes to enable them to contribute and share experiences and knowledge in a way that they feel safe with. This evaluation recognises the challenges and specific issues in screening for wahine Māori.

This all encompassing approach also applies to Pacific women, and this evaluation acknowledges the seven main Pacific nations (Samoa, Tonga, Fiji, Cook Islands, Niue, Tokelau and Tuvalu) represented in New Zealand, and the needs of each of these groups. Careful consideration was given to these individual groups, particularly in the design of the focus groups.

To visibly demonstrate our commitment to the recognition and uniqueness of Māori and Pacific peoples, we inherently followed the seven Kaupapa Māori practices as defined by Linda Smith (1999) and our approach is similar to the approach adopted by Pipi et al (2001):

Aroha ki te tangata (a respect for all participants involved in this evaluation)

Kanohi kitea (meeting with the providers and women face to face)

Titiro, Whakarongo…. Korero (taking the time to listen and empathise with the women who participated in the focus groups)

- Manaaki ki te tangata (having cultural and personal respect for all those involved in the evaluation)
- Kia Tupato (caution was taken culturally, socially and personally – notably in the planning stages as to ensure the safety of the participants and the evaluation team)
- Kaua e takahia te mana o te tangata (the evaluation team were mindful of the women and their views and respected their decisions to not participate or comment)
- Kia ngakau mahaki (KTC were humbled by the time, knowledge and experiences shared by participants and their comments)

Finally, improving health outcomes for Māori and Pacific women is of utmost importance to this evaluation. This research aims to make a positive difference (Smith 1999) to health promotion services for Māori and Pacific women. Rather than focusing on why these two priority groups may not be participating in BSA and NCSP, KTC approached this evaluation with the aim of identifying how health promotion providers can best meet the needs of Māori and Pacific women through effective and well-planned health promotion.

2.2 Process evaluation methodology

An evaluation plan and an implementation plan were developed in the planning stages of this evaluation. Objectives for the evaluations, processes and questionnaires for the process and impact evaluations were finalised by NSU and KTC.

2.2.1 Process evaluation methods

To meet the objectives of the process evaluation, KTC undertook key informant interviews and an email survey, both of which were informed by a literature review.

The process evaluation was structured into three phases.

Phase 1: the baseline process survey – key informant interviews and site visits to each of the providers were conducted in July and August 2004 to establish the baseline of health promotion activity.

Phase 2: the midway process survey – an email survey was conducted in 2005 to determine any changes or movement since the baseline.

Phase 3: the final process survey – key informant interviews were followed up by staff in 2006 to determine the extent of change over time.

The process evaluation involved the 29 providers contracted by the NSU to provide health promotion services for breast and/or cervical screening. All 29 providers participated in the initial phase, and 22 of the 29 responded to the midway email survey. As of early 2006, one of the ISPs is no longer delivering health promotion services, so 28 providers were interviewed during the final process survey.

2.2.2 Baseline and final surveys

Key informant interviews, for both the baseline and final surveys, were conducted on-site with health promoters, managers and related staff of all NCSP and BSA providers. The initial survey aimed to elicit information from providers on:

how services plan and organise BSA and NCSP health promotion programmes

the types of programmes run and the nature of each, and how providers identify those programmes working well and those that are not

the local and national health promotion resources used by services

how providers meet health promotion objectives, both locally and regionally

evidence of provider stakeholder links with Māori, Pacific and other providers (meeting minutes, memoranda of understanding)

any evaluations of resources, strategies or approaches undertaken

any unpublished literature relevant to improving the coverage and participation of Mäori and Pacific women in both the NCSP and BSA

any recruitment or workforce development issues.

Supporting documentation such as formal evaluations and current and past health promotion plans were also provided where applicable.

2.2.3 Email survey

Twenty-nine providers contracted to deliver health promotion were invited by email to participate in the survey in December 2005. The email included the survey in Microsoft Excel format and an invitation letter. The survey consisted of open and close ended questions, with a number of questions specifically asking providers to rank areas in order of importance. Email addresses for providers were obtained from the NSU, and the emails sent were followed up with a phone call. Of the original 29 providers who were invited to participate, 22 responded.

2.3 Impact evaluation methodology

2.3.1 Background

To conduct this research, KTC used the qualitative method of focus groups to gain an understanding of attitudes, perceptions and knowledge from the target groups. It was noted in the original evaluation plan that KTC recommended using telephone surveys in order to conduct a broader survey to meet the objectives of the impact evaluation. However, focus groups were used at the request of the NSU to provide a more face-to-face approach to reaching the target groups.

The qualitative information gained through this process is insufficiently robust to make valid comparisons between the ethnic groups, and the findings cannot be reliably extrapolated to the general population due to the relatively small numbers of participants. Rather than a strict comparison, this information provides insight into the motivations of target women, and gives different reasons why women participate in the NCSP and BSA and why they do not.

2.3.2 Impact evaluation method

Originally, the focus groups were intended to include Māori and Pacific women only, but after discussions with the NSU, New Zealand European women were added to ascertain differences and similarities between Māori, Pacific and New Zealand European women in terms of access, knowledge and barriers to the programmes.

Following approval from the NSU and ethical approval (see section 2.6), KTC conducted two phases of focus groups over 2005 and 2006. The two phases were set out as follows.

Phase 1:	Thirty-nine focus groups were conducted– 13 Māori, 13 Pacific and 13 New Zealand European, to gain an overall view of the perspectives of women in each region.
Phase 2:	Eighteen focus groups were conducted – eight Pacific groups (one for each of the seven main Pacific nations and a group of young Pacific women), five groups of Māori women and five groups of New Zealand European women.

2.3.3 Focus group questionnaire design

Each focus group included questions on both the BSA and NCSP, even though some women had participated in only one of the programmes and not the other. The questions concentrated on three areas:

the women's knowledge of the programme(s) and their experience in participating in either or both programmes (including reasons why they did not, or chose not to, participate)

their attitudes towards screening

their perceptions around screening.

The additional review of the Māori resources component was incorporated into the initial focus groups of Māori women. Current health promotion resources were provided to the group to ascertain how they felt about the resources, which ones they thought were effective for Māori, and any potential suggestions for improvements to help reach Māori women.

2.3.4 Survey sample

The survey sample had to meet a broad range of criteria. Focus groups over both phases needed to include women:

- from 13 different regions, ideally in fairly even numbers
- from three different ethnic groups, ideally in fairly even numbers
- from two significant age groups (the BSA age range and NCSP age range)
- from the various Pacific ethnic populations
- who participated in screening as well as women who did not participate in screening.

The objective of the survey sample was to aim to meet these criteria as much as possible. Women were invited to participate in the focus groups through Māori and Pacific health providers not contracted to deliver screening health promotion, panui (announcements) on radio (eg, Niu FM and Māori radio), and panui posted or emailed to the specific communities.

2.4 Data collection

The baseline and final process evaluation findings were collected by face-to-face interviews and recorded on a questionnaire. The midway process findings were collected via email. Providers were sent the survey by email and were encouraged to return it in whichever form suited them – by email, fax or hard copy. All focus groups were facilitated by a competent facilitator, and a note-taker was present to note down themes as the groups progressed. All focus groups were recorded, and where required, tapes were played back to expand on any notes taken by the note-takers.

2.5 Analysis

Analysis of both the process and impact information was carried out using two methods.

- The N6 Qualitative Research database was utilised to analyse all qualitative information, such as the providers' views, opinions or descriptions of their health promotion service, and the perceptions, opinions and other qualitative feedback from the focus groups, including opinions on the Māori resources.

Microsoft Excel was used to analyse quantitative information to compile the rankings and collate numbers from the closed questions and analysis of attendance, including: ethnicity, age, yes/no questions and relevant resource questions from the focus groups.

As each response was received from the provider, it was separated into quantitative and qualitative responses, and was then imported into the respective databases and analysed. For the focus groups, data was recorded by region, by ethnicity, by age and by question. Common themes were identified for this report, including an analysis of repeated responses versus singular responses to questions.

2.6 Ethics Committee approval

KTC applied for ethical approval in August 2004 for both the initial regional focus groups (February 2005) and the follow-up focus groups (September 2006), following NSU and Technical Advisory Group approval in July 2004. Applications were made to the 13 regional ethics committees, with the Wellington Regional Ethics Committee nominated as the lead committee. Final approval was gained in January 2005.

All NSU data used in the reports was collected from the NSU with approval from the National Kaitiaki Group and the Pacific Women's Advisory Group.

2.7 Evaluation Advisory Group

An Evaluation Advisory Group (EAG) was established in the early stages of the evaluation to support the evaluation team. The composition of the group has changed throughout the evaluation.

2.8 Reporting

This final process and impact evaluation report incorporates the findings of three prior reports and recent process and impact activities. The three prior reports are the:

Baseline Process Evaluation Report 2004 (baseline survey)

Impact Evaluation Report 2005 (initial impact survey)

Midway Process Evaluation Report 2006 (midway survey)


REENING
EARLY DETECTION IS YOUR BEST PROTECTION
CERVICAL SCREENING
My health, my body, my future

3. NGĀ KITENGĀ – PROCESS FINDINGS

3.1 Health promotion planning and approach

3.1.1 Reducing inequalities – reaching priority women

Identifying the needs of priority women

Identifying the needs of priority women in order to plan and deliver effective health promotion is essential. Throughout the three-year evaluation the main methods used by providers to identify the needs of these women included using:

- NCSP or BSA screening data to identify where priority women are situated and their ethnicity distribution
- key women / leaders in the community
- data (eg, Census, territorial local authority and deprivation scale data)
- anecdotal feedback
- community consultation
- their own needs analysis or evaluations.

In the initial survey we found that six providers carried out some form of community needs assessments in their region, but few actually used these in their planning processes. Providers largely used anecdotal feedback from key women in the community and from community groups and networks they had established connections with. However, the six providers who had undertaken needs analysis had used a variety of methods to develop demographic profiles, assess the enrolment and coverage in their region, and identify where specific priority groups were located.

In the midway and final surveys we sought more detailed information on how providers were identifying the specific needs of Māori and Pacific women. When planning for Māori women for 2005/06, screening data was the most influential form of evidence for seven providers, whereas six providers used key women or leaders in the community. When planning for 2006/07, five providers used screening data as their main source of evidence and a further 10 providers considered key women in the community to be their main influence.

Two providers in the midway survey did not use any data (NCSP or BSA screening data or territorial local authority data) at all when identifying the needs of priority women, while a further four providers did not use any screening data. Eight providers in the midway survey did not undertake any needs analysis for Māori women.

Two main methods were utilised by providers to identify the needs of Pacific women for the 2005/06 year: screening data and consulting leaders or key women in the community. Needs analysis was used by two providers as their main source of evidence in planning, while Census data was used to locate Pacific women and to direct health promotion activity to the areas of need. Other methods used to inform planning for Pacific women included building relationships, establishing a reputation within the Pacific community, and capitalising on well-known events in the Pacific community.

In the final survey, key women or leaders in the community were still the foremost method used to identify the needs of both Māori and Pacific women. The midway survey noted that seven providers used key leaders for Māori women, while five used key leaders for Pacific women. In the final survey, 10 providers used key leaders for Māori women to inform their planning, while 14 used leaders within the Pacific community.

One example of community consultation and utilisation of leaders in the Pacific community in the Auckland region has been the development of the Community Partnership event. This involved consultation with the Pacific community on their health needs (the Health Conference) and a follow-up event later in the year (the Health Fair) to report back on action undertaken as a result of the Health Conference. The providers involved in this initiative commented that they have been inundated with enquiries and interest from the community because of this initiative.

From the final survey it is apparent that providers are increasing their consultation with the community, and using data to inform their planning, although there is still room for improvement. Overall, providers are becoming more aware of the need to document feedback rather than rely on anecdotal information. However, across the board there is no standard needs assessment process and the rationale for the health promotion plan is more of an afterthought than the basis for activity included in the plan.

Although providers can build their own evidence around their community, they largely rely on the NSU for accurate screening data. This data includes the latest enrolment numbers, and data on ethnicity, coverage and participation. However, data – whether from the NSU or territorial local authority – was largely not utilised in the baseline survey, and this has only slightly improved over the three years. In the final survey only eight providers considered screening data as the main source of evidence when planning, compared with seven in the midway email survey.

One reason for this is that it has been difficult for providers to use data that is not only intermittent but not always accurate. One NCSP Regional Screening Services commented in the midway survey that:

> *... not having enough ethnicity data or statistical evidence affects the ability to identify areas to target, particularly with large geographical rural areas as time and resources must be allocated to areas of most need.*

Two providers commented in the final survey on how they have strategically focused their health promotion on areas they know are high need, based on Statistics NZ information, but that this is difficult without accurate screening data.

BSA lead providers and Regional Screening Services have received sporadic BSA and NCSP data over the three-year period, with the last data received in early 2006, but it appears that ISPs had received even less recent data, if any at all. While all data is sent by email to all health promotion providers (when available), the lack of data among ISPs may be due to frequent staff turnover and subsequent changes in email addresses.

For NCSP providers, further difficulty arises through the process of applying for data through the National Kaitiaki Group (NKG). This is a lengthy process, and while providers understand and respect the NKG, many commented that the delay in receiving the data was so long that it was no longer relevant when it arrived.

A further issue exacerbating the problem is that when providers do receive data, particularly the NCSP data, it is not in an easily readable format. This makes it difficult to interpret the data and use it effectively. It should be noted that it is difficult for BSA to have a rapid turnaround on the provision of data to providers due to the dependence on all providers sending their data on time. BSA is moving all (lead) providers on an information system, which will enable comprehensive, accurate, almost real-time internal audit, as with the Orion SBS, APS and RS suite.

Focusing on priority women

To increase coverage and participation of priority women in the programmes, health promotion services need to focus more strongly on Māori and Pacific women who are not participating in screening. The NSU specifically funds health promotion for Māori, Pacific and other priority women, and expects planning and delivery of health promotion to target these women.

For ISPS, as either Māori or Pacific health providers, these priority women have always been the focus of health promotion activity. However, through increasingly tighter planning and direction from the NSU there has been a gradual shift of focus for some of the mainstream providers who previously targeted health promotion for the general population of women. Providers commented in the baseline survey that due to the more rigorous planning methods they were concentrating more on Māori and Pacific women, and two providers noted in the final survey that they have put more effort for 2006/07 into Pacific women and a further two have increased activities for Māori women in 2006/07. This focus has appeared to continue throughout the evaluation as providers become more conscious for the need to have a reducing inequalities focus. In the final survey, 4 providers had increased their focus on Māori women and a further 6 increased their focus on Pacific women compared with the previous year.

One BSA lead provider commented in the final survey that:

> *There is no point writing a health promotion plan if you target all women. There is a need to have a reducing inequalities focus*

> *and directly target Māori and Pacific Island women.*

Although there has been a progressive shift to priority women, there still appears to be less emphasis on health promotion for Pacific women. At present there are only two Pacific providers, both of which are in Auckland. For the rest of the country, health promotion for Pacific women is either delivered by mainstream or Māori providers (who are not expected to plan for Pacific women). Although the mainstream providers may aim to capture Pacific women through other methods, the lack of specific health promotion for these women was highlighted in the baseline survey, and again in the midway survey. There has been improvement since the midway survey, however in the final visits six providers had increased their efforts for Pacific women since the previous year, while eight had increased collaboration or involvement and two had hired new Pacific staff to support development in this area.

A compounding issue for providers is recognising and then meeting the separate language and cultural needs of the seven main Pacific nations. These distinct needs have been identified throughout the evaluations by the Pacific providers, who undertake their own community consultation to identify the needs of these groups. These two Pacific ISPs recognise that it is not always possible to cover the needs of these groups individually and that they need to prioritise their time and resources. This affects mainstream providers differently, in that they may have small pockets of the different groups within their region and find it a challenge to approach these women. English is often a second language for the women, and providers often rely on other Pacific workers within their organisation or strong relationships with Pacific groups to build relationships.

The providers who are putting the effort into reaching Pacific women are starting to reap the benefits, however. One Māori ISP commented in the final survey that:

> *We were finally successful at penetrating the community by utilising key women in the Pacific community. We learnt the most successful methods for targeting and attracting Pacific Island women and we increased involvement with the right community people.*

3.1.2 Health promotion models and approaches

When undertaking health promotion planning, the model used by the provider to develop their health promotion plan and the philosophy or approach of the health promotion team were two major factors influencing the direction and subsequent activities of the health promotion plans.

Health promotion models

Discussion of planning during the baseline visits largely centred on the Ottawa Charter planning template, with many providers finding it difficult to adjust to the planning model. This was particularly apparent for BSA lead providers and ISPs who had previously had looser planning requirements. Providers spoke about the "high-level wording", the activities they would like to do that did not appear to "fit" within the Ottawa Charter model, how the NSU's template was repetitive, and that this model didn't allow for innovation. Many providers commented in the early visits that it was easier to just fill in the boxes of the templates, and that they found they were working to fit the template and not the community.

Although the majority of providers disliked the model, they generally felt supported by the NSU through the change to the new template and in learning the processes. Planning support was required from the NSU, who were forthcoming in their knowledge and assistance, although one provider felt the NSU had not provided enough direction when moving to the Ottawa Charter and four felt there was a slow turnaround to provide feedback. One provider felt the toolkit was excellent support to planning but that it could use updating.

In the subsequent email survey and final visits it appears that with time and experience the difficulties using this planning template have subsided. While thirteen providers had found the Ottawa Charter template challenging in the initial visits, it was an issue for only six in the midway email survey, although providers did still comment about the "prescriptive" and repetitive nature of the template. From the final visits it appears that providers have settled into using the model and are accustomed to the NSU planning requirements. In saying this, fourteen providers (6 ISPs, 3 BSA Leads and 5 Regional Screening Services) still feel that Te Pae Mahutonga or another kaupapa Māori model would suit them and the delivery of their service better.

One ISP has since commenced delivering their service using Te Pae Mahutonga. They commented that this model allows "a more specific focus on Māori women from a holistic approach". During the planning stages they took the model out for consultation and found that they could share the model with women from their community and that women could relate to it, whereas the Ottawa Charter was too "clinical".

In summary, providers have adjusted to using the planning template, but do not necessarily see this as being the best and most appropriate model for planning.

Health promotion planning approach

Planning and delivery of health promotion is largely influenced by the approach or philosophy of the health promotion team. This covers several areas: whether to use holistic or differentiated health promotion, whether to focus on health promotion or recruitment into the screening programmes, and whether to use one-on-one or population-based methods.

Holistic versus differentiated health promotion

Throughout the evaluation many providers stated that Māori health promotion operates holistically, and that breast and cervical screening should be delivered as one service. Kaimahi struggled to deliver health promotion for one topic only, particularly in education sessions with women, because they would ask questions about both programmes. Therefore, even though the majority of the providers deliver either NCSP or BSA, many approach health promotion from a holistic, well-woman approach and do incorporate both topics. The difficulty arises for the providers and kaimahi where they are only funded to deliver health promotion for one programme and not two.

To combat this, providers may job-share staff between BSA lead providers and regional screening services, sub-contract kaimahi from another provider to deliver the other topic, utilise their whānau ora contract, or just deliver it to the women without the funding because they believe it is necessary. The NSU have recognised this desire for the holistic well-woman approach and have recently acted on this by contracting three ISPs to deliver both BSA and NCSP health promotion in a new dual contract.

A holistic, well-women health promotion approach will often encompass other women's health issues (not just breast and cervical screening), and providers often find they are answering questions about menopause, pregnancy, menstruation, sexual health and a number of health-related issues. One NCSP DHB commented that:

> *We need to show women the changes that occur in their bodies. They need to understand their bodies before they understand why they need to be screened*.

Holistic health promotion is not limited to women's health issues, and many providers commented on the need to address the health of the whānau as well. Providers recognise that both Māori and Pacific women often put the needs of the whānau before their own. Two NCSP DHBs in the midway survey commented that they found that cervical screening health promotion fits within wider family health issues, which allows health promoters to discuss this topic within all the other health areas they have concerns about. Providers often put the focus back on the women in terms of their importance to the family, and talk "about looking after the women's own health as they are the mothers and carers of the family".

Conversely, holistic health promotion may not always be appropriate for Pacific health promotion. In the initial baseline survey one of the Pacific providers felt that breast and cervical issues were very distinct, and that time needed to be spent on each rather than merging them as one topic.

Health promotion or recruitment

The NSU recognises the fine balance between health promotion and recruitment in the Health Promotion Framework and further that both approaches should be used in conjunction (as necessary and appropriate). However, the implementation of the framework has been subject to a number of differing interpretations by health promotion providers around the country. Many health promoters believe their primary role is to promote screening to ensure women have robust information on which to make informed screening choices, and only secondly to assist the women into the screening pathway if they choose to participate. However, having health promotion as the first priority can sometimes lead to women choosing not to participate, and therefore reducing the rates of coverage and participation, whereas identifying and assisting individual women into the pathway who may have chosen not to participate increases the screening rates.

As one BSA ISP commented on the effort to reach and inform women, it is:

> … *especially for the hard-to-reach women who don't attend the health days and fun days. They like to be met on their ground on their terms. They like to get to know me and they are free to ask as much as they want and as little as they want. Some of these women in the workplaces have lots of other things going on and they want to do their job and leave. They like health promotion on their terms*.

During the baseline survey, providers noted that the performance of their health promotion activities was measured according to changes in coverage and participation rates. They felt if they were being measured on numbers it was better to actually recruit women to the programme and thereby increase their rates. Not surprisingly, the balance between health promotion and recruitment and the subsequent activities used by providers to achieve the desired results differs throughout the country. One BSA lead provider commented that health promotion is about "ensuring kaimahi make the time to truly inform a women and not merely going for the numbers".

One-on-one versus a population based health promotion approach

As with the above section on holistic health promotion, the baseline survey highlighted the number of providers who utilise a more one-to-one, and therefore more of a recruitment approach to their health promotion. Health promoters commented that the personal face-to-face contact was more effective for Māori and Pacific women, but that through the shift by the NSU to a more population-based approach, providers were being strongly encouraged to deliver health promotion to the wider population. In the initial survey three providers commented that they planned according to the NSU requirements, but still incorporated a one-to-one approach because they felt it was necessary to meet the needs of their women.

3.1.3 Planning methods and processes

All three phases of this evaluation highlighted a number of factors that affected and/or influenced each provider's plans. This section discusses who is involved in planning, what influenced planning, and changes to plans and planning processes throughout the evaluation.

Who is involved in the development of health promotion plans?

The development of the health promotion plan is largely an internal process within the provider. Both health promoters / health promotion co-ordinators and managers featured strongly in the midway survey and again in the final survey, and they often collaborate to write the health promotion plan.

Although providers meet regularly, it is evident that actual regional planning is limited, as providers within a region had little or no input into each other's plans throughout the evaluation. It appears that providers meet to discuss initiatives and plan for specific events rather than undertaking collaborative planning to ensure coverage of the region. However, one BSA lead provider mentioned that they meet with the ISPs in the region so that all providers can have input into writing their plans.

Similarly, the community may be consulted when providers are working on identifying their needs, but this community consultation does not always continue into the actual plan development. Only three providers utilised the community to develop their plan. One ISP used their iwi advisory group, another ISP utilised the input of their subcontracted providers to the 2006/07 plan, and one NCSP DHB took their plan out for consultation to the community and asked for input into activities and initiatives based on their needs and requirements. This last provider noted that not all suggestions were feasible, but all suggestions and input were followed up with face-to-face contact. In this case, once the plan was signed off by the NSU it was taken back out to the community to inform them of their intentions.

In the baseline survey one provider felt there was a drawback to consulting on planned activities using established community groups because it was always the same women who attended these meetings.

Factors influencing health promotion activity

A number of factors influence health promotion activity. Providers have realised through experience that they have limited time and resources and they cannot afford to hold or attend every event possible. Providers therefore often make the strategic decision to attend events where the larger numbers of priority women will be, or to focus on actual screening activity.

For BSA providers, health promotion activity often occurs around the mobile unit. The influence of the mobile unit was established in the baseline evaluation, and this was still the case in the final visits. This is a practical influence, and health promotion occurs in the three months before the mobile unit arrives. Promotion involves informing local GPs, advertising on local radio or in papers, and promoting the unit with local community groups. A large amount of effort goes in before the mobile unit arrives to prepare the location, raise awareness and ensure the accessibility of the venue. Providers feel that health promotion associated with the mobile unit maximises actual screening numbers.

Many health promoters attend regional or local events where they know that large numbers of priority women will attend, because it enables them to capitalise on opportunities to reach large numbers of women. Providers may have a stall, sponsor events or go to support the overall event in order to build relationships within the community. These events may be:

- fairs and community days around the region (eg, A&P shows, local fairs)
- national festivals (eg, Matariki)
- iwi-based festivals (eg, Tainui games)
- cultural shows or competitions (eg, national kapa haka competitions)
- sports events (eg, national waka ama championships)
- career expos such as Spacifically Pacific
- promotional weeks such as Mana Wahine Week or Breast Cancer Awareness Week.

Although regional events and the mobile unit influenced what activities were included in the health promotion plan, the most influential factor identified in both the midway and final surveys was the previous year's plan. That is, we found the process many providers followed when planning for the upcoming year was simply reviewing and revamping (or cutting and pasting) the previous years plan based on anecdotal information, rather than adapting the plan and health promotion activities to reflect documented needs assessments, consultation and evaluation.

Changes to planning processes

Providers are increasingly recognising the need to continually change and update each year's plan. In the development of the 2006/07 plans 21 providers said they had made some changes to their planning process compared with only 12 in the midway survey. The main change in both phases was increasing consultation with the community in the planning process. Nine providers (5 ISPs, 1 BSA Lead and 3 NCSP Regional screening services) increased their consultation with the community for the final survey, while two used more evaluation and a further two used more data. However, one BSA lead provider felt they "didn't have enough time" to include other regional stakeholders or the community in the planning for 2006/07.

In the midway survey 11 providers had made changes to their health promotion activities for Māori women for 2005/06 while eight had continued with the same activities as the previous year. The changes included an increased focus on Māori women (increased involvement with the Māori community or more collaboration of activities with other providers).

As already mentioned, there appears to be less of an emphasis on health promotion specifically for Pacific women across the country. This is reflected in our findings that there were limited changes to health promotion for Pacific women for 2005/06 identified between the baseline and midway surveys. Only four providers made any changes to their activities in the 2005/06 plan for Pacific women from the previous year, meaning the other providers continued to implement the same health promotion activities for Pacific women. One implication is that these other providers are not identifying the specific needs of Pacific women from year to year, or planning to meet those needs.

3.2 Health promotion implementation and delivery

Both BSA and NCSP providers undertake a number of activities to reach, inform and then motivate priority women to be screened. When providers are planning and delivering their health promotion services, they aim to reach women through a variety of methods and in a number of settings to help as many women as possible to make an informed decision about participating in screening. The following sections document important considerations for the development and types of health promotion activities for Māori and Pacific women.

3.2.1 Reaching and informing priority women

Providers noted – mainly in the midway survey – what they consider to be important factors in reaching and then informing Māori and Pacific women about screening. Many of these factors are similar for both groups, such as building relationships and trust within the community, using a one-to-one personal approach, and providing a safe environment where the time can be taken to discuss these issues. Providers recognised that this stage cannot be rushed, and only through taking the time to understand these communities and establish a relationship can BSA and NCSP then be discussed.

According to the providers, and in their own words, the activities used to reach and inform Māori and Pacific women about screening are those that include the following.

Face-to-face contact through one-on-one health promotion

> *Some prefer one on one, because they feel whakama about their personal hauora. When they have been through the screening process they become our champions and are able to share their experiences*. (BSA ISP)
>
> *One on one sessions with Pacific women in their homes*. (NCSP DHB)
>
> *Face to face with women and supporting them to go with a friend so they can awhi each other*. (BSA lead provider)

Building a rapport

> *Consistent personnel employed at organisations to build up trust*. (BSA lead provider)
>
> *Build up trust through involvement in Pacific activities*. (NCSP DHB)
>
> *Need the time to develop a relationship so that issues can be discussed in-depth*. (NCSP DHB)

A community focus

> *Working with all Pacific nations in the community and reaching them through church gatherings and key women recognised by these groups. (BSA lead provider)*
>
> *All activities that involve Māori women in the whole process – from consultation to implementation. (BSA lead provider and NCSP DHB)*

Recognising the importance of whānau and friends

> *Honest, clear, simple information and be able to make the need relevant to women, have whānau input and make the women aware of the crucial importance of being screened. (BSA lead provider)*
>
> *Informing women for the benefit of the whānau. (BSA ISP)*
>
> *Encouragement from their families. (NCSP DHB)*

According to the providers, the health promotion activities that produce a screening result for both Māori and Pacific women are those events that provide the option to have the smear or mammogram right there and then. This may mean having "smear takers present at hui" (NCSP ISP) so the screening is available "on the spot" (NCSP DHB). Māori nurse smear-takers are beneficial for Māori women "so women can be offered the choice" (NCSP DHB), but also because "Pacific women do not mind having a Māori smear taker" (NCSP DHB). For breast screening, especially in rural areas, providers take advantage of the BSA mobile unit when it is in their area: "Waiting for the mobile is difficult for a lot of women so if the unit will not be in the area for ages they are not keen. So we promote around the time of the mobile" (BSA ISP).

Providers also noted that an actual screening result should only occur after clear and honest information has been provided to women. For Māori women, one NCSP provider noted it is beneficial to have "female smear takers who take the time and are skilled in communication and tikanga" (NCSP ISP). For Pacific women, it is ideal if health promotion is "delivered in Pacific languages" (NCSP DHB) so women are fully prepared for the smear or mammogram. One BSA lead provider commented that they "utilise another health worker for language support if available" to meet this need. One NCSP commented:

> *… having a Pacific health promoter accompany women through the process, particularly someone who can speak her language so she is comfortable and not on her own. An ethnic speaker to meet the language and culture would be ideal. (NCSP ISP)*

An NCSP DHB commented that having transport available for women to attend often ensures a screening result.

3.2.2 Activities used to increase coverage and participation of priority women

The activities included in this section have been described in terms of the NSU's Health Promotion Framework activities: community development, communications and health education. Community development is described as "building relationships and developing long-term ownership of initiatives with priority groups". Communications is distributing "accurate and appropriate information related to screening", and health education is "constructed opportunities for learning".

Although these three components have been separated for the purposes of this report, this is not to say that they mutually exclusive: they are all often intertwined to achieve the desired outcomes. One Pacific provider believes that only through the combination of radio advertisements and talkback (communications), outreach clinics (health education) and their community partnership events (community development) have they become successful.

This section offers a comprehensive look at the range and nature of activities being undertaken under each of the three sections of the framework, from all three phases of the evaluation and for both Māori and Pacific women.

Community development

Innovative activities with a well-woman focus

Providers have recognised that the hard-to-reach women rarely access health education sessions and do not attend or participate in regular events. To reach these women, providers have become innovative by offering more personal and appealing activities to attract these women. These events do not primarily focus on breast or cervical screening and therefore provide other incentives for women to become involved in the events, while allowing the health promoters to share the key messages of the programme.

Activities such as pamper days and ladies nights have become a regular event for many providers because they "bring women in for some other reason than cervical screening" (NCSP DHB) and provide "an incentive to create some interest". Many providers commented that these types of events were the most successful activity over the 2005/06 year because "a face to face relationship was established" (BSA ISP and NCSP DHB) and they give the "time to develop a relationship so that issues can be discussed in-depth" (BSA lead provider). These types of events have also been successful for Pacific women, although it involves "intensive community networking and establishing contacts to identify where Pacific women work and participate", but the result is that the "numbers of women have grown as the event continues" (BSA lead provider).

Although there have been many activities over the past year, two innovative initiatives included:

- a Fashion the Facts fashion show, which involved a fashion show of local women to raise awareness of screening issues among Māori and Pacific women – approximately 200 women attended the event, which was supported by a media campaign
- Wahine – a black-and-white photographic exhibition telling the story of eight Māori women living in the region. The exhibition included 24 photos accompanied by a story sharing the lives of the women, the importance of whānau, and survival of cervical cancer. The women shared their stories and aimed to break down barriers and encourage other Māori women to have a cervical smear.

These types of community development activities have a reach much further than just the event itself, and while they are often time and cost intensive they build strong relationships within the community and have a long-lasting effect.

Marae-based activities

Providing health promotion and subsequent screening on the marae has proven effective for a number of providers, and many said that activities based on the marae were the most effective for 2005/06. The marae is used to reach and inform women about screening. As one ISP commented, it is always effective as a venue and hui at marae often have large numbers of wahine and whānau attending. This setting also receives a positive response because the marae is "readily accepted as a non-invasive approach to informing wahine" (BSA lead provider) and is a "safe environment" in which to offer these services.

Marae screening has been an extremely successful activity for one provider, who stated that "the health promotion team was on board from start to finish (for the event", "all staff (including radiographers) are welcomed onto the marae and they feel safe there", and that they now go "to the same marae each year and are now established there". (BSA lead provider). Another provider commented that subcontracting a health promoter located within a marae was their most successful activity, because "It pays to have a person in the organisation on the marae" (NCSP DHB

Building relationships with community leaders and groups

Relationship building is an essential aspect of health promotion, particularly because breast and cervical screening are sensitive issues. Health promoters identify appropriate individuals or leaders within the community to gain their support and influence among the community. For Pacific women, this often involves recruiting church or community leaders. As one BSA ISP commented, an important aspect of effective health promotion is "building relationships within the community groups before any action is undertaken".

Using well-known people, key women or 'champions'

Many providers utilise champions or survivors of breast or cervical cancer to share their stories, because "Personal stories of wahine who survived cervical cancer are a great asset to motivating other women to be screened" (NCSP DHB). This is particularly effective when local or "well known wahine of the community speak at events about their own personal journeys in the programme" (BSA lead provider). A number of providers felt that champions sharing the impact of their journeys is the most effective of their activities used to reach Māori women.

However, it is not always just well-known women who encourage other women. Providers have also commented on the effect a positive screening experience can have on a woman and her family and friends. As one NCSP DHB noted in the midway survey, "When a Pacific woman has a positive experience and takes it back to her family networks and encourages them through the screening process, other Pacific women are then encouraged to participate".

Collaborative community development events or promotions

Providers and health promoters often capitalise on collaborating with other providers, events or promotions, particularly where they are working in large geographical regions and have limited budgets. This collaboration may be between an ISP, a BSA lead provider and an NCSP DHB; between Māori or Pacific health providers not contracted for screening health promotion; within a provider with other health promotion services offered in-house'; or in collaboration with the community to deliver an initiative.

This type of collaboration has proven especially effective for providers with large geographical regions to cover. By tapping into already established events they can maintain a presence at events around the region. One BSA ISP "piggy backs onto other events" and notes that "geography can dictate the ability to attend several hui on different days". For other providers, having a presence in wider community activities develops "trust and knowledge of [the] programme and its messengers" (NCSP DHB).

This approach is often successful because it applies a holistic model of health promotion, distributes the time and cost of health promotion among providers, and often forges strong relationships in the community.

Some events have been initiated by health promoters within the community only to eventually be taken over and led by the community. Two such examples are community health days and community netball tournaments. One NCSP provider started (along with other health promoters in the area) a community health day for Māori in 2003. The health day offered a free hangi to people who completed a 'body check', which included cervical screening. This community day is still running annually and in 2006, the provider noted that the community organised the event themselves this year and will continue to do so. The community netball tournaments, which take place in various regions around the country, arose from the providers recognising that many Māori women participate in sport, which makes these events appropriate vehicles to promote breast and cervical screening. These events involve strong collaboration between providers and have significantly grown over the years.

Following are a few examples of other events undertaken by NCSP/BSA health promoters and the community.

- Walk Your Way to Sydney – this supports women in the region to improve their health through a 13-week programme, with weekly education sessions and support for the women through their exercise.
- Sisters in Health – this originally arose out of two women diagnosed with cervical cancer and involved training 25 mainly Māori and Pacific women to become ambassadors to promote breast and cervical screening. The initiative provided the initial training and offered ongoing support for the women. The train-the-trainer concept has been incorporated into many different activities and is not limited to Sisters in Health, which is just one example.
- The low-cost smear initiative for NCSP – this involved the NCSP programme working in partnership with local health providers and community groups to offer low-cost, accessible and culturally appropriate smears in the community, and developing promotional information to advertise the low-cost smears.
- Wahine Collaborative Project – this builds on the Sisters in Health project and involves training wahine Māori leaders within the rohe to become champions within their own rūnanga. The training and support and follow-up are a collaborative effort between the NCSP DHB and the ISP.

Workplace initiatives

These activities often involve health promoters establishing relationships with workplaces in their region that have high numbers of Māori and Pacific employees. This involves encouraging workplaces to support well-women initiatives, such as working with management to initiate policies to include time off for screening, putting education information into payslips, providing education sessions on-site, or even allowing cervical smear-takers on-site.

Clinical and/or cultural training and support for smear-takers

Qualified and culturally appropriate smear-takers are always required, and some providers have supported, supervised and/or mentored Māori and Pacific smear-taker trainees as a way of increasing the choice of smear-taker for Māori and Pacific women. Health promoters may be utilised to provide cultural support for nurses working with Māori and Pacific women.

Relationships between BSA and NCSP providers

A number of initiatives are undertaken as collaborative efforts between the NCSP and BSA to capitalise on the opportunities that each provider brings, and to maximise the opportunities to reach priority women. For example, the positive relationship between a BSA lead provider and a Pacific ISP has established a block-booking system whereby five slots are available every Tuesday for the ISP to book women in. The ISP uses the same staff member, who contacts the women, picks them up, goes through the screening process with them and takes them home. The GPs notify the women and the ISP so they can complete their own files, and then the woman is removed from the list until two years later.

This initiative was piloted at the beginning of 2006 and both providers feel it has had a positive influence on the number of Pacific women brought into the programme. Another positive relationship between a lead provider and a BSA ISP involved taking "the mobile for the first time out to extremely rural areas". The ISP felt this was their most successful activity for Māori women because the women responded so positively and the community got behind the promotions and put "articles in the paper" (BSA ISP),

Communications

Providers generally utilise communications activity to promote awareness of the programmes or to advertise events or the BSA mobile unit. The different types of communication activity are described below.

Local media

This is the most well-utilised communications activity, which may involve advertisements on the radio to advertise the mobile unit, or slots on community radio to discuss breast and cervical screening issues. Providers promote and advertise in the months prior to the BSA mobile unit being in an area or region. This is the most important communication activity for providers, as demonstrated in the midway survey.

We found that health promoters saw radio programming as an effective medium for both Māori and Pacific women, because it is possible to reach a large number of priority women and often in the appropriate language. Providers utilise native-language speakers to deliver messages in Māori and the Pacific languages. Radio programming involves talkback with promotional messages in between, advertisements of services, and interviews with key women or champions. Often these promotions are co-ordinated with screening or awareness weeks or events.

One Pacific provider uses the radio to advertise clinics being held in the community through 30-second messages played five times a day in eight languages. The messages promote screening and say where to go for more information. They also utilise radio discussion programmes for half to one hour each week in Samoan, Tongan and Cook Island languages (all weekly) and Niuean (monthly). The radio discussion programmes often have women call in to encourage other women to go along and share experiences. The provider noted that the talkback session can focus on relevant issues; for example, raising the awareness of the effect a 'did not attend' (DNA) can have, and emphasising the importance of turning up to the appointment because another Pacific woman could have been screened.

Magazines and newsletters

Advertising in magazines is mainly an auxiliary activity and usually involves profiling an event, activities or a local woman. This may include iwi, trust or organisational panui or newsletters, or other community panui or notices

Sponsoring events or teams in the community

In the midway survey half of the providers had sponsored, or routinely sponsored, teams or events in the community to raise the profile of the programme.

Distributing programme information

This may include inserting flyers into pay packets, flyers for children to take home from kōhanga reo or marae, and school newsletters. These flyers may include information about screening, where to go and who to contact.

Utilising programme resources

The NCSP and BSA programme resources are utilised by providers in a number of settings, such as health education sessions. Providers utilise all programme resources to varying degrees and many commented that the most effective are the “informative brochures that are easy to read” (BSA ISP), and those that “are useful, simple and not covered with the word CERVICAL SCREENING” (NCSP DHB). Many BSA providers believe the BSA mobile unit is itself a useful resource because it advertises the programme and women are aware when it is in their region.

An example of a successful communications initiative was the Joint Venture for Priority Communities (involving three low-decile communities within a region). This was a cervical screening media campaign to support strategies aimed at priority women in identified priority communities. The activities were developed in consultation with health providers and community groups in the three target areas, and included the ‘Be a friend’ theme, which encouraged friends to support each other to have cervical smears. All activities were promoted by radio and print media. The evaluation from this initiative found that both radio and print campaigns are effective media for sharing cervical screening messages, whereas flyers were not as effective.

Health education

Providers use health education to inform women about the programmes and their choices. Health education often involves sharing information with women using the NSU’s national resources, including the flipcharts, posters, pamphlets and friezes. Providers often share resources and distribute them among their networks, and some providers have developed their own resources. Static displays often involve providing pamphlets and information set up at stalls at community fairs, outside malls or stores, or other similar venues.

Other settings for health education include pamper sessions, ladies nights, smear parties, flax-weaving, and drop-in clinics to share screening information while also imparting other knowledge or experiences. One BSA ISP conducts monthly presentations in conjunction with an NCSP health promoter delivered from a well-woman approach.

Although health education sessions often involve standing in front of a group of women and delivering a session on the programme and its resources, health promoters have commented that the information often ‘goes in one ear and out the other’. In the final survey it was established that in order to deliver a more effective session, health promoters are using a more interactive approach. One

NCSP health promoter asks women to share their views and experiences of screening, and guides the discussion by sharing the key messages of the programme and answering any questions through using the resources of the programme. She has found this method involves the women more and has a longer-lasting effect as the group share their stories and experiences.

Throughout the three years of this evaluation, providers have increased their recognition of the important role GPs play in both breast and cervical screening. As a result, health promotion activities focused on GPs have increased throughout the three-year evaluation. Initially, GP activities occurred in the baseline evaluation as a 'special project', whereas now many providers employ a GP liaison person to co-ordinate these activities. Health promoters develop and maintain collaborative relationships with GPs, Independent Practitioners Associations (IPAs), practice nurses and practice managers to share client lists, update GPs on the programme, encourage GPs to be proactive in enrolling women onto BSA, or undertake smears where possible. Health promoters are also able to inform GPs and practice nurses about the cultural needs of Māori and Pacific women.

A number of providers have undertaken booking or voucher schemes with their PHOs, and some providers also receive lists from GPs of their hard-to-reach women, which the provider, often an ISP, will follow up.

3.2.3 Approaches for women who choose not to participate

Many providers mentioned throughout the three years that they often came across women who chose not to participate in either programme. The providers discussed how they approached these women, and many commented that it was important to really listen to the woman, provide honest and clear information and then respect their choice. The providers' comments are listed below in their own words.

Listen to women

> *Listen to their stories, explaining the benefits and harms. Emphasise that it is a choice*. (NCSP DHB)
>
> *Listening without being judgemental and never completely closing doors on a client, even though they may choose not to participate in the programme. In time attitudes can change, and a no, a maybe, then a yes is not an unrealistic target to reach.* (BSA lead provider)
>
> *Talk them through the process and get them to ask any questions that may "stop" them from wanting to participate.* (NCSP DHB)

Respect a woman's choice

> *We respect their choice and continue to support them while subtly trying to get our message across. For some women we have worked this way for 3–4 years before they shift; some still haven't after 8 years. (NCSP DHB)*
>
> *Accept their wish and explain they can always change; keep the door open. (NCSP DHB)*
>
> *Document the numbers of women who don't want to be screened so the clinics don't send letters out. Some say it's not for them at the moment but always let them know the door is open if they change their mind. (BSA ISP)*
>
> *Respect the woman's choice not to participate in the program, but continue to encourage her to use the screening as a wellness measure for this particular time in her life. (BSA ISP)*
>
> *We allow them the choice. We do not get pushy with any women. We tell them that it is ultimately their decision, we feel it's important to be as transparent as possible. (NCSP DHB)*

Provide accurate honest information

> *Ensure they have accurate information, including the importance of contacting their health professional if there are any signs or symptoms concern. Give them information about the choices available to them. Inform them of their right to a support person. (NCSP DHB)*
>
> *Be clear and honest. The experience of screening is not pleasant, but*

should abnormal cells develop the procedure is more evasive and intrusive so screening is a method by which they avoid this treatment. (BSA lead provider)

Show them the new equipment and how user-friendly plastic speculums are. How smear taking has changed. (NCSP ISP)

Provide options for information and screening

Providing choices, appropriate information and support. (NCSP DHB)

Health promoters advise these women of the region's free smear taking service. NCSP nurse smear takers provide women with a compliments/complaints form. Feedback is all positive from women who have had bad experiences in the past. (NCSP DHB)

We liaise with women in the community who have personal stories, we give out our messages, give them options of where they can go. (NCSP DHB)

We explain that changes have been made to the smear taking process. That they have options of different smear takers and Health Services. We give them local contact details if they wish. (NCSP DHB)

Refer to outreach provider. (NCSP DHB)

Offer free, appropriate, female smear takers. (NCSP ISP)

Include whānau

It's about whānau and including all members to participate. (BSA ISP)

We are finding women are starting to be more proactive, and coming into the programme. Whānau and whakapapa are two key strategies that are priority at present. (BSA ISP)

We also offer direct support for women and their whānau should they need it. (BSA lead provider)

Work through the bad experiences

To identify what the bad experience was and to work through that with wahine, with focus of kaimahi support always being available. (BSA ISP)

Try to sort out the issues. Explain the benefits of being part of the programme and then ultimately respecting their decision. (NCSP DHB)

> *Allow women to talk through their experiences acknowledging the effect on them. Peer support helps to assist with persuading women that smear-taking has changed. (NCSP ISP)*

3.3 Evaluation of health promotion

3.3.1 Evaluation activity undertaken by providers

Evaluation activity undertaken by providers includes the following.

- Informal or anecdotal feedback from women or the community – this ranges from discussion straight after an education session, through to discussions with women in the community.
- Feedback forms after health education sessions or health promotion events – these usually ask women their views on the session, if they are up to date with their smears/mammograms, and suggestions for improvement. One provider stamps evaluation forms after a session so that later enrolments on the form can be attributed to their health promotion.
- The number of women attending sessions or events, particularly as events are repeated over the years – providers count the number of participants who attend and note any increases in numbers.
- Own evaluations of events, promotional tools and health promotion activity – this is often used for special events, and may include lessons learned and suggestions for improvement for the next event.
- External evaluation of communities and the effect of health promotion activity.
- Databases such as Lifedata, which collects information about women who come into contact with the provider – this database records all contact the provider has with a woman, including attendance at health promotion events. One Pacific provider noted that this allows them to look at how many times a woman attends a session or receives information about screening before she decides to have a smear or mammogram.
- Documenting activities – such as recording minutes of meetings with stakeholders and the community.
- Photos of women attending sessions and events – these were used by two providers in the baseline survey to visually document participation and success of the event because they felt feedback forms were not completed.

- Special projects to investigate certain issues – for example, one BSA Lead provider with a high DNA rate investigated why Māori and Pacific women did not attend their appointments. It was established that DNAs correlate with how the women were enrolled (eg, if the doctor enrolled the women they were more likely to DNA than if they made the appointment themselves). From this evaluation it was decided to phone women to remind them of their appointments.

3.3.2 Extent of evaluation of health promotion activity

The initial baseline survey highlighted that evaluation was not routinely included in the planning and implementation of health promotion initiatives and was often more of an afterthought. Providers usually measured their success on informal or anecdotal feedback from women or the community. Twenty providers conducted informal evaluation only, and most feedback from women was verbal and personal, given directly to health promoters at the time and rarely documented.

The initial survey found that only four providers were undertaking regular evaluations of their own activities (other than informal education session and anecdotal feedback). The remainder did not, sometimes because of lack of time, knowledge or resources, and sometimes because they saw it as someone else's role to evaluate health promotion programmes (eg, the NSU). Two providers used the Innovation Funding available during 2003/04 to externally evaluate their service. Five providers undertook programme - or event-specific evaluation, such as evaluations after promotional hui, but on the whole there was no systematic internal evaluation done locally or regionally. Despite the lack of formal evaluation of their own activities, providers were aware it was something they did need to consider undertaking more regularly.

In the midway survey it was established that verbal feedback was still the main method of evaluation for 12 providers to measure how effective health promotion activities are for Māori women, and five providers mainly used this method for Pacific women. A further five providers largely used their own evaluations to establish whether or not the activity had been successful for Pacific women compared to six providers who did their own evaluations for Māori women.

Four providers used the numbers of Pacific women who attended sessions or events to evaluate the success of their health promotion, as distinct from those who subsequently take up participation in the programme, compared with two providers who used this second method to monitor effectiveness for Māori women. As one BSA lead provider commented, they feel their health promotion has been effective by counting:

> *... the numbers of women, who subsequently attend for mammogram, encourage others to attend education/screening, or contact the lead provider for further information/ sessions.*

One NCSP DHB uses external evaluation of activities to identify which activities are working and which are not, and another NCSP DHB uses interviews or questionnaires. Most providers appear to agree that written feedback is not a successful way to evaluate activities for Pacific women. One provider uses interviews of the women and/or the community to gauge the value of the events.

In the final survey, ten providers said that all health promotion activity is evaluated (one of these providers also utilised external evaluation for certain activities), while six said they evaluate only education sessions. Five providers evaluate certain events or projects, which, as one provider noted, they evaluate "for projects in specific screening weeks". Two providers use external evaluation. The remaining providers use a combination of verbal or numeric information to measure their effectiveness

One of the providers who evaluates all health promotion activity noted that "it was time consuming". A BSA ISP stated that "most of our health promotion activities are evaluated, and at times we rely on external evaluation", while a BSA lead provider commented that they evaluate "health promotion activity both informally and formally, quantitatively and qualitatively".

One Pacific provider who utilises feedback forms to measure their success has recently changed their form to gain more specific feedback from women. Their new form allows health promoters to know what they need to improve on, and after each session the provider summarises all evaluations to sum up the positive aspects and identify what could be improved.

External evaluation was identified by two providers as being carried out during the previous year. One provider stated that they carry out evaluations of big events and every second year undertake external evaluations of communities in their region. The provider stated that external evaluation "gives objectivity and some awareness of where the programme is at". They have found through the previous evaluation that there has been a huge increase in numbers, and the next evaluation will give direction on how best to direct time and resources into the area.

Kaimahi from one NCSP DHB commented that they felt their management was not supportive of evaluation activity and was not interested if they do it, which meant they struggled to get support to undertake any evaluation. Another NCSP DHB felt their evaluation is "at a very beginner's level", and two providers are utilising evaluation knowledge of other DHB staff for support. One BSA lead provider had done no evaluations of any activity for Pacific women during 2005/06, and one NCSP DHB provider does no written evaluations and said in the final interview that "the extent to which we evaluate our health promotion activity is a debrief" following the activity. Another BSA ISP commented that "there is room for improvement".

3.3.3 Linking the evidence back to planning

In the initial survey, providers commented that through their own experience and efforts they felt they were becoming more efficient with their time and resources, and no longer attend every hui and expo. Providers had learnt how difficult events are if they are not planned well and had become more focused and specific in their planning of events. Most providers had reviewed the activities over the previous year and decided what to continue with and what was not worth it. Rather than having a rigorous evaluation process, providers largely rely on 'gut' feelings and what they feel works.

Reviewing the previous year's plan was a large influence in planning, as identified in the midway survey: "Some planning around each initiative was dependent on the effectiveness of it in previous years" (BSA lead provider). As one ISP commented in the final survey, "There is no consistent method of evaluating activities and at times it becomes difficult for the following year's plans".

3.4 Relationships and links

3.4.1 Building and maintaining relationships with the community

Building and maintaining strong, robust relationships with the community was acknowledged throughout the evaluation as an essential first step for health promotion, particularly for Māori and Pacific women. Providers utilise community relationships to:

- meet with the Pacific community group twice a week to keep them updated with the programme, and attend any other community monthly meetings (as able) and often give a brief update (BSA lead provider)
- ensure we get into the Māori community. We attend hui or events of the various hapu in the region and support hapu when requested (NCSP DHB)
- commit to a lot of collaborative events among the Māori community, and encourage inter-sectoral collaboration (BSA ISP)
- try to identify key leaders in each Pacific group who are on board with screening and continue to build on the relationship (NCSP DHB)
- ensure that Pacific women are part of local support communities, and encourage and support Pacific champions (BSA lead provider)
- ensure that Māori women are fully informed of the screening programme, and

that we support women through the screening pathway (BSA ISP)

- build and strengthen relationships with other stakeholders and organisations local, regional, and nationally (BSA ISP).
- keep showing our face before Māori organisations, community, marae, runaka, hui and any event where Māori gather (NCSP DHB)
- network with Pacific organisations and workers, and attend meetings of the Māori and Pacific Women's Interest Group (NCSP DHB)
- ensure dialogue occurs with other providers/NGO's/community groups on a regular basis, and that in turn allows for the joint venture process to occur more consistently (BSA ISP)
- maintain the relationship by going into Pacific homes and discussing any other health issues – keeping involved in this way gives them the confidence to discuss what they need (NCSP DHB).

> *Seeing programmes come to fruition and community engagement in hard to reach areas become a reality. Having more participation with the community as community engagement occurs. Building relationships with community organisations so that partnerships can occur and more effective programmes delivered*. (NCSP ISP)

3.4.2 Building and maintaining relationships between providers

As previously mentioned, relationships and links between NCSP and BSA providers have brought about a number of positive health promotion initiatives. These include:

- Networking with other health promoters to see what works well for them and sharing ideas (BSA lead provider)
- Communication with ISP regarding their plan (Lead provider)
- A collaborative approach by all health promoters in cervical and breast screening areas (BSA lead provider)
- Ability for all health promoters in the lead provider area to work together on total screening pathway (BSA lead provider)
- Iwi advisory expertise (ISP)
- Subcontracting health promotion out to Māori (Lead provider).

Relationships with subcontractors or other providers in the region can assist providers to maximise their networks and knowledge for example:

- Subcontracting health promotion out to Māori providers can utilise their knowledge and integrate breast and cervical screening where necessary. (NCSP DHB)
- Positive relationships with the lead provider (BSA ISP)
- Team building with other health providers (NCSP DHB)
- Work in collaboration with the Pacific Health Promotion provider in the region. (BSA lead provider)
- Developing regional relationships with many community providers of many services. (NCSP DHB)

Strong relationships with other providers allows the "ability for all health promoters in the Lead Provider area to work together on total screening pathway" (BSA lead provider), however one BSA ISP commented that while they "work with a number of organisations but there is limited relationships with other BSA providers".

It was identified in the initial survey that providers in one region have a strong focus on working collaboratively and they meet bi-monthly" to plan hui and events. Two providers said they have had differences in opinion over some of the initiatives, but this does not seem to have had a dramatic effect on regional relationships. Collaborative initiatives arising from the regional planning included the DNA project for BSA women and a collaborative hui to identify ways to improve coverage and participation throughout the region.

In another region, quarterly meetings were held to discuss issues, and the initial survey documented disharmony between the regional providers over the movements of the mobile unit. In the past the lead provider has made the decisions about the movements of the mobile unit without consulting the other providers. This is particularly frustrating for the other providers, who have to spend the lead-up time (usually some months) preparing their community for the mobile. One BSA lead provider stated that their time and money is wasted. They also feel their credibility is at risk, because women who were prepared for their screen are let down and may not attend again when the next round of the mobile is scheduled.

One provider, who has dual contracts for both breast and cervical screening, subcontracts eight providers to deliver health promotion in its region. There are four providers each in the northern and southern parts of their region. These providers receive no specified funding for the positions, so they fund them out of general health promotion funds. The providers distribute resources such as pamphlets and posters, and participate in community events to promote both breast and cervical screening.

Relationships between providers in this region have been strained, but things have improved over time. The term 'lead' is believed by some ISPs to have the unintended implication that the ISPs are somewhat subservient to the lead and must report to it. Some lead providers believed that ISPs do not understand screening and assessment processes, and these beliefs have caused some tension between providers. Overall this issue has not been insurmountable, and providers have been able to work together and they believe they have a robust relationship.

The initial survey highlighted that providers throughout the country have a number of informal relationships with organisations and groups. These relationships may involve providing contacts within the community or actually undertaking health promotion within these organisations. Providers have relationships with organisations and groups such as:

- local preschools, kōhanga reo, kura kaupapa Māori, primary and secondary schools
- universities and tertiary education establishments
- iwi, hapū, rūnanga and marae
- Māori Women's Welfare League
- Pacific Island network groups (eg, Cook Islands Health Network)
- Ethnic Community Council
- Women's Refuge, Victim Support and Rape Crisis

- local GPs, IPAs and PHOs
- laboratories, non-medical smear-takers, private health services, colposcopy clinics
- Arthritis Foundation, Blind Foundation
- Community and Church groups (eg, Baptist Church Women's Group)
- local workplaces (eg, The Warehouse, Cadbury, New World and factories such as Tegel (health providers may utilise OSH nurses at these factories)
- Citizens Advice Bureau
- Family Planning Association
- Māori and Pacific health providers (that do not deliver BSA or NCSP health promotion)
- Plunket, Salvation Army
- Disability Networking Group, disability and information services, Disabled Persons Assembly
- women's prison
- local city councils and community centres
- sports foundations and groups
- government departments in the area (eg, Department of Corrections, WINZ, ACC, CYF, Ministry of Pacific Island Affairs)
- regional health providers (both Māori and non-Māori) and public health units
- internal staff at DHBs (eg, Māori and/or Pacific team)
- Taitokerau Health Promotion Network and Korowai Aroha Hauora
- Foundation for the Blind, Deaf Association of NZ, IHC and senior citizens groups
- Breast Cancer Coalition, Cancer Society and Māori Cancer Support and Cancer Awareness Groups.

In the initial survey it was revealed that there were very limited formal relationships between providers. A memorandum of understanding may be created to assist in developing a formal relationship between all parties, to recognise the integrity and spirit of partnership towards achieving a mutual goal. That being -

> *"to create an environment that is conducive to, and supportive of, informed participation in screening".* (NSU 2004c)

One provider had a formal agreement with a local polytechnic to enable nursing students to get practical experience within the provider. In the final survey, five providers mentioned having a formal relationship with other groups or providers in the region.

3.4.3 Relationships with GPs and PHOs

The importance of GPs and PHOs to screening was acknowledged in the initial process and impact surveys. In the midway survey providers were asked to identify what they felt the role of the GP was in screening. Eight providers believed GPs proactively inform women about the screening programmes: "If the GPs know Māori and Pacific women are overdue for a smear, the woman or NCSP DHB are notified and they become eligible for a free smear" (NCSP DHB).

Six providers believe GPs provide actual cervical screening services, while two BSA ISPs consider health information is provided on request by the GPs to the women. GPs refer women on to the programmes according to two further BSA lead providers, while another BSA lead provider said GPs collaborate with health promotion teams to inform women about the programme.

One NCSP DHB did not comment, while another NCSP DHB commented that GPs use the register and "over 90% of women are on it and the GPs use it all the time". They added that "very few women are not registered with a GP". One NCSP DHB commented that:

> *Some GP practices do all of the above, others do some of the above. The regional service supports and works with practices to improve their delivery of screening and the provision of information*.

The majority of providers (20 providers) collaborated in the 2005/06 year in some form with GPs, whether through their own GP clinics (ISPs) or through relationships with GPs and/or PHOs in their region.

Sharing of information occurs between providers and GPs. Providers distribute both NCSP and BSA resources and provide information on updates to the programmes. GPs are able to identify eligible women and supply client lists to providers and the register. While this information is often confidential, ideally when it is shared providers abide by privacy laws. Sometimes this privacy issue has become a barrier prohibiting ISPs from accessing this information.

For BSA, some activities are initiated by the GPs, who often identify eligible women in their practice and directly refer them to the programme. Health promoters may initiate further activity by visiting regional GP clinics in the month before the mobile unit is in their area. Other activities include:

- previously contracted GP services undertake a specified number of breast screenings, and are remunerated accordingly (BSA GP funding and recruitment pilot) (BSA lead provider)
- providing PHOs with statistical screening data to assist them with their quality plans (NCSP DHB)
- all mobile sites receive lists of women previously screened; when the new IT system is up and running it will also provide this service for fixed sites (BSA lead provider).

For the NCSP, providers offer clinical updates to practice nurses and smear-takers, and encourage and support nurses to become smear-takers and attend Family Planning trainings. One NCSP provider offers smear-takers training updates, which include a PowerPoint session on the NCSP priority groups, while one ISP specifically supports Pacific nurses to become smear-takers.

Supporting nurses to become smear-takers is often a lengthy process, involving on-site supervision for the nurses' first 15 smears, which GPs can often not afford the time to do. In some instances, practices notify the register of new patients; in exchange for a smear history of the clients the practices provide the updated address and details to the register. Some GP practices review their women to ensure they are on the recall system for screening.

GPs do provide screening services for the NCSP, but they sometimes refer women to other GPs or health providers for women who prefer a female smear-taker.

Current activities with GPs for the NCSP include:

- a GP project involving following up overdue Māori and Pacific women with GPs in Christchurch, with high numbers of Māori and Pacific women enrolled (NCSP DHB)
- developing guidelines to assist practice nurses send invitations to women when they receive the client lists (NCSP DHB)
- the cervical screening register on-site working with every GP in the region (NCSP DHB)
- surgeries contacting register staff to activate second and ongoing recall letters (NCSP DHB)
- GP surgeries being provided with details of free smear-taking clinics in the region for priority women, or the provision of smear vouchers to provide free smears to priority women
- GP audits identifying women not active, incorrect recall, or living in another part of New Zealand (NCSP DHB)
- providing a quarterly newsletter and annual smear-taker update
- providing a presentation at smear-taker training about screening, the register and screening health promotion issues.

ISPs who have a GP clinic attached to the service are able to tap into the clinics for a variety of activities. Clinics identify women to follow up, have a recall register available, distribute resources as necessary, refer women on to the BSA programme, and take a collaborative approach to informing women of their choices. Kaimahi actively visit GP clinics to inform them of the dates the mobile unit is in their region:

> *The doctors are proactively asking women if they had been smeared. If they wanted to they were referred to a smear taker within the clinic. We have just got a female doctor in the clinic downstairs, which has influenced numbers.* (NCSP DHB)

3.5 Screening health promotion workforce

3.5.1 The current screening health promotion workforce

Over the three years of the evaluation the providers were asked about their current workforce, the types of training provided to staff, and the types of issues providers experience.

In the baseline survey providers identified a number of workforce issues, particularly relating to recruiting and retaining competent staff. To determine actual numbers, the midway survey aimed to document the screening health promotion workforce. It looked at the number of new staff employed and their length of service, the number of candidates applying for the positions, and the types of competencies available in the current workforce.

From the responses of the 22 providers who completed the midway survey, the following data was obtained covering October 2004 to February 2006.

- Fifteen providers (five ISPs, four BSA lead providers and six DHBs) employed new staff. Fourteen recruited new staff to fill a vacated position, while one ISP created a new wahine hauora Māori position to focus more on Māori women at the request of the NSU.
- Eleven of the fifteen providers who recruited personnel received between one and four candidates only. Only two received five to nine candidates, and the remaining two positions were filled in-house or by secondment.

- Of these 15 providers, six found that community knowledge was the most common competency of the applicants. Four providers considered health promotion experience the most common among the applicants, while a further three identified ethnic or language skills. One provider received applicants with screening knowledge, while another said that all applicants had tertiary qualifications but none had any health promotion experience or qualifications.

Attracting and retaining qualified staff is difficult, and at times providers are compromising on experience or knowledge. This is not limited to the health promoter, in that there is also a limited number of Māori and Pacific smear-takers, thereby limiting options for Māori and Pacific women. Some ISPs, as non-government organisations, have found it difficult to train the new health promoters in all the required areas for financial reasons. Some DHBs have mentioned that their training is limited due to managers not being supportive of training.

Changes in staff are difficult for providers because they have to train new employees in all aspects of the position, including planning, but also have to rebuild relationships with other regional providers and with the community. In the initial survey one provider commented that "it takes around three to six months for a new health promoter to be productive in terms of contacts, getting into communities and getting to know the programme". One BSA lead provider commented that turnover affects community trust and relationships, while constant changes at the team leader level had meant no consistency for one NCSP ISP, and staff changes were reported as often affecting the health promotion process.

In February 2006, as identified in the midway survey, the providers had 17 new employees between them who had been in their positions for under a year. Four of these employees had been employed for less than six months and 13 had been in the positions between six and twelve months. Although there is often a high turnover of staff in the first 18 months of a health promoter taking on the position, there are many long-term staff involved in the programmes in positions ranging from managers, health promoters, kaumātua, and subcontracted kaimahi. The midway survey identified that eight personnel had been in their positions for between four to six years, and a further 12 staff had been involved for over six years. A number of these had been involved with breast and/or cervical screening for some 12 to 14 years.

It was suggested that new health promoters could do an 'internship' alongside a health promoter from another regional provider to "learn the ropes". In the final survey, 14 of the providers mentioned using an internship or a placement within another NCSP or BSA provider. One provider commented that the benefit of this placement within another provider is the educational experience, but the downside is the cost of travel to the providers. Some providers receive mentoring from other health promotion teams within the organisation.

The continual and unsustainable turnover of staff prompted a Pacific provider in the Auckland region to move to an integrated model of service. Rather than continually training one health promoter in screening services, all staff are trained in a range of health promotion issues (eg, oral health, smokefree and pregnancy support). This enables the provider and staff to cover a vast range of topics and utilise the Pacific languages available in-house. Another provider uses a similar approach, with the single FTE split into four positions so that each can tap into their own networks.

3.5.2 Developing the health promotion workforce

Many providers discussed training in the baseline survey, but in the midway survey all of the 22 providers who responded had undertaken some form of training in the previous 18 months. In the final survey 19 of the 28 providers had undertaken training. Some of this training was provided by the NSU, while others were offered training through various training institutions.

Training is an important aspect of developing the health promotion workforce, and one provider commented:

> *We recognised the need to have a workforce kept up to date not only regionally, but also nationally and internationally with all aspects which may impede or encourage well women to access the national screening programme.* (BSA lead provider)

Various training undertaken between 2004 and 2006 included:

- NSU introduction to breast and cervical screening
- an NSU train-the-trainer course
- a Health Promotion Short Course offered by the Health Promotion Forum (this is now called the Certificate of Achievement in Introducing Health Promotion)
- tertiary training
- a workshop/seminar or conference, such as the screening symposium.

The NSU training on screening for new health promoters is the most readily available and relevant training for new kaimahi, because it is required by and paid for by the NSU. This training is often an easy and appropriate option for providers to support new staff to. Providers have identified that this training meets the screening knowledge needs, but lacks a greater depth in health promotion principles and applying those principles. In saying this, the NSU training touches on general health promotion theory and provides an insight into the field, which is beneficial for those new kaimahi with no prior knowledge.

Overall, the training provides new health promoters with the scope of their new role and where they fit into the screening programmes. This is often enough to orient new staff into the programme. One NCSP DHB commented that this is an:

> *... essential form of training and while the screening updates are necessary, the health promotion principles may be going over some health promoters' heads. This is particularly true for those health promoters who have only recently started the position – often a lot of the information goes over their heads*.

Similarly, workshops and seminars are readily available to providers and their kaimahi, and appear to be frequently attended by providers due to being easily accessible and the relatively low cost, and the variety and number available. Workshops, seminars and conferences often do not have the same specific screening knowledge and application content as the NSU training, but do provide knowledge in wider public health or related issues.

Tertiary training offers the next step for experienced health promoters, and allows them to build on their practical knowledge and experience while gaining a formal qualification. However, tertiary training, much like other health promotion or other relevant training is often located in the main centres (Auckland, Wellington, Christchurch or Dunedin). While courses may be offered extramurally or offered around various parts of the country (e.g. some Health Promotion Forum one day courses), providers may have some element of travel for block days and therefore costs are involved. The time and cost requirement when undertaking tertiary training or some other courses is sometimes limiting for kaimahi. Providers therefore have to prioritise the training needs of the health promoters to gain the required knowledge and skills with the most cost- and time-effective training available.

The ability to undertake training is also dependent on the current requirements of the role. Although it is not expected that the NSU will provide all health promotion training, direction from the NSU on health promotion training with specific screening components would help providers to prioritise health promotion training and develop their staff.

Currently the NSU screening training is only available for new health promoters when they take up their positions, and staff who have already participated in the training are unable to attend. As a result, providers feel there is no way in which to continue upskilling health promoters with screening knowledge. However, although there is no specific training set aside in the same format as the initial training, the NSU convenes quarterly health promotion uni-disciplinary groups for NCSP, bi-monthly teleconferences and twice-annual BSA health promotion UDG meetings, and the kaimahi teleconference is held monthly.

Kaimahi hui as training was discussed at all points during the evaluation, and it was often a contentious issue. The providers and their kaimahi greatly appreciate the hui and many commented that it provides positive peer support for Māori kaimahi. However, many kaimahi also commented that "there is too much information crammed into the three days" and that kaimahi would like more down time to soak in the information and discuss with their peers. Kaimahi also commented that the hui should be "driven by the kaimahi". It should be noted that the agenda items for the 2006 Kaimahi hui programme were sent to all kaimahi for feedback and were discussed through the monthly teleconferences.

Providers who employ non-Māori staff to work with Māori women faced some difficulties as their non-Māori staff are ineligible to attend the kaimahi hui. These providers commented in the baseline survey that if the kaimahi hui addresses ways to increase coverage and participation among Māori women, they would like their staff to attend regardless of the ethnicity of the health promoter, as it is in the women's best interests not their own.

Health promotion competencies

Each of the currently available types of training meet a different need, but with no current NSU health promotion competencies available providers feel there is a lack of direction for screening health promoters. As one BSA ISP provider commented:

> ... *there is no pathway to identify where a health promoter is at. We would like to have some guidance and there should be some movement from theory to the practice*.

Although the NSU has developed draft competencies for screening workers, they are currently on hold until the Public Health Directorates' generic competencies have been finalised to avoid any duplication. The consultation on the Public Health Directorate's draft competencies has commenced, and once this process is complete the NSU will put the draft competencies for screening workers out for consultation (the majority of the kaimahi were not aware of this).

The Health Promotion Forum of New Zealand also developed their own health promotion competencies in May 2000 after extensive consultation with the health promotion workforce, to "strengthen health promotion practice and training", and the Forum consider these competencies "a tool for workers to critically reflect on their practice, and a framework for trainers to develop relevant and useful courses and qualifications" (Health Promotion Forum 2000). Further, these competencies support providers and health promoters in a number of ways, including "Quality improvement programmes, training courses, strategic development, staff development and staff recruitment and selection" (Health Promotion Forum 2000).

Other identified training needs

In both the midway and final surveys providers were asked to identify any other training needs that would assist in the delivery of screening health promotion. The main areas identified for training included:

- te reo Māori – to assist in communicating with Māori women
- increasing knowledge in health promotion – many providers felt they received enough information in the initial NSU training, but that there was no follow-up or updates (providers did mention the kaimahi teleconferences, but many commented that these "drift off the topic" and don't so much provide training as a "catch up" between kaimahi)
- understanding and using data to inform best practice
- career pathways for health promoters, particularly within a screening perspective
- training in the BSA and NCSP standards
- more practice (eg, taking a new health promoter through a whole education session at the NSU new health promoter training)
- guidelines for non-Māori health promoters to deliver health promotion to Māori women
- improving knowledge in evaluation to support evaluation of one's own programmes and initiatives.

One provider feels that access to more diplomas, graduate and postgraduate studies in health promotion would be beneficial, and in particular having these available locally rather than having to travel.

The lack of support for training is an issue for some health promoters, particularly those within a DHB. One health promoter commented that she applied to do further study but was told by management that there was no budget for training. Another kaimahi within a DHB commented that she doesn't "bother putting in for training, even cheap or free training, because it doesn't get approved".

4. NGĀ KITENGA – IMPACT EVALUATION FINDINGS

4.1 Knowledge of screening

4.1.1 Knowledge of the age ranges for both programmes

The 2004 impact evaluation report highlighted that women's knowledge of screening was variable. At that time, 36% of women interviewed knew the age ranges for the BSA programmes and 64% did not. For the NCSP, only 9% knew the age range while 91% did not; many did not know there was an age range for NCSP. The 2006 study has revealed that New Zealand European women know about both screening programmes, and the vast majority know that the age range for BSA now commences at 45 years and goes up to 69 years. Most women (Māori, Pacific and European) think the NCSP commences at age 20 or when a woman has a baby or commences contraception. Many Māori and Pacific women did know there are screening programmes, although they were not necessarily sure of the age ranges.

4.1.2 Knowing where to go for screening

In 2004 93% of women knew where to go for a smear and 55% knew where to go for a mammogram. The 2006 impact evaluation continues to reveal that women generally know where to go for a smear, with most saying it is done by their GP. However, the presence and use of the Family Planning Association came through more strongly in the 2006 evaluation, especially among Pacific women.

For BSA, women identify strongly with the mobile unit and there is less knowledge of where local fixed sites are. Women tend to rely on letters coming from the BSA programme to tell them where the sites are. Recall letters from BSA play a significant role in identifying sites as well as reminding and encouraging women to attend screening.

4.1.3 Where women get information on screening

For the NCSP, GPs remain the main source of reminders and information, especially information provided by their practice nurses. In the 2004 study the majority of women heard about cervical screening from their GP. Other sources of information, in order of importance, were:

- television
- lead maternity carers
- health educators and education sessions (both NCSP as well as Māori/Pacific providers).

These three sources of information continue to be important sources of knowledge for women, although in the most recent study the influence of radio – in particular Pacific radio / Niu FM – has come through much stronger alongside television for most Pacific women. Similarly, the influence of Maori radio has increased. Lead maternity carers appear to be of less significance in 2006 and health promoters of greater significance, with the Family Planning Association being profiled more by women in 2006. Younger women particularly identify the Family Planning Association, particularly young Pacific women, as a key source of information and services.

For BSA, the main source of information in 2004 was also their GP, followed by:

- television
- family and friends
- BSA health educators and education sessions.

This trend has continued in 2006, although both Māori and Pacific women who regularly participate in screening identified reminder letters from the programme and advertising of the mobile unit as two key influences that encourage them to keep participating. While information and encouragement from the family GP, family/friends and television are the initial reasons that women (both Māori and Pacific) think about being screened, it is primarily the BSA health promoters and BSA recall letters – as well as a positive experience at mammography – that help women to remain in the programme once they are enrolled, and to return for screening.

Other sources of information continue to be the same as those identified in 2004, although circulated messages and promotions by email in workplaces is now appearing as a strong method of information dissemination. These other information sources are:

- kōhanga reo and Māori Womens Welfare League networks
- brochures and pamphlets
- family and friends
- Maori radio e.g. Tahu FM
- independent Māori and Pacific providers
- women's groups/gatherings
- newspaper advertisements on the mobile unit programme
- sex education sessions at school (for young women).

4.1.4 Does information sufficiently prepare women for screening?

The 2004 study highlighted that the majority of women did not feel sufficiently prepared for cervical smears. When receiving information from a friend or family member, women generally felt well prepared, but where information was given by a health professional they did not feel as informed or prepared. The main reasons for this included:

poor explanations of the potentially uncomfortable procedure for smears

lack of good information on the process and instruments used – including showing women the speculum and how it works

a male doctor not explaining things well either beforehand or during the procedure

beds being uncomfortable (particularly for larger women).

Similarly, the 2004 study identified that the majority of women did not feel well prepared for their mammogram and generally did not know what to expect. Where information was from a BSA health educator or a nurse, and information was comprehensive, women generally felt well prepared and the process occurred as explained. The main reasons for not feeling prepared for a breast screen included:

- poor explanations of the procedure by doctors and radiographers
- not knowing what is happening until it is done

- the level of discomfort not being explained properly
- the level of personal touching (of breasts) not being explained fully.

> *My first breast screen I didn't know I had to put my breast on the thing. I thought they just scanned the breast.* (Samoan woman, Wellington)

Although women still expressed concerns about some levels of discomfort in 2006, there appear to be improvements in the information that is being provided to prepare them. BSA clients interviewed in 2006 are certainly feeling well prepared and supported by health promoters and radiographers before the procedure begins. They noted clear explanations being given of the technology, how they will be touched, and the reasons why different positions are used.

However NCSP clients are still very concerned about the lack of information and preparation being given to them before a smear is done, particularly by male GPs. Many women, from all ethnicities, have expressed concerns about the lack of information provided, and that the environment that is created for the procedure is often not conducive to feeling prepared, relaxed and comfortable. This includes matters such as:

- being covered while lying on the bed
- curtains around the bed being pulled
- music or informal talking being used to relax the woman (or pictures on the ceiling)
- offering different positions to lie in
- offering plastic speculums instead of metal ones
- warming speculums before using them.

Many women still highlight the lack of preparedness and the level of discomfort and pain experienced during a smear with a GP. Many, however, complimented female GPs for taking more time to explain the procedure, and female smear-takers for being more gentle and sensitive with the procedure. These issues were prevalent across Māori, Pacific and European women.

4.2 Behaviours of women in relation to screening

4.2.1 Personal reasons for participating

Life choice

In the 2004 study the main reason women participated in cervical screening was "self care" – they underwent smears in order to care for themselves and to assure themselves that they were all right. The focus on self-care was strongly demonstrated among the European focus groups in 2004. Information and encouragement from the family GP was the second main reason for participating in cervical screening.

In 2006 the study sought to explore in greater depth the reasons why Māori and Pacific women participate in cervical screening and whether self-care is also a strong incentive for women to participate. Responses included the following:

> *The thought that this can prolong your life, is an encouragement for me.* (Māori woman, Rotorua)
>
> *I go because I want to be safe. It's just one of those health things that you have to do. It's about your own health.* (Samoan woman, Wellington)
>
> *I go because I want to be sure everything is okay. For my personal well-being. To be safe – you just never know unless you check.* (European

> woman, Waikato)
>
> *I like to feel I am okay. To keep safe.* (European woman, Napier)
>
> *The consequences of not doing it – make me do it.* (Māori woman, Wairoa)

Other Māori women commented that they wanted to see their children and mokopuna grow up, so they ensured they were screened to stay healthy. Some Māori women also said that prolonging their life, and taking personal responsibility for themselves, was often a hard thing to do, but they knew it was important. Some felt that concepts of self-care almost felt "selfish", especially when a cost was involved and they were spending money on themselves instead of on food or clothing for their children.

European women commented that they wanted peace of mind and that screening was now one of their health habits. Many of the Pacific women commented about screening programmes being new to them, if they had only recently emigrated to New Zealand, because their home countries did not have similar programmes. Unless they went to see a doctor for illness, or a family member happened to mention it, they often did not find out about free screening programmes and how to access them.

Reasons/influences for participating in breast screening

The 2004 study identified that the main reasons for women participating in breast screening – apart from self-care – were:

- having a family history of breast cancer
- being referred by the family GP
- encouragement from family and friends
- the provision of a free service (this both encourages women to begin screening as well as helping maintain them in the BSA programme).

The 2006 study has identified that a family history of breast cancer is still a major incentive for participating, along with a general fear of cancer.

> *I go because I am afraid of the big 'C' – that's the main reason for me. I don't want to lose any body parts if they have to cut something off.* (Māori woman, Christchurch)

> *My aunty had breast cancer so that made me go.* (European woman, Wairoa)
>
> *I am terrified of cancer. I go because I don't want to get cancer.* (Cook Islands woman)
>
> *I go because it is hereditary in my family. I definitely believe in it [screening].* (European woman, Napier)

Other key reasons for *continuing* to participate in breast screening include the following, which are discussed in a little more detail.

Cost

Women from all focus groups identified that the free service is a strong incentive for participating. Women from four of the 2006 focus groups identified that if it were not free they probably would not attend. The free service has again been identified as important to women joining and continuing to participate in the BSA programme.

Recalls and reminders

Many women who were regularly participating identified that reminder letters from the BSA programme were the reason they continued to attend. Most said that once they were registered with the programme, they left it to the programme to remind them when it was time to go back. The reminder letters did not appear as a strong issue in 2004, but with the programme now being in place for a longer period of time the recall letters are now more influential for many women.

A positive experience

A relatively significant number of women commented that the breast-screening experience was one that made them comfortable enough to continue participating in the programme. The experience of being screened was less of a positive factor in the 2004 study, and many commented then about pain, discomfort and feeling dis-engaged from the process. The recent feedback perhaps demonstrates that there have been some improvements in the quality of BSA services in the past three years to make the experience more responsive for women.

A positive experience for women involves many factors, such as clothing cover provided, staff care and attitude, and being provided with information.

> *The cloak they give you at the breast-screen is lovely. You feel lovely. You don't feel embarrassed that you have nothing on underneath.* (Māori woman, Christchurch)
>
> *I buy a new bra when I have to go because I want to look nice when I go. I don't feel shy any more about it because they make you feel nice.* (Māori woman, Wairoa)
>
> *The radiographer was really good. She made the experience good. She talked the whole time and explained what she was doing all the way.* (European woman, Auckland)
>
> *She [radiographer] told me it would hurt a little bit but it wasn't as bad so I felt good. They pushed the pedal slow and didn't rush me.* (Māori woman, Waikato)

Information and explanations

Women in the 2006 study were very positive about the BSA staff and the way they made the screening procedure comfortable for them. They respond positively to being shown the equipment, having everything explained, not being rushed until they feel confident to proceed, and feeling respected when they are touched. As one woman put it, the feeling of empowerment through receiving good information and explanations has encouraged her to promote the service to others:

> *When we know things we pass it on – we feel like we are a "mohio" then – so we can tell others about it.* (Māori woman, Rotorua)

Reasons/influences for participating in cervical screening

In 2004 the main reasons or influences for *commencing* having smears were self-care and having a family history of cervical cancer among sisters, mothers or relatives. The main reason for *continuing* to have smears were a fear of cancer, a history of abnormal smears (thereby making them higher risk) and recall systems from GPs.

In 2006 these reasons are still very prevalent among women. The recall system operated by GPs is a vital component of the NCSP programme and was mentioned by women from all ethnic groups in all focus groups. Many women commented about the recall system being effective at encouraging participation because they "do not stop contacting you until you go". (The influence of the recall system operated by general practices is further discussed in Section 4.2.2)

Fear of cancer

Māori, Pacific and European women continue to identify fear of cancer as a primary reason for continuing to have cervical smears. This was particularly so for women who had a previous abnormal smear history and rated themselves higher risk as a result. A significant number of women from Pacific and Māori focus groups identified previous abnormal smears as the reason for their continued participation.

> *I had abnormal cells from my smear a few years back so I go regularly because I'm afraid of cancer. When I first heard about abnormal cells I immediately thought it was cancer – I was afraid to go back. Once it was explained to me that it could get treated and that if I go regularly they can deal with it, I agreed to keep going. I feel I have a higher risk.* (Māori woman, Christchurch)
>
> *A big reason I go is because I am afraid of cancer.* (European woman, Waikato)
>
> *I go for smears but they were abnormal and I was terrified. Have always gone because of my Mum – she ignored her health but I need to learn from that.* (European women, Wairoa)
>
> *I go because I don't want cancer.* (Cook Islands woman)
>
> *I go because I want to know so I can plan ahead for my children if I need to. Prepare the family.* (Tuvaluan woman)

Cost

Where smears were cheap or free, this was an incentive for women to participate in cervical screening. Some mentioned free smear services provided through their local Māori health provider. Others said they used a Māori health provider because it was free, whereas their GP charged them for it. Women from Māori and Pacific focus groups identified that sometimes they waited until they went to the GP for another reason such as illness, and then asked for the smear at the same time so they only had to pay once. Where GP fees have reduced for low-income women – particularly through PHOs – women noted that this had made smears more accessible for them.

Many of the women interviewed said that if the service were not free or low cost then they probably would not go at all.

> *I only have a smear if there is something else wrong with me. It costs so much to go to the Doctors I wait until I have to go for something else first.* (Samoan woman, Wellington)

Having a baby

One reason some women join the NCSP programme and begin having smears is that it is encouraged by GPs and midwives when women get pregnant. Women were particularly encouraged to begin having regular smears after the baby was born. This was identified mostly in the European and Pacific focus groups. Some Māori women stated that they thought smears were only necessary once you had had a baby.

4.2.2 Influence of general practice / family doctors

Recalls/reminders

For cervical screening, the reminder letters sent from GPs were the most significant reason for many women continuing to participate in the programme:

> *Constant reminders from GP or other providers.* (Māori woman, Christchurch)
>
> *My GP is a bully – won't leave me alone until I go.* (Māori woman, Christchurch)
>
> *His Practice Nurse also follows up – they do the chasing not the GP. They send you letters as well as leave phone messages.* (Māori woman, Rotorua)
>
> *The reminder letters from the Doctor are sent out. They remind you if your name is on their register. If you haven't been for a while they chase you up. The nurse reminds you and constantly calls you. If the Doctor is really passionate on the topic they urge you to go.* (Māori women, Auckland)
>
> *The regular letters and follow ups reminds me to go. They keep sending reminder letters until you go. It's up to the doctor to remind me.* (European Woman, Waikato)
>
> *Doctor sends reminder letters. They chase you until you go. I have a female Doctor and she spends more time explaining things to me. I go once the GP reminds me – I wouldn't think about it otherwise.* (European women, Christchurch)
>
> *I'm quite aware of it but if I wasn't sent reminder I wouldn't go probably.* (Samoan woman)

Women from the Pacific focus groups also said reminder letters from their GPs were the main reason they kept going for cervical smears.

Information / encouragement from GPs

Many of the European and Pacific focus groups identified information and encouragement from GPs as one of the reasons they continued to have cervical smears. They identified GPs who gave good explanations, detailed information about the risks of having abnormal smear histories and highlighted the importance of cervical smears to one's life as key reasons that GPs had encouraged them to have smears.

> *Doctor told me to go after I had abnormal smear – he told me I have to come back annually. Prior to that I didn't get much information.* (European woman, Waikato)
>
> *I get information from GP. I went to GP for another issue and he raised screening. It was difficult for me to talk to him as he is a man. When I came here from NZ we didn't have this back home so I learned about it from my Doctor. Took 6 months for me to go and get a smear.* (Cook Islands woman)
>
> *Doctors need to explain things. When it is explained I am happy. They should use easy terms. When I understand I will go.* (Tongan woman)

Family Planning Association

The influence of staff and services from the Family Planning Association was identified as a strong indicator for encouraging smears in the 2006 study compared to the 2004 study. This was particularly so among Pacific women, where this second round of focus groups was able to explore in more depth the reasons why Pacific women had regular smears.

> *Family Planning told me about it and they did it. They have my files and tell me when to come in.* (Samoan woman)
>
> *Family Planning gives information out. They give it in a way you understand.* (Tuvaluan woman)
>
> *Family Planning Association provides information. They also ring up and chase you up.* (Tongan woman)

4.2.3 Influence of families and friends

Information from family/whānau

In 2004 information from family members was more prevalent in the BSA programme than the NCSP programme, in terms of encouraging women to attend screening. While family histories of cervical cancer were a strong indicator for encouraging women to have smears, the actual discussing of the topic of disseminating information and encouraging people to have smears is not as prevalent among families as for breast screening. This implies that family members are more likely to feel comfortable discussing breast screening with women in the family rather than cervical screening or smears. One woman said this phenomenon was likely because:

> *... it is easier to talk about breasts because they are more public and accepted with breast feeding being around, but talking about "down there" is a more private personal thing that is not easy to talk about without getting embarrassed.*

For the 2006 study the focus was on exploring the family influence in more depth. The ability to explore family influences in more depth in the 2006 study has allowed specific influences of different members of the family to be identified.

Comments from Māori women

> *Other whānau members tell me to go get screened because they had gone themselves. / Some whānau had suffered either breast or cervical cancer and so they encourage you to go. / Whānau members who have had it become a big encouragement* (Rotorua)
>
> *Whānau and word of mouth is when I hear about the bus coming. We don't really talk about when smears are due. / As a Mum I felt I had to tell my daughters at age 13. People told me I was stupid but now they always go. Mothers should tell their daughters. Never too young to know about it. / It's my personal thing to tell my daughters – who better to tell you but your Mum? Some parents don't feel comfortable though – I know that. / We have the responsibility as women to tell our whānau.* (Wairoa)
>
> *Wasn't brought up talking about it [smears] – not a normal thing. It was never discussed.* (Auckland)

Comments from European women

> *Family and mother in particular.* (Waikato)
>
> *My mother told me.* (Christchurch)
>
> *Mothers don't talk about it but I think time is changing.* (Wairoa)
>
> *Family encourages me to go.* (Auckland)

Comments from Pacific women

> *I heard about it when I came to New Zealand but there is nothing like this at home. They don't know about it over there.*
>
> *I told my daughters – it's better to talk about it.*

> *I go because friends encourage me to go.*

Influence of grandmother, mother, tamariki or mokopuna

The younger and older generations were highlighted particularly by Māori and Pacific women as key influences within the fanau/whānau context. Older Māori women who attended screening focused on wanting to see their mokopuna grow up, while younger women who had lost a nanny to cancer wanted to prevent it for themselves. Mothers also identified that they wanted to see their children grow up, and the thought of not having someone else to care for the children if anything happened to them (such as cancer) was sufficient incentive for them to regularly get screened.

However sometimes the influence of a grandmother/nanny was also a potential deterrent for some Māori women, particularly if the grandmother chose to keep information to themselves:

> *My nanny had cancer and knew she was going. She decided she wanted to spend whatever time she had left with her kids and mokos – not in a hospital getting treatments. I think a lot of kuia keep things to themselves so as not to worry other people in the whānau – they won't share it with the whānau. It's a comfort zone for them I guess*. (Māori focus group, Waikato)

Influence of men/partners

In the 2006 study, opportunities arose for more in-depth discussion and feedback to be gained on the role of men as whānau members in encouraging women to attend screening. The role of men was identified strongly in the Māori and Tongan focus groups more than in the European and other Pacific Island focus groups.

Some Māori women felt that more education and information needed to be developed to reach Māori men in particular in a way they will find acceptable. Women noted that men might feel a lump on a woman's breast, but then panic if they don't know what to do next. They may panic because of a fear of losing their wahine. There was a view that some men would not know how to react and would be too scared to even think about the impact. For some, like many wahine, the men might prefer not to know the truth even if there is cancer. As one woman said, "We need to support the men to take action too. They are whakama too". Another woman said, "When the spouse [wahine] is mauiui, so is the man – the men act like their world is over and don't know what to do".

In order to better reach men, the main suggestions were to use TV promotion because many men watch TV and don't have to admit they are watching some of these messages. The use of Māori TV was particularly supported. The women who were interviewed believed that men would not come to meetings or read brochures or pamphlets.

> *Men encourage you as well if they are informed – husbands and partners are important but they need to know what to do.* (Waikato focus group)

Influences from friends

Friends were considered to be highly influential. The Wairoa focus group stated that if friends have had a bad experience, they are likely to tell their women friends and most likely put them off. Younger women from the Auckland meeting identified school friends as a source of information about having smears and using the Family Planning Clinic to avoid going to a family GP, where parents might find out. Female friends were noted as being supportive of their women friends – both in giving advice as well as providing moral and physical support at actual screening events. For some women, particularly young Pacific women, accessing information and support from friends was easier than asking their mother or other close family members about cervical screening.

4.2.4 The influence of health promotion

The influence of health promotion – both the services provided by BSA and NCSP health promoters as well as other health promotion providers and strategies – is significant in both programmes. In the 2004 study the influence of BSA health promotion was more significant than the influence of NCSP health promotion activities. The 2006 study sought to explore this issue in more depth by reviewing issues in accordance with the NSU Health Promotion Framework, which includes three components: health education, community development and communication activities.

Health education

Feedback from women in the 2006 focus groups identified that health promotion from Māori and Pacific health providers (not necessarily BSA or NCSP providers) was one of the key reasons they were aware of the need for screening. Many women named local providers, marae groups, the Māori Women's Welfare League and groups like Pasifika as being those who promoted screening.

Few were able to identify DHB regional screening services as organisations that promoted NCSP screening, but were able to identify specific workers who promoted cervical screening.

Many women identified the BSA centres and the mobile unit as providers of health promotion services. The 'brand' of BSA as an identifiable programme versus the NCSP as a programme was better able to be remembered and identified by women. The mobile unit in the community helps reinforce the BSA programme brand, unlike scattered smear-taking services which are not as identifiable as working within a single programme.

Where providers sent out reminder letters or information about the route of the mobile unit for BSA, for instance, the profile of those providers was even greater. For NCSP, most women still relied on information about cervical screening and engagement in the programme from their family GP. If the general practice was aggressive in chasing women for smears, women tended to 'give in' and attend the smear simply to stop being chased. In 2004 women were able to identify the NCSP resources (eg, posters) as identifiers for the NCSP programme, but did not necessarily associate these resources with providers of NCSP health promotion programmes. Many younger women who attended the 2006 focus groups received information about cervical smears from sex education in school and felt this was appropriate.

Community development

Where providers were using health expo days or other venues for promoting screening – such as workplaces, community meetings, rural women's meetings and polytechnics – these were seen by women as good methods for promoting screening. Many women said they would probably not attend meetings or promotions that focused solely on breast and cervical screening, but they would attend an event that looked at wellbeing overall and promoted health as a holistic issue. Other community promotions that involved events such as fun runs, sport tournaments, pamper days and women's health days were also seen as more attractive for women.

Communications

The 2004 study identified the use of TV advertising and promotion as one of the main reasons women were aware of screening, as well as a key reason why they actually proceeded to engage in screening. The use of TV – and now Māori TV – is still viewed as a critical source of information and encouragement, alongside radio.

Key communication activities that women have identified as encouraging them to participate in screening are:

- TV and radio advertising
- newspapers and magazines
- posters and pamphlets
- for BSA, the mobile unit
- agency newsletters (eg, Te Puni Kōkiri newspaper).

These are discussed in more detail below.

TV / radio promotion

Many women identified TV advertising as a key source of information and encouragement for screening.

- Anything on Māori radio or Māori TV is good. It reaches the audience. (Māori woman, Christchurch)
- TV ads is where I get information. Other media such as radio reminds you. (Māori woman, Auckland)
- Saw advertisements on TV – they encourage me. (European woman, Auckland)
- TV advertisements provide information as well as Pacific radio. (Tuvaluan woman)
- Newspaper / magazine promotion

Some women saw newspaper advertising as a good way of signalling when the mobile unit is coming (for BSA), or if any providers are having free smear clinics. This was especially so for rural communities with local newspapers, which are closely and widely read. The reading of articles in magazines related to real cases of women affected by cervical or breast cancer and who did not regularly attend screening was encouragement for some women to get screened to avoid the circumstances they read about.

Posters and pamphlets

Some women identified the BSA and NCSP posters as being a good prompter when they visited the doctor. Many of the Pacific and Māori women identified and knew of the posters in the waiting rooms of their doctor. Pacific women particularly liked pamphlets that were written in their language.

BSA mobile unit

Women from all ethnicities gave examples of seeing the BSA mobile unit in their community, with the signs on the outside which made them aware of needing to be screened. Women from the Cook Islands group said the mobile unit was so distinctive with its signage that it was enough to encourage them to go over and ask about registering for a breast screen. Because the NCSP programme does not have an identifiable entity, clinic or bus, the programme does not appear to have the same visual impact for women.

4.2.5 Reasons for not participating and barriers to screening

General issues

In the 2004 study the main reasons for not participating in the programmes, in order, were:

NCSP:

- embarrassment / whakama / shyness
- male doctor doing the smear
- cost of smears – too expensive
- fear of the result (cancer)
- pain and discomfort
- not knowing what to expect

BSA:

- fear of the unknown / scared of the screen and the result
- cost (outside age range)
- pain and discomfort

- embarrassment / whakama / shy – usually of body image
- too busy
- better not to know if it is cancer.

A number of examples were given in the 2004 study of statements made by women in relation to these reasons for not participating. In the 2006 study the reasons for not participating have been identified as general issues for screening as well as specific issues for each programme.

The key barriers or influential factors for women not participating in screening are the same for the 2006 respondents as for the 2004 respondents, although some women prioritise the issues differently. For the NCSP the key issues are still embarrassment, cost, fear of the result and male GPs doing the smears. For BSA the issues are fear of the unknown, fear of a bad result and fear of the potential treatment outcomes if something is wrong (eg, mastectomy).

Pain and discomfort for smears is still a *very* prevalent issue, as is the issue of male GPs performing smears, but pain and discomfort, embarrassment and shyness for breast screens have emerged as *less* of an issue among the 2006 respondents. This aligns with some of the reasons that women continue to participate in the BSA programme (the 'positive experience').

Fear of the unknown

Some women in all of the respondent groups in 2006 acknowledged that fear of the unknown was a major factor for why they did not attend screening. Many said they would rather not know anything, as demonstrated by some of the comments made:

> *Fear of the unknown is a big factor. Don't know what it is like to have a screening, but then don't know what it is like to have cancer. So rather not know anything. I am scared. Just too scared to go.* (Māori focus group, Wairoa)
>
> *I would just rather not know, than know if there is cancer.* (Māori focus group, Auckland)
>
> *Don't want to know – better I don't know if I have it than know. Ignorance is bliss.* (European focus group, Wairoa)
>
> *Fear of the unknown. Fear of the result and that it might be getting worse*

> *so better not to know.* (Tuvalu focus group)
>
> *Fear of cancer makes you afraid to go.* (Tongan focus group)

For many of these respondents, while they acknowledged being well informed and knowing the benefits of screening, the fear often overwhelmed any desire by them to make the step towards actually getting screened.

Access

Some women commented that the hours for services could be improved. Some did not go because they could not get time off work and wanted screening in the evenings or on a Saturday. Two groups raised the issue of transport being a difficulty for them if they lived in rural areas and only came to town once a fortnight or once a month.

Attitude

Three of the Māori focus groups identified low self-image or low self-esteem as an issue for some women not participating in screening. As one woman said, "Some of our women are lazy – they don't realise the importance of it and that they need to make it a priority for them and their kids". Another women said that "Some don't give their own health a priority". Only two of the respondents said they had made a conscious decision not to go, even though they had received a lot of information and had good knowledge of the benefits of screening.

Language barriers

Some women from the Tuvalu focus group said that language was a barrier because they could not understand the GP and felt that the GP may not understand them. They appreciated pamphlets and written materials being written in different languages, and services where translators were available. The Tongan focus group felt that clear 'plain English' writing was more important for written materials.

Whakama

A few respondents said that sometimes being shy of one's body "shape and condition" was a factor that prevented them having breast or cervical smears, particularly for larger women. They said some of the larger women felt shy about their weight and did not want anyone to see them undressed in any way, and some felt the beds were too small and uncomfortable for them.

Cervical screening: specific barriers

- As indicated above, the main reasons for not participating in cervical screening for the 2004 respondents were:
- embarrassment / whakama / shyness
- male doctors performing the smears
- cost of smears
- fear of the result
- pain and discomfort.

For the 2006 respondents, these issues remain as significant in deterring women from having cervical smears.

Embarrassment / whakama / shyness

Respondents from the 2006 focus groups strongly identified embarrassment as a key reason for not having smears. However, this is strongly related to being embarrassed at having a smear done by a male GP (see below). From the suggestions made by women to improve the cervical screening experience, (and therefore the NCSP screening rates), many women advocated for more female smear-takers to avoid embarrassment.

While many Māori women feel more comfortable with a Māori smear taker, this slightly differs for a number of Pacific women, especially young Pacific women. These women noted a preference to have a non-Pacific smear taker to whom they have less chance of being associated with in their community. Cervical screening has associations to sexual behaviour and women commented that going to have a smear was like declaring you are sexually active. There are fears that their health history could be divulged by association.

Male GP

Women from all the 2006 focus groups identified problems with having a male GP undertake smears and that this was a key reason for not having a smear:

> *Having a male GP puts me off going.* (Māori woman, Auckland)
>
> *Sometimes the Doctor or Nurse are not right – if I don't like them it puts me off ... I don't like having a smear from a male GP – I got my midwife to do it.* (European women, Auckland)
>
> *The male GP puts me off – would rather have a female – especially young male GPs doing older women.* (European woman, Wairoa)
>
> *Would prefer female smear-taker – don't like male GP doing it.* (Cook Islands woman)
>
> *Don't like men doing it. Having a Pacific nurse is good – but want someone I won't see in church.* (Tuvaluan woman)
>
> *Male GPs – not as gentle. Do not inform as much as a female GP ... I prefer female smear-takers if possible. Having the same person each time is good.* (European woman, Waikato)

When women did attend their GP for a smear, some were put off by the experience because they did not feel fully informed. Women spoke of feeling that the procedure was not explained to them properly before the GP commenced, including:

- preparing the women mentally and ensuring she was relaxed
- ensuring they saw and understood how the instruments (speculum) would be used
- creating a relaxed environment (eg, with music, pictures, warm room, blanket to cover).

Some women who had gone to a Māori or Pacific provider, or the Family Planning Association, felt these providers addressed these needs much better than general practices.

Cost

Women from all the groups interviewed – Māori, Pacific and European – cited cost as a reason for not having smears. One Christchurch woman quoted $30 for her smear; another quoted $25. At another meeting one woman said it had cost her $65 to see her regular GP just for a smear. Another said she did not go because she would rather use the money to buy food for the children. Paying for smears was a strong factor for many women not having smears.

Some women used local Māori and Pacific providers and smear-takers because they were free, and others in the same group were not aware they could get free services elsewhere and that they had a choice.

> *I know it costs but I still go because I think it is important, but would be much better if it was free. I know it puts others off.* (European woman, Auckland)
>
> *If it stopped being free [at a Māori provider] that would be a barrier. I wouldn't go any more.* (Māori woman, Wairoa)

Cancer fear

The fear of finding they have cancer is a significant deterrent for women. Many would rather not know. These women wanted to "carry on thinking and hoping they are alright because it isn't as painful to know if you do have cancer'.

> *You don't want to know if you've got cancer – the fear of getting a bad result is definitely there. If I knew I had cancer I wouldn't go back. Wouldn't want to go through chemo etc – I'd just live my time out that I have.* (Māori woman, Auckland)
>
> *I think there is a difference between women who think "I'd rather not know" and those who think "I'd rather find out early so I can do something about it to stop it".* (Māori woman, Christchurch)
>
> *The fear of cancer is always there – you think about who is going to look after my kids if something happens to me.* (European woman, Waikato)

Pain or discomfort

The pain and discomfort of smears is a problem for many women, and this issue arose in both the 2004 and the 2006 respondent groups. Women talked of smears being painful, feeling uncomfortable, being sore, male GPs not being gentle when they do the procedure, the instrument being cold, the procedure being very invasive, and uncomfortable or under-sized beds. The same issues arose for Māori, Pacific and European women, although many did say that female smear-takers and GPs seemed to be more gentle and allowed women to lie in different positions if it felt better. Many women considered that females were more sensitive to their needs.

Breast screening: specific barriers

The 2004 study identified the following key reasons, in order, for women not participating in breast screening:

- fear of the unknown, scared of the result, scared of cancer
- cost (outside the age range)
- pain and discomfort
- embarrassment / whakama / shyness
- too busy
- fear - better not to know.

The key issue for the 2004 respondents is still the key issue for the 2006 respondents: the fear of finding cancer is a significant factor for women, and many would prefer not to know. There is a strong link between issues 1 and 6 above for many women. Their fear of finding cancer leads to their decision to prefer not to know anything at all. One group did, however, suggest that this was because women were generally poorly informed that finding anything early was better than finding something when it was too late.

The issues of cost, pain, embarrassment and being too busy did not arise for the 2006 respondents, and this was supported by comments of women feeling better informed, supported and confident about the breast-screening procedure. This appears to be linked to apparent improvements to the BSA experience (the ‘positive experience’) outlined previously among this group of women, for those who regularly participate.

4.3 Suggested improvements from women for screening

4.3.1 General ideas

Offer breast and cervical screens simultaneously

Two of the Māori focus groups in 2006 suggested that screening for both breast and cervical abnormalities should be done together: firstly so that it was more convenient for women, secondly so that it could be cheaper (two for the price of one), and thirdly because it would help women ‘get it out of the way in one hit’. One of the European focus groups also supported a combined service.

Information on early detection and stages

Two of the Māori focus groups recommended that more information be produced to let women know about the stages of cancer – for instance that small (breast) lumps could be dealt with early, so the earlier they get screened the better. These groups felt that some women would think a lump was automatically cancer, and then automatically think this leads to death. They would not know that while lumps are small they can be treated. They felt that this would be the same as finding abnormal cells in a smear, and ensuring these were being detected early before they turned into something cancerous. Their strong message was that women need to know that early detection is imperative, however it does not stop women from getting breast cancer.

4.3.2 Improving cervical screening

Home-based and community-based smears

Women from the Tuvalu focus group suggested that a mobile unit with a nice environment (eg, music) would be acceptable for smears, providing the mobile unit was parked in an appropriate, but private, place. They based this idea on having a positive experience on the BSA mobile unit.

Māori women from one group suggested that more smear-takers coming to the home at a time convenient to the woman, on their own comfortable bed, would be better for many women without transport.

Make smears free

Women from the Māori, Pacific and multiple European focus groups felt that having smears should be free, like having mammograms. It was strongly suggested that screening rates within the NCSP programme would vastly improve if the service were free like the BSA mammograms. It was also noted by one group that it was 'inequitable' to have women pay for smears but not pay for mammography when both procedures prevent cancer and death among women in New Zealand.

While it was acknowledged that some Māori and Pacific health providers already provide it free, the concern was with doctors who provide smears with charges ranging up to $65 per smear. There was significant concern that paying $25, $35 or $45 for a smear is a problem, both because there is a cost in the first instance, and also because the costs are so variable for women and there is no consistency.

Use different group settings

Three of the Māori focus groups supported the use of different settings for conducting smears – such as smear parties, women's nights or pamper events, wine and cheese meetings, massage/mirimiri group sessions, etc. They felt that Māori women would be more likely attend a more generic event than one specifically saying 'come and have a smear'. The smear-taking should be a secondary activity integrated into a broader kaupapa to attract women. One of the European focus groups also promoted group smear-taking through using a morning tea, or conducting smears at rural women's meetings or similar forums.

Train more female smear-takers

Many women across all three ethnic groups who participated in the focus groups recommended training more female smear-takers. Māori women supported the need for more Māori female smear-takers, and that smear-taking services and locations need to be more widely advertised.

> *I would prefer a woman to a man Doctor! Smear-takers need to be trained well to do it softly and properly inform you.* (Māori woman, Waikato)
>
> *We need more female smear-takers / We need to target younger women 20 years of age and older. Young women need to be encouraged so it sinks in. / Having the same person each time is important. / Have more female smear-takers.* (European women, Waikato)
>
> *We need more Māori smear-takers and then advertise them so we know*

> *who they are and where to go.* (Māori woman, Auckland)
>
> *We need more female smear-takers trained and available through the GP to access. Sometimes it is good to have the same person.* (European woman, Christchurch)

Doctors need to improve their provision of information

GPs clearly have a significant influence in encouraging women to attend screening, but by the same token, women across all ethnic groups have expressed concern at not feeling sufficiently informed and prepared by their doctors for either cervical or breast screening. Women from all three ethnic groups suggested that doctors need to take more time to explain things before any procedure is performed.

> *Doctors need to take time to explain things. Most of the time they hurry you in and out of their office and don't tell you things.* (Māori woman, Waikato)
>
> *Sometimes they assume you have had a smear before and know what is going to happen. They need to explain and not take anything for granted.* (European woman, Waikato)
>
> *Sitting women down beforehand and explaining process then again afterwards to be sure we understand. / Go through process slowly. / Have more concentration on a woman's mental state. / Encourage us to take someone with us.* (Cook Islands women)
>
> *Doctors need to give more information. Prepare the person mentally for what is going to happen. Maybe get translators to help.* (Tuvaluan woman)

Improve the experience/procedure

From the 2006 focus groups, many of the ideas on improvements to screening related to the process of smear-taking rather than breast-screening. Many women provided ideas on improving the 'experience' of smear-taking to make it more acceptable and positive for women, so that they have a smear and then return for follow-up smears.

> *Heat up the speculum – it's always cold. Suggest different ways of lying.* (Māori woman, Waikato)
>
> *Ensure the smear-takers and doctors have the skills to do it properly and compassionately.* (European woman, Waikato)
>
> *Maybe have something to cover yourself while having the smear like the cloak for breast-screening – so your legs not open and embarrassing when you feel exposed.* (European woman, Christchurch)
>
> *Doctors need to listen when you say it hurts. / They should all have plastic speculums. / Lying on your back so exposed is not good. A nurse told me I could lie on my side and that was much better. / The Wairoa Doctor is a female and that is really important. / It is very embarrassing – having a sheet over you helps and a curtain around the bed. Talking to you while you*

> *do it also helps.* (European women, Wairoa)
>
> *Have a more relaxed environment – soft music or something to take your mind off it. / Use plastic speculum – make it more comfortable.* (Pacific women, Dunedin)
>
> *Make the environment warm and welcoming (music, nice pictures on the ceiling).* (Māori woman, Rotorua)
>
> *Improve reception and communication skills – tell staff to be more friendly when you come in, like Māori providers are. They welcome you and give you a cup of tea. In other places like laboratory place they treat you like a number on a waiting list.* (Māori woman, Christchurch)
>
> *I ask now about the equipment they use – that tool they use for smears. I heard they have different sizes and have a plastic one instead of a metal one.* (Māori woman, Wairoa)

Promotional advertising

Two of the European focus groups recommended continued and increased television advertising, especially for cervical screening. They also suggested having providers promote NCSP on their cars and vehicles – not just NCSP ISP providers but other health providers, so that it is mobile advertising like the BSA bus.

4.3.3 Improving breast screening

Sustained promotion

One group suggested that breast screening needs to be promoted all year round and not just intensely during Breast Cancer awareness week. They felt the issue needs to be treated as a priority all the time and that women need to be 'constantly aware all the time'.

BSA Mobile Unit

One group suggested that the mobile unit should come more frequently and that hours should be extended so that women can attend after work or in the evenings. One group also wanted weekend screening.

4.3.4 Improving health promotion approaches

<u>Age-specific promotion</u>

A significant number of the focus groups from all three ethnicities suggested more age-specific health promotion approaches, particularly for younger women at school, to prepare them for cervical screening. As well as school-based promotions, one group suggested educating parents about discussing cervical screening with their daughters to make it easier for them to discuss the topic.

> *Focus advertising on different age ranges.* (Māori woman, Rotorua)
>
> *Educate and prepare young women early while still at school. / Advertising is good. Using local people you know – normal people of all shapes and sizes.* (Māori women, Waikato)
>
> *Normalise it in schools so it becomes a normal thing to do – not something just some people do. If kids are old enough to have sex then they are old enough to have smears.* (Māori woman, Wairoa)
>
> *They should have a campaign targeted at parents on how to talk to their children on these things.* (Samoan woman)
>
> *Educate different age groups. / Rather than go for ethnic-specific health promotion, should look at targeting different age groups. / Young messages for young people. / Educate school age.* (Pacific women, Dunedin)
>
> *Information should be taught to kids early at school so they prepare for it and that it is part of life – make it normal. / Education is really important. / Keep the information coming out – keep the reminder letters going. / Educate and inform the men more.* (Māori women, Auckland)

<u>Use of role models</u>

Māori women in three groups suggested using local and national role models to promote screening – of all shapes and sizes, women and men. This supports ideas promoted by focus groups in the 2004 study.

Radio and TV

Māori and Pacific women wanted to see more use of TV and radio for promoting screening.

> *Should use Samoan radio and Niu FM more.* (Samoan women)
>
> *Use Māori Television more and Iwi Radio.* (Māori women, Christchurch)
>
> *Use Pacific radio more. Programmes when they have speakers [of our language].* (Tuvaluan woman)

Targeting men

Four of the Māori focus groups suggested that men be targeted more for messages on screening (Christchurch, Waikato, Auckland, Wairoa). They felt that this should be primarily through TV, because men would not attend public meetings or read brochures. Targeting men for messages on screening was also promoted by one of the European focus groups and the Tongan focus group.

Use different forums and settings

Many of the focus groups promoted the use of different forums, settings, events and hui to promote screening, rather than having an event that only talked about screening. Ideas included:

- use Māori health hui, marae hui – put screening on the agenda of hui (Māori women, Waikato)
- use more health expo days (Māori women, Wairoa)
- use different venues, like Rotary and Lionesses meetings (European women, Wairoa)
- promote messages for older women through church groups (Pacific women, Dunedin)
- get into church communities – contact leaders and spokespeople (Tongan women)
- facilitate more meetings like this where women can talk about these things – sharing stories of women coming together often and promoting messages
- go to fitness and swimming groups, where people are comfortable, and to other places like sewing groups, church groups, workplaces (Cook Islands women).

Resources

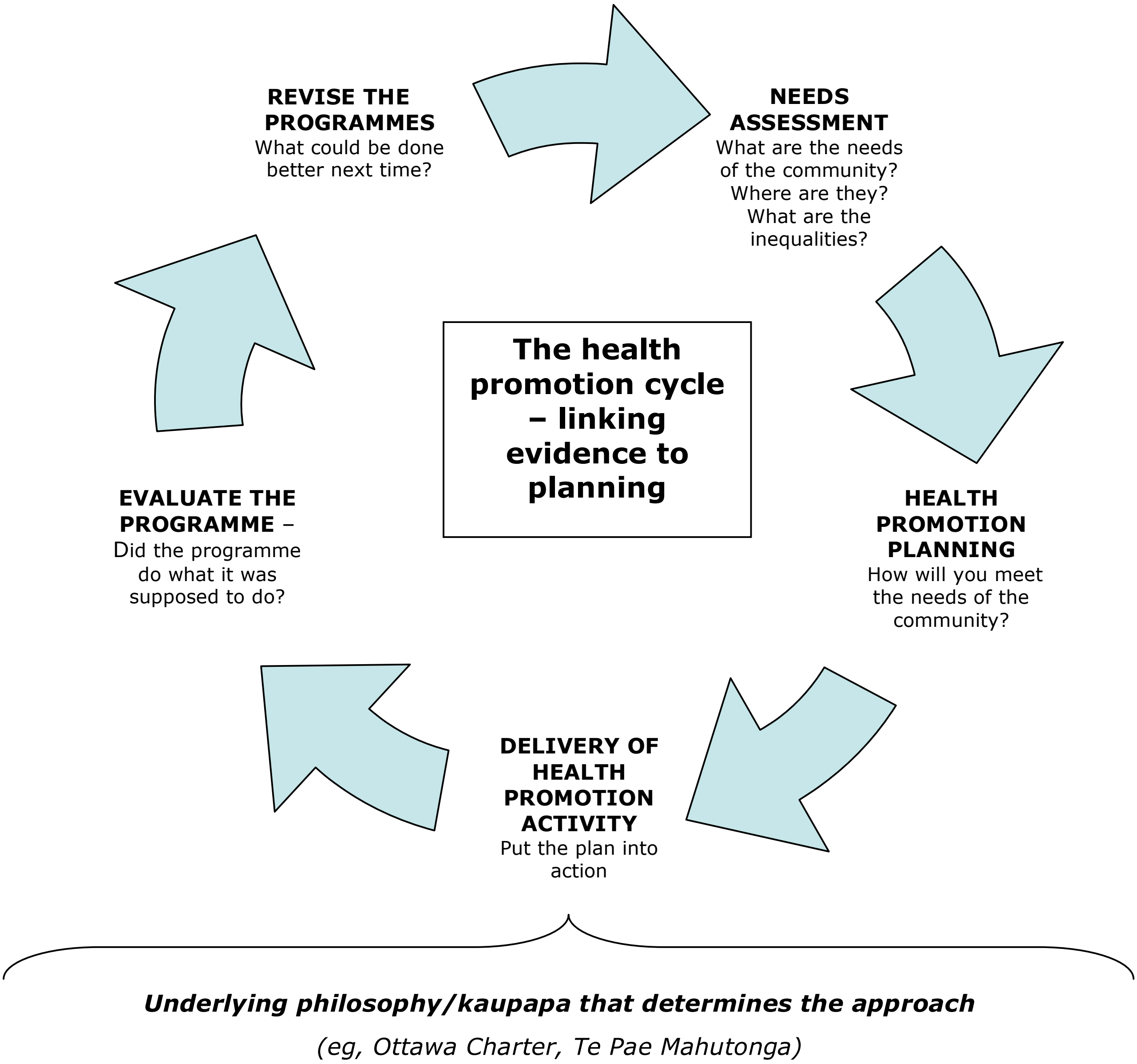
Most of the Pacific women focus groups asked for materials to be written in Cook Island Māori, noting that where this has occurred it has been helpful and useful for them. They supported the idea of resources continuing to be translated and made available for women, and also noted that such resources need to be included in materials given to people who have just moved from the Islands to New Zealand so that they know about the screening programmes as soon as they arrive.

5. TĀTARITANGĀ – ANALYSIS

5.1 Health promotion planning

5.1.1 The health promotion cycle – linking evidence to planning

This analysis is based on the following model of health promotion[1], which involves assessing the status of each activity and how this is currently performed by providers of BSA and NCSP health promotion services.



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

5.1.2 Model/philosophy of health promotion

Ottawa Charter and kaupapa Māori models

The Ottawa Charter has been used by the NSU as the basis for health promotion for screening. Based on the Charter, the NSU developed a planning template for providers to use for their annual health promotion plans. At the beginning of this evaluation in 2004 the application of this new template was fairly recent and providers were still adjusting to its use, having previously gone through a period of fairly loose and unstructured planning processes.

During the baseline visits in 2004 it was apparent that providers found it difficult to adapt to the Ottawa Charter planning template. Many considered it too "prescriptive", not offering sufficient flexibility for providers to adapt activities to their own regions, approaches and circumstances. Some felt it was the actual Ottawa Charter that was at fault, compared to using kaupapa Māori-based models, while others felt it was the template that was the problem for them. Those providers who particularly wanted to utilise Māori models as the basis for planning found the Ottawa Charter-based template restrictive.

The NSU had drafted guidelines for providers to help them work through the planning template, and the NSU intended that the activities in the templates would be indicative examples of ideas that health promoters could consider. It appeared that some providers appeared to receive mixed messages, as some said they were told it was an option to use the template and that they had the choice of adapting it to suit their own activities. Others felt they were told that use of the planning template was not negotiable, and that they were forced to describe activities for each area described in the template, even though those activities were things they did not think were suitable for their populations. As one provider said, "We were told to put radio activities into the plan, even though this was something we had never planned to do. It's just that it was in the template". Another provider said, "The NSU wants something in every box in the template, and sometimes we would put things in just to get our plan approved".

By 2006 it is evident that providers are now more accustomed to using the planning template and to incorporating this into their thinking. Providers are better able to complete the plan according to NSU requirements and to have their plan approved where they have adopted the planning template uniformly.

Using Māori models that operate within and through te ao Māori can be a very effective means of reaching Māori whānau. Health promotion initiatives coming from the Māori world have proven effective (Minister of Health and Associate Minister of Health 2002). During the baseline process visits all providers were using the Ottawa Charter because they were applying the NSU planning template. Three years later, only one Māori provider has developed their plan based on a Māori model of health and had their plan approved by NSU. This does not include the three formative providers who have been contracted for dual services (BSA and NCSP health promotion), who were encouraged to pilot other models such as Te Pae Mahutonga as part of the formative evaluation.

During this three-year period the NSU was also expected to develop a Te Pae Mahutonga framework and guideline for use by providers, and although a framework was developed (and has since been utilised by the three formative providers and the one ISP included in the process evaluation), it has not been widely implemented.

Many mainstream and Māori providers appear to still show an interest in underpinning their plans with a kaupapa Māori model, including other models such as Te Wheke and Te Pae Mahutonga. The NSU needs to allow this flexibility if they desire greater innovation, relevance and ownership of health promotion models used by providers to undertake their health promotion activity. It appears that the two Pacific ISPs have accepted the Ottawa Charter as their planning template and foundation for their health promotion activity in the absence of an identified Pacific model for health promotion.

Population-based versus one-on-one models

Generally, providers plan and conduct a combination of population-based and one-on-one approaches to improving screening rates.

Population-based health promotion involves utilising broad-ranging activities such as radio promotions, events, public meetings, media, and advertising/branding on the BSA mobile buses.

One-on-one health promotion tends to work with an individual woman, and perhaps her whānau or other small groups, to provide the key messages and encourage screening.

For priority women a combination of these two approaches is utilised – *holistic health promotion* – which can incorporate:

- NCSP and BSA health promotion at events for women, even if delivered by different providers
- NCSP and/or BSA health promotion with other well-women topics or events such as contraception, maternity or parenting
- well-women topics with other family health topics, such as female health and male health issues.

Some Pacific women indicated that they prefer a focused health promotion approach that deals with one issue at a time so that appropriate time can be allowed to fully discuss the issue, and the messages are not mixed. They feel that breast and cervical issues are very separate.

Recruiting women

The evaluation tends to indicate that one-on-one holistic health promotion works better for *recruiting* Māori women to the NCSP and BSA programmes: the personal approach that is not specific to one issue but takes a holistic focus, and is more effective at both informing women and encouraging them to make a decision to proceed with screening.

For Pacific women, the population-based health promotion approach works to raise awareness at a broader level, but targeted health promotion is needed in smaller groups to focus specific information for the different ethnic groups. This follow-up strategy might be termed group one-on-one health promotion, to reinforce and stress the population-based messages in the right language, setting and with an appropriate messenger. Pacific women prefer the use of written messages (from BSA and NCSP resources) in their own languages, after receiving oral messages.

For European women, the population-based health promotion approach appears to be the most effective, combined with the use and dissemination of written resources.

Retaining women

Once women are enrolled in the programmes, they are generally able to be retained in the programme through a combination of:

- continued awareness-raising from population-based health promotion
- having positive experiences from the screening (mammography or smear) itself
- a robust recall/reminder system that constantly prompts them to return.

These latter factors help to maintain *coverage* of priority women, but all three elements must be 'in sync' for it to work effectively. Women need to have a positive experience in both BSA and NCSP that does not put them off remaining in the programme(s). Despite the good work of health promotion and recall systems, a less than positive screening experience (either for a mammography or a smear) is likely to deter a priority woman from remaining in the programme(s), thereby undermining coverage rates. Regaining the woman's confidence and trust in the system is extremely difficult for health promoters and providers if a woman has had a bad experience at any time in her life.

5.1.3 Assessing needs

Providers have used a number of sources to identify the needs of eligible women in their communities.

- NCSP and BSA screening data provided by the NSU – this has, however, not been consistently provided to (eg, monthly), or consistently utilised by, all providers to plan or monitor their own progress.
- Opinions and views from key women in their communities and other networks – much of this has not been documented, nor have key contact lists or schedules been maintained in a central or transparent manual or electronic database which other workers (or future workers) can have access to.
- Other data (eg, Census, territorial local authority data, deprivation data) – only some of the providers obtain this information and have links with the staff of their territorial local authority to gather additional data. Those that do

access deprivation data are able to target inequalities for Māori and Pacific women more effectively.

- Anecdotal feedback or conversations with women and networks – again much of this is not documented, nor are records routinely maintained of key contacts within organisations that are part of the network (eg, meeting minutes). Without this evidence there is no formal proof that the anecdotal feedback is used formally for planning, or who the key relationships are with, and what arises from these relationships in terms of information that can be used for planning.
- Community consultation – there is little formal community consultation done by providers. Most rely on the organisations they network with to tell them what their client groups are saying. Few keep meeting minutes if there is formal consultation, or records of meetings held with networks.
- Formal needs analysis or evaluations – a handful of the providers undertake formal formative and process evaluations of their activities, but these are usually specific to a health promotion activity and not for the health promotion service as a whole. Those that have completed activity-based evaluations (eg, feedback forms after an event) have often filed them away and not used them to contribute formally to future health promotion plans.

It has been difficult for providers to use NSU data for planning or monitoring their progress, because accurate NSU data is sporadic and inconsistent. A few providers have used what limited data is available to set themselves specific targets; these providers tend to have more robust data collection, monitoring and reporting systems. They also tend to collect better evidence of their activities, and formally evaluate what they do. As a result of their more formal processes, they have been able to track improvements to their participation rates, and to target their health promotion to specific communities and women.

The evaluation has shown that few providers use formal processes for conducting needs analysis. Most use the anecdotal evidence and views of key women in their communities, but unfortunately much of this is not written down anywhere and is stored in the heads of many health promoters! Most providers use their own in-house knowledge of staff and previous work they have done, and informal processes that are often not documented to support their health promotion plans and activities.

The ideal elements for effective needs assessment for NCSP and BSA health promotion services include the use of formal quantitative data (eg, NSU screening rates, deprivation data, territorial local authority information) and formal qualitative data (eg, formal evaluations, meeting minutes, documented information from local networks and community leaders, formal public consultation and records of discussions).

As distinct members of the priority groups, the needs of Māori and Pacific women must be considered separately and individually. It is clear from the process and impact evaluations that these population groups should not be combined. Pacific women come from different population groups and have separate languages, separate cultures and separate needs. It is imperative that health promotion recognises the individuality of the seven main Pacific nations, especially given that the evaluation showed there was a propensity to treat Pacific women as one population group. Only three providers in the final survey formally undertook needs assessment that sought to identify the needs of Pacific women as a distinct population group. Most used the reason – or excuse – that their Pacific population was small. It is worth noting in this context that eight providers in the midway survey identified that they did not undertake specific needs assessment processes to identify the needs of Māori women.

While it may not always be feasible and/or practical to meet the needs of each of the seven main Pacific nations, it is only through robust needs analysis that this decision can be made. It is envisaged that following formal needs assessment processes, providers assess and prioritise how best to meet the language and cultural needs of the Pacific women in their community. In the absence of robust and formal needs assessment, the majority of providers tend to do what they have done previously, and they use the previous year's plan as the basis for current plans, rather than good needs analysis information. Also, the same networks and relationships continue to be used to support their annual efforts.

Overall, there is a general absence of formal needs assessment that combines qualitative and quantitative information, addresses the range and types of relationships and networks that support focused strategies, and targets the needs of Māori and Pacific women. The saying 'If you do what you have always done, you will get what you have always got' seems appropriate here. Only those providers who have used their data and information well, and formed the relationships and networks that support these, have been able to alter their plans and activities each year to target specific groups and areas in their regions. In a small number of providers, the use of more robust needs analysis and planning procedures has led to some significant in-house changes to the way the health promotion plans are developed and operate.

Effective needs assessment will occur when a combination of quantitative and qualitative data is used to target the providers' efforts to specific population groups and geographic areas in their regions, and in particular, to inequalities that exist in their regions. It is clear that strong needs analysis activity can lead to:

- recruiting a workforce that better reflects – and therefore understands - the target client group(s)
- implementing activities that are appropriate and specific to the target client group, and altering these activities when they don't work
- focusing energies on reducing inequalities and not continuing to do the same things that have always been done.

5.1.4 Planning health promotion

Once a provider has determined their approach and the model they are operating under, which for most is the Ottawa Charter, they then develop their annual health promotion plans based on the NSU template, which also largely determines the activities that are planned. The planning of activities is therefore based on the approaches and models outlined in 5.1.2.

Evidence from the all three years of the evaluation evaluation, indicates that planning is generally an internal process undertaken by health promoters and/or their managers. Planning that includes external parties or networks, and in particular other NCSP/BSA providers in the region, is not common, which means there is a general lack of regional planning across the country. A small handful of providers (2 BSA Leads and their respective ISPs) proactively get together each year to undertake regional planning, and one BSA Lead follows this up by sharing their draft plans with each other before they submit them to the NSU. One NCSP Regional Screening Services undertakes consultation with their draft plan to gain community feedback. Part of the reason for this is the often short time-frame that providers are working to for planning, and in some years not receiving approval for the plan until some months later. Where plan approval has not been forthcoming until midway through the year, providers are sometimes delayed in implementing the plan, and then find themselves running into the period for the following year's plan.

Currently, the NSU have an expectation as to what they should see in the annual health promotion plan, in terms of areas that need to be covered or questions that need to be answered. However, it seems that the rationale part of providers' plans is more of an afterthought rather than the basis for all health promotion activity in line with the chosen health promotion model.

KTC believes that the annual health promotion plan should address the following areas and questions.

- *The health promotion model* – What philosophical service model are you using and why have you chosen this? How has the chosen model been reflected or interpreted by you for your plan?
- *Rationale* – Who is in your population (based on the Census)? Where are the eligible women located? Where do the women in your region gather? What marae, groups, associations, clubs etc are there in your area? What is already established for health promotion in your region? What is already established for breast and/or cervical screening? Who have you consulted with and what

were the results? What evidence have you used to define the needs of your population? What are the screening rates in each territorial local authority in your region compared to the eligible population? What are the specific Māori and Pacific rates, and what does this tell you about where to target your efforts? What does all of this evidence tell you about who you need to focus on and where they are?

- *Planned activities* – What planned health promotion activities do you intend to use to reach the identified target populations? Why are you using these activities? What evidence is there that these work? How do you intend to measure the effectiveness of these activities?

It would also appear to benefit both providers and the NSU to revise the timelines for health promotion plans from annual to three-yearly. If providers developed a three-year plan – and did it well, in collaboration with other providers – they would develop more long-term responses while still providing an annual revision of that plan to the NSU rather than writing a whole new plan. This would encourage providers to think more strategically about their needs analysis information, and to plan ahead for improving participation and coverage. At present, the transaction costs for both the NSU and the providers appear to be relatively high for health promotion plans – both in terms of preparation as well as checking, providing feedback, redrafting and approving plans, which may occur over a period of months. Moving these activities to a three-year cycle may overcome some of the current deficiencies with planning in terms of lack of formal needs assessment, lack of public consultation, and lack of regional focus.

5.2 Health promotion in the screening pathway

5.2.1 Differences between BSA and NCSP health promotion in the pathway

According to He Korowai Oranga, the Māori Health Strategy, the majority of Māori receive their health care through mainstream services, and considering the current screening coverage and participation rates it is imperative that mainstream providers prioritise Māori health needs (Minister of Health and Associate Minister of Health 2002). Further, the New Zealand Cervical Cancer Audit recognised that there was an impression that Māori women are less well served at all steps along the screening pathway (University of Auckland 2004).

Health promotion is the first step in the screening pathway, but there is often a disconnection between health promotion and the other services in the pathway. For example, it is clear that in some areas, even if health promotion does an excellent job, this work can be negated by a bad screening experience elsewhere in the pathway. Where the pathway is controlled by the NSU in its entirety – such as in the BSA programme – the chances of monitoring and enforcing quality and responsiveness are relatively high. However, with the NCSP programme the NSU is not in control of all facets of the pathway.

Feedback between 2004 and 2006 has indicated that women today are not as concerned about uncomfortable breast-screening experiences as they were in 2004. They have described respectful, caring, informed experiences within the BSA mammography service. This also appears to show a better integration and sharing of information, knowledge and resources between health promotion services and mammography services – whether at fixed sites or on the BSA bus, which are equally identifiable. There are many examples of health promotion and the associated support to services supporting women into mammography as well as supporting mammography staff to be more responsive to the cultural needs of women.

The BSA register, appointment and recall system appears to be working well for women, and they are returning for screens based on having a positive prior experience and receiving timely reminders. This is borne out by the results of the impact evaluation as well as provider feedback. Women also identify with the BSA brand (particularly on the bus) and the BSA identity, which has a high profile among women from all ethnic groups. There does appear to be some impact from the BSA audits, however, which were conducted in 2006 and have provided lead providers with direct feedback on their practices and specific areas for improvements.

It is therefore clear that the control of the BSA database, appointments, data, recall, health promotion, mammography and audit/monitoring of the services has a direct impact on the quality of the BSA programme. The NSU is effectively overseeing all aspects of the BSA screening pathway and therefore has a strong influence over the whole pathway.

The combination of strong links between the health promotion team, call centre staff, data managers, mammography services and audit findings appears to have shown improvements in the quality and responsiveness of BSA services already. There is evidence, for instance, that co-location of health promotion with the call centre staff who make appointments is beneficial, in that women can be enrolled and given a date and time for screening immediately through health promoters accessing the appointments system straight away.

With the NCSP programme, however, the NSU does not have control over all facets of the programme. For example, they do not have control of smear-taking services provided by general practices, or much of the data held by general practices, which determines their appointment and recall systems. This means they do not have direct access to 'do not attends' (DNAs) for smears due at general practices, nor appointment-making that suits women. The NSU does not have direct control over the quality of smear-taking services of GPs either, and does not audit or monitor the GPs for their quality or compliance with national standards. Finally, the NSU does not have any influence over the level of information provided to women by GPs to ensure women are prepared and respected throughout the smear-taking process, unlike their influence on radiographer performance within the BSA programme. However, the right to privacy, respect and to be fully informed is expected under the Code of Health and Disability Services Consumer Rights.

The impact evaluation results provide evidence that GPs have the greatest influence over the majority of women in cervical screening. Although the baseline survey found there was limited health promotion activity with GPs and PHOs, in 2006 evidence has emerged that health promotion services have recognised the influence GPs and PHOs have, and have started to work more closely to access information from PHO member practices in regard to un-enrolled, overdue and under-screened women, often through a GP liaison position. This new position often supports collaboration between health promotion and the rest of the screening pathway, but there is much to be done to improve the links between health promotion services and PHOs, particularly so that the screening pathway can be fully implemented within the NCSP programme.

It must be noted, though, that some health promoters within the NCSP report ‘banging their heads against a wall’ to get access to a positive working relationship with their local PHOs, and for some it is taking many months or even years. There would also appear to be an argument for the NSU to work with Ministry of Health personnel to develop performance indicators and measures for all PHO contracts, to ensure PHOs have incentives to collaborate with NCSP service providers.

Finally, the fact that the NSU can ensure breast screening is free for women has a direct influence on the ability of health promotion services to encourage women to be screened. They cannot promote a similar free service for smears, and this presents a barrier for both them and women. Similarly, it is more difficult for providers to offer support to services for women to obtain a smear at their local GP because cost is a barrier, unlike the support they are able to provide for women attending the mobile unit or a fixed site for mammography. Where Māori providers have on-site smear-takers, who are usually free, this makes it easier for health promoters to give effect to a strong link within the screening pathway and to ensure women are screened – with a positive experience.

5.2.2 Health promotion vs recruitment

As mentioned under ‘Planning health promotion’ (section 5.1.4), there is a growing trend for providers to have a focus on recruitment included in their health promotion plans and activities. Some providers have designated functions in their health promotion positions that incorporate health promotion, recruitment and GP liaison. This move has come about for two main reasons:

providers themselves have identified that GPs have a major role to play in identifying eligible women for BSA, and in ensuring women commence or return for smears

providers are effectively measured on their participation and coverage rates so they need to have a direct means of affecting rates.

Generally, providers appear to have self-defined the three functions needed when working to improve coverage and screening rates:

- health promotion – sometimes involving shared Māori/Pacific roles, which focus on raising awareness and ensuring all women are informed of their choices

- GP liaison – which involves working with GPs to promote BSA/NCSP, and to access the records of women who have not been screened or have just become eligible, DNAs, etc
- recruitment – which focuses on enrolling women once they have been informed, capturing un-enrolled women and deliberately increasing participation rates.

It is then up to each programme to *retain* women in the programmes after the above health promotion team has informed or captured them, by ensuring they have a positive experience in their screen, and by operating an effective recall system.

Some providers still argue that health promotion services should not be measured and monitored on the state of their screening rates, because (a) they do not have the sole or direct influence over rates (which can be affected by other providers or issues outside of their control, such as the quality of smear-takers or radiographers), and (b) they see their role as *raising awareness* among women so that they can make an *informed choice* about screening.

The impact evaluation has provided some evidence of the effectiveness of this pure health promotion approach. The evaluation measured awareness among selected women in the focus groups, and attitudes to feeling informed, through three primary channels:

- knowledge of the two programmes and age ranges applicable to each
- knowledge of where to go for screening
- knowledge of where to get information.

Where women consented and proceeded, the evaluation measured whether they felt sufficiently prepared for the screening (smear or mammography).

The impact evaluation demonstrated that in 2004, although all women interviewed knew of the breast and cervical screening programmes, only 36% knew the age range for BSA and only 9% knew the age range of NCSP. Some did not even know there was an age range for the NCSP programme. For NCSP most women thought it started at age 20 or when a woman had her first baby or started on contraception.

The majority of eligible women who participated in the 2006 focus groups knew where to go for a smear or mammogram, and this was aided by the recall letters that women receive once they are enrolled. For both programmes, women rely on their GP to provide information about screening, followed by TV promotion and then lead maternity carers for cervical screening, and family and friends for breast screening. In both programmes, health promoters and educators – from BSA/NCSP as well as other Māori and Pacific providers – feature as the fourth-ranked source of information.

In terms of feeling prepared and informed for the procedures themselves, women rely on health professionals to do this for them (ie, their GP, radiographer or smear-taker). Clearly some are better at doing this than others. Women did not generally rely on health promotion services to prepare them for screening procedures, but did access them for support when needed.

The results of the 2004 impact evaluation appear to indicate that health promotion services are on the 'radar screen' of women when it comes to thinking about where they have received information about screening. It is logical that most women would rely on their family GP or lead maternity carer to provide initial information about screening, and that family and friends would feature highly also.

Areas in which health promoters can improve the awareness of women include promoting the age ranges (along with printed resources and other NSU media communications) and continuing to inform women about their rights to support and advocacy when dealing with health professionals and services. It is clear the NSU can also play an advocacy role via the Ministry of Health to provide feedback through PHOs to general practices across the country to improve their informing of women about screening, and to improve smear-taking procedures for all women (including training female smear-takers within their practices).

The recruitment approach and the pure health promotion approach adopted by providers are both appropriate. Health promotion of screening blurs the line between public and personal health, and recruitment is a critical outcome of health promotion activity as both the BSA and NCSP screening programmes rely on high levels of participation (NSU 2004c). Pure health promotion is about raising awareness and informing the public so that they make informed choices about their lifestyle. However, in a screening programme, the health promotion takes on an added responsibility of encouraging an enrolment so that people *are* in fact screened.

There would appear to be an argument for the NSU deliberately splitting and defining these roles contractually and paying specifically for the 'pure' health promotion aspect, while ensuring this is targeted to address inequalities, particularly among Māori and Pacific women through more robust needs analysis, and then also paying specifically for the recruitment and GP liaison functions. The suggestion is to formalise the funding of a combination 'promotion and recruitment team'. The health promotion role would then have separate performance indicators from the recruitment and retention role.

5.3 Delivery of health promotion

The 2004–2006 process evaluation has identified a number of activities that providers are utilising in their health promotion programmes to reach Māori and Pacific women. Categorised within the NSU Health Promotion Framework, these include:

- Community development
- group sessions or events – smear parties, pamper parties, ladies nights, fashion shows
- marae-based screening or promotional hui around well-women
- building relationships with key leader and 'movers and shakers' in communities
- using role models/champions, including kuia/taua
- collaborating with others for community events or promotions (eg, Te Ahurei (Tuhoe Festival), Te Whare Roimata (Māori community health day in Christchurch)
- train-the-trainer events

- using netball and other sports tournaments or events
- workplace initiatives and promoting a well-women policy with employers
- clinical or cultural training for radiographers and smear-takers

Communications
use of local media (radio, including Māori and Pacific radio, and newspapers)

magazines and newsletters (eg, via kōhanga reo or Te Puni Kōkiri)

sponsorship of events in the community, including providing resources

distributing programme information through other Māori and Pacific providers using all these activities to promote the arrival of the mobile unit for BSA for Māori and Pacific women approximately three months prior

Health education
convening health education sessions using the programme resources (flipcharts, friezes, etc)

providing education with other providers or at community events

one-on-one sessions with small groups (eg, Tongan women, or a woman and her whānau)

GP activities (eg, via the GP liaison roles).

They also use a range of specific activities to support the hard-to-reach Māori and Pacific women in order to further address inequalities, including:

- using or referring to female smear-takers
- identifying free smear services for women so that cost is not a barrier
- helping women with transport and accompanying them to screening events
- ensuring use of appropriate language, particularly for Pacific women, supported by translated resources
- support to services
- encouraging group screening.

The most successful health promotion activities for Māori women appear to be where appropriate role models are used and personal stories are promoted. Story-telling and sharing is a widely known effective method of health promotion for Māori used in other fields. One-on-one small group promotion also works well, as does promotion that is holistic and incorporates a range of positive activities like pamper days or mirimiri. Finally, marae-based screening has been noted as being very positive. Delivery of health promotion by Māori is widely accepted, more so than delivery by non-Māori.

For Pacific women, the most effective health promotion mechanisms are those that are ethnic-specific and allow first languages to be spoken, stories to be shared and a safe atmosphere to be created that allows women to be open. For Pacific women, the delivery does not necessarily have to be by a Pacific person, although language would be a barrier for others. It is important for Pacific women that the health promoter is informed and knowledgeable on the topic, and able to answer their questions.

The key lessons from this are that the Health Promotion Framework supports a good model for planning and organising the activities of health promoters into logical and measurable areas. There also appears to be a direct link between disconnections in the screening pathway (discussed in section 5.2) and problems faced by health promotion services to reach and inform Māori and Pacific women and to ensure a positive screening experience. Most of the work they do aims to overcome the attitudinal barriers and opinions among women about why they do not participate in screening. The creative approaches used by health promotion services are designed to make the idea of screening more positive for Māori and Pacific women, as well as enhancing the access to, affordability and experience of the screen itself.

5.4 Evaluation of health promotion

The process evaluation has identified a range of methods that are used by providers to evaluate what they are doing, varying from informal to formal evaluation, and that are usually activity-specific. Providers generally use feedback forms following specific events or promotions, and some providers document their activities through records of meetings or counting attendances and taking photos of women at events. In the baseline survey it was noted that few providers undertook formal evaluations, but that by the final survey formal evaluation had increased, as evidenced by a number of providers undertaking their own evaluations (often with the support of other health promotion teams or networks) to determine the effectiveness of specific health promotion events.

The gaps were in the use of this information in future planning and making improvements to service delivery. Where such changes were made or improvements were made to their delivery, the *link* was not documented so that it was clear that evaluation from previous events had led to the changes. Much of this occurred informally, so that while on the whole most providers collected the information, they did not know how to link it directly to changes to their approach or future health promotion plans. Some made changes using their own staff knowledge and ideas, but there is no nationally consistent approach to evaluation.

Some providers considered that because evaluation is not a specific component in the contract, there is no dedicated funding or a specific requirement to conduct a formal evaluation.

There would be benefits in the NSU developing an optional toolkit – by assembling existing examples – for all providers, which includes a brief on the types of evaluation that can be conducted, some templates that can be used, and demonstrating how providers should link their evaluation to future plans and activities. This toolkit could be distributed to all providers and should be included in the orientation process and training of all new kaimahi.

5.5 The impact of health promotion

5.5.1 Why women go to screening

Women who participate and enrol in screening have identified the key reasons for doing so.

For both programmes, the primary reason for *being screened* is making a positive lifestyle choice. Much of this could be attributed to effective health promotion informing women to make positive lifestyle choices.

For breast screening the reasons included:

- there is a family history
- being referred by the GP
- encouragement from family and friends
- having a free service.

For cervical screening reasons included:

- there is a family history
- it was suggested by the GP/Family Planning.

The reasons for women *continuing* to participate included:

for breast screening:

- the free service
- the recall/reminder system from BSA
- having a prior positive experience at the mammography

for cervical screening:

- fear of cancer
- a history of abnormal smears meaning they feel at higher risk
- the recall reminder system from their GP.

This shows that where health promotion is effective at encouraging women to make positive lifestyle choices for themselves, the enrolment and participation rates are likely to improve, particularly if health promotion prompts women to be aware of family histories of breast or cervical cancer. The reminder and recall system of both the BSA and the GPs are just as crucial to ensuring women *remain* in both programmes once they do enrol, so the monitoring of both registers continues to be vitally important to improve coverage. The free service offered by BSA is also a big incentive, while charges for smears continue to be a barrier for many women, as evidenced by the fact that those who do go tend to try to find a free smear-taking service.

The outcome from this analysis is that continued promotion of positive lifestyle choices, linked to awareness of family histories, is the key message that health promotion services need to continue to push among Māori and Pacific women.

5.5.2 Why women do not participate

The process evaluation identified why providers believe some women do not participate in screening, and how they attempt to address this. The majority of providers believe that Māori and Pacific women do not participate because:

- they do not want to be judged and are shy or whakama
- they are not well informed (mostly by their GPs) or have been misinformed
- they have had a bad experience somewhere along the line that has put them off
- some are just not ready and may take a while (sometimes years) to come around
- some are afraid – particularly of cancer – and the impact of this on their children and family
- having a male GP puts them off having a smear.

To overcome some of these attitudes and barriers, health promoters generally take the approach of respecting a woman's choice and not being pushy with them. The majority respect their decision, but continue to provide relevant information so that women are as informed as possible to make a decision for themselves. Methods used for this are longer one-on-one sessions that allow individual woman to discuss and work through bad experiences, ask questions without being embarrassed, and have things (including all the equipment) explained fully for them, and providing support for them to attend if necessary.

Providers also refer women to smear-takers they know are good with Māori and/or Pacific women. The approach taken by the health promoters here aligns with the pure health promotion approach discussed in section 5.2.2 above, which focuses on the role of ensuring women are informed to make good choices for themselves.

Generally the reasons outlined by the providers align with those offered by the women themselves in the 2004 and 2006 focus groups, which informed the impact evaluation. Women identified that they do NOT participate in screening because of the following reasons (in order):

NCSP:

- embarrassment / whakama / shyness
- male doctor doing the smear
- cost of smears – too expensive
- fear of the result (cancer)
- pain and discomfort
- not knowing what to expect

BSA:

- fear of the unknown / scared of the screen and the result
- cost (outside age range)
- pain and discomfort
- embarrassment / whakama / shy – usually of body image
- too busy
- better not to know if it is cancer.

These reasons indicate that health promotion services can contribute to overcoming some of the barriers by focusing on informing women about the *experience* of screening and what will be involved. It is not sufficient to discuss the benefits of screening and what a positive lifestyle choice this is. Women also need to know more about what to expect and what is involved. Pictures of instruments or machines may help to prepare women better so that the smear-taking or mammography is not such an unknown for them.

Health promotion services cannot control the quality of the smear or mammography, which is dependent on other providers, but they can inform women of their right to have whānau or other support, advocacy, and respect given to them during the procedures. They can continue to provide the support to services they currently provide, although obviously there is more need for this in smear-taking than in breast screening as women are more concerned about male GPs, pain and discomfort and shyness with smear-taking. Identifying more female smear-takers in the community that health promoters can refer women to would be very useful, including possibly producing a small local directory for women.

Improving the actual experience of a smear being done by general practice could be the role of the NSU working with the Ministry of Health to inform PHOs and GPs of the results of this evaluation, and in particular the results of the impact evaluation. This could also be achieved through the GP liaison roles within health promotion providers at a local level. Disseminating the substantial feedback from women across New Zealand would provide direct feedback to general practices across the country about the quality of services and fears that women have about screening. There are also other areas that general practice influences (eg, alerting women to screening) that could be incorporated into dissemination of the information.

As we have seen, in many areas of New Zealand the screening rates for Māori and Pacific women are well below 50% for both BSA and NCSP, although the BSA monthly reports by ethnicity (incorporating information provided by territorial local authorities) note that as of April 2006 certain territorial local authorities (eg, Kaikoura District and Grey District) had over 90% coverage (NSU 2006). Health promotion services need to identify specifically *where* the particularly low rates are, and to develop very specific and targeted strategies, working with other local providers in the screening pathway to reach women in these communities. It appears from results of the process and impact evaluations that too many service providers are still doing what they have done in the past, and without accurate data are not able to target these inequalities accurately.

There would seem to be an argument for the NSU setting very specific performance measures in contracts, which are monitored routinely, for providers to:

- conduct needs assessments to reach the hard-to-reach and wavering women in their regions
- plan better how they intend to reach and inform the women in these categories
- help women in these categories to overcome fears, barriers and lack of information to enable them move through the continuum from being disengaged, to participating with support, to participating on their own
- allow the recall systems of the programmes themselves to maintain the engagement of the group that is already enrolled and participating well, and avoid a generic focus.

5.5.3 Informed consent

Obtaining informed consent from eligible individuals is paramount. This includes the right to make an informed choice *not* to participate in screening, based on sound information (NSU 2004b). This is a key role if health promotion is to be truly effective, because it ensures that health promotion services are focused on raising awareness so that women make informed decisions. This role is interpreted differently by health promoters, but the issue is strongly linked to the issue raised in section 5.2.2 on the role of recruitment versus pure health promotion.

It is evident that services/providers who have a focus on recruitment through their health promotion teams may be compromising the need to ensure women give informed consent in their eagerness to attract an enrolment. Because they have historically been measured on rates, their focus has been on recruiting women into the programme, and possibly not giving some women the opportunity to make a different decision than the one they are making. They may unwittingly encourage enrolment without fully informing the women and allowing them to go away and make an informed decision, for the sake of increasing their enrolment rates. In other words, 'getting the numbers through' has been more important than ensuring women are fully informed. This is because the NSU has closely monitored screening rates and raised concerns about some regions having low rates, thereby attributing these low rates to ineffective health promotion services. Because of a resultant fear of compromising their funding and their contracts, some providers have focused on enrolling rather than fully informing women.

Other providers believe their role is to inform women, even if the outcome is that they choose not to participate. In such cases their coverage numbers may be low but their awareness rates are high. Women may be highly informed but still make the decision not to participate. Research on other health promotion initiatives (eg, smoking) has shown that while awareness of an issue may be high, this does not necessarily lead to high rates of behaviour change. In fact sometimes the opposite may be true, and it is difficult to link or attribute health promotion awareness campaigns to increases or changes in the behaviour of a population.

The difficulty for many providers of health promotion services is that they are currently measured on their coverage and participation rates – not on their awareness and knowledge rates. They are successful if they have high participation numbers, not if they are informing women and the women choose not to participate. It may be that a system needs to be designed within the BSA and NCSP registers that aligns with the National Immunisation Register, where 'declines' to screening are recorded so that actual rates of declines can be included in any analysis without penalising health promotion services. A 'decline' feature may also allow BSA and the NCSP to follow up on these women at a later time in case their views have changed. Doctors could record a decline for a smear in their registers, which could be linked to the national NCSP register. Women who are contacted through BSA health promotion services or any other service, and who decline, could also sign a decline form that could be entered into the BSA data register. An important feature would be the ability to follow up, at an interval specified by the NSU, to see whether women have changed their minds.

5.5.4 Improving screening rates

Women were asked to provide ideas about how best to encourage non-participating women to attend for screening. For health promotion services, a key recommendation is that more information is disseminated about the stages of cancer development and the importance of early detection. There is a view that many women who fear cancer may not be aware that if they get in early they can be treated. The fear of cancer has led to many women just not wanting to know anything, and preferring *not* to know. This could be because they are misinformed about the stages of development of anything potentially cancerous and the benefits of early detection.

The majority of other NCSP improvements suggested by women in this report are targeted at smear-taking services delivered mostly by GPs, and include:

- improving information dissemination
- improving the smear-taking experience
- providing more female smear-takers (eg, training practice nurses, or referring patients to local female smear-takers, particularly those who are free).

Again these are issues that should be communicated to PHOs and GPs via the Ministry of Health, and quality-based incentives could perhaps be introduced through PHO contracts.

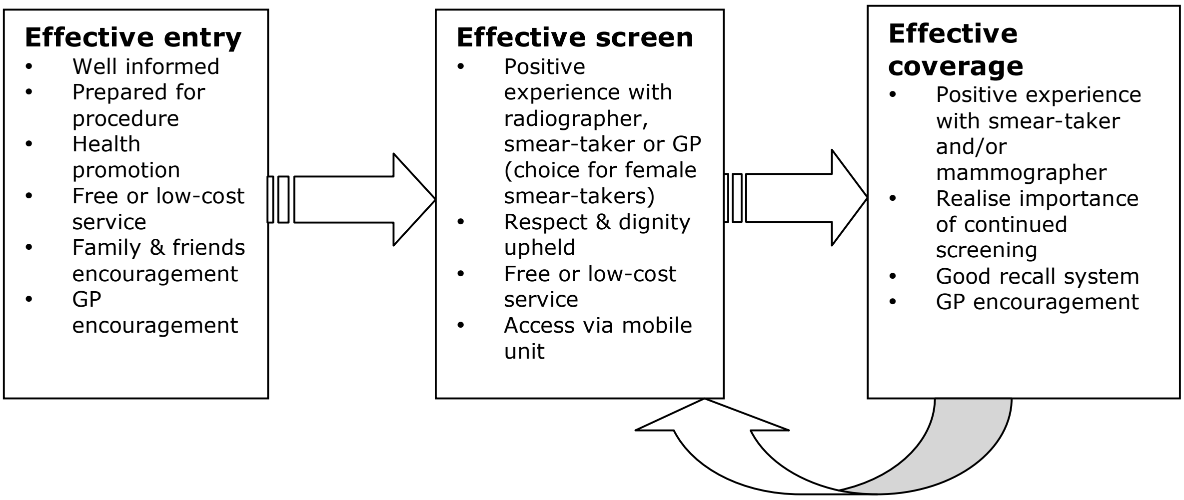
General improvements to health promotion services for both programmes would incorporate:

- age-specific health promotions
- more use of role models (for resources as well as presentations)
- more use of Māori and Pacific radio and TV
- targeting men for promotional activity
- using different settings
- building relationships with other Māori and Pacific health providers.

These are specific suggestions that health promotion services could build into future plans to improve awareness and ultimately contribute to improving screening rates. Ideas for improvements to resources have already been taken on board by the NSU through the Review of Māori Resources in 2005.

The ideal model is described in Figure 3.

Figure 3: The ideal model for improving and maintaining screening rates



5.6 The health promotion environment

5.6.1 The structure of providers

There is evidence that sometimes the structure of providers may have a positive or negative influence on the effectiveness of health promotion services and their contribution along the screening pathway. Providers are structured in many different ways in both programmes, but fall into two main groups: successful models and challenging models.

Successful models

Successful structural models are those that promote successful relationships and have a positive influence on the health promotion services and the screening pathway. These may include:

- ISP providers of health promotion services who have smear-takers or their own GP service, and who can therefore make internal referrals and access data about women (current and future potential)
- BSA providers who combine health promotion services plus the mammography service for appointments, so that opportunistic appointments can be made via the health promotion team if women contact them directly

- BSA lead providers who have multiple ISPs in their region, but network and visit regularly to co-ordinate regional planning, share plans, provide resources and share information and data (this may be further enhanced by a good relationship between the ISPs and the appointment staff, who can secure appointments for women identified by ISP health promotion services quickly and responsively)
- NCSP services that have subcontracts with local ISPs and other Māori providers, and who link well through strong relationships to inform and find women.

Challenging models

Challenging structural models are those that impede the ability to deliver effective health promotion services and often allow a disconnect between the screening pathway. These include:

- BSA services that subcontract some of their services to private laboratories but do not ensure the subcontractors have mechanisms in place to be culturally responsive to Māori and Pacific women who use their services (some of these subcontractors may also not have any relationship with, or awareness of, health promotion services covering their community)
- regional NCSP services located within DHBs, and therefore often lacking an identity or brand that is as identifiable as a mobile unit or a dedicated clinic, as in the BSA programme
- ISP providers who operate in the community without a strong link to the BSA lead provider or the regional NCSP screening service or colposcopy service (these weak links may manifest themselves in the lack of regional planning, non-sharing of information, lack of relationship or regular get-togethers, or staff not working together; ultimately these providers work independently of each other and probably duplicate effort and waste time and resources trying to reach the same women)
- difficult relationships between BSA and NCSP services and PHOs and GPs, where PHOs are not amenable either to a relationship or to sharing data or information.

Where service integration can be promoted through co-location, this has shown benefits in terms of BSA health promoters being able to respond quickly to enrol a woman and determine an appointment time immediately. Also, if BSA health promoters work well with ISPs and radiographers, there is significant opportunity to ensure services are culturally responsive for Māori and Pacific women. There is evidence that this is occurring well already in some areas.

However, with the NCSP programme it is virtually impossible to co-locate NCSP health promotion services with smear-taker services that can enrol women and make appointments. There is no way that NCSP health promotion can locate itself with every GP or other smear-taker in its coverage area. This means they have to spread their resources to tap into the GPs by primarily working through PHOs.

As discussed in section 5.2.1, the screening pathway works well where the NSU can control and determine how everyone works together, and monitors the quality and effectiveness of those relationships. With the BSA programme it is easier for the NSU to influence BSA lead providers to work well with ISP providers and vice versa, conduct regional planning, share information, ensure they are all culturally responsive to Māori and Pacific women, and work collegially for the benefit of all women. However, for the NCSP programme the NSU has little direct influence over ensuring general practices and PHOs collaborate with regional screening services, plan together, share data and information and ensure cultural responsiveness during smear-taking procedures. Neither the NCSP health promotion service nor the NSU can monitor every smear-taker in their region – only those it contracts with directly.

As a result, the support of PHOs nationwide to ensure all general practices support and inform women, and encourage a positive smear-taking experience, is vital. At the highest level the NSU will need to work with the Ministry of Health to influence PHO contracts and PHO communications, to encourage improvements in PHO performance, and in particular to encourage their relationship building with NCSP regional services and health promoters. At a regional and local level, providers can utilise their GP liaison role to build positive and collaborative relationships with PHOs to support the sharing of information, data and plans.

5.6.2 Regional provider relationships

Strong provider relationships are integral to providing acceptable and accessible screening services, yet this does not always occur, which results in a lack of co-ordination and often duplication of services. Regional provider relationships are variable across the country. In some regions the NSU-contracted ISPs, BSA lead providers and NCSP regional screening services work together very effectively. They discuss a regional approach, share or analyse the data, and share their plans. They identify hot spots in the region, and look at proposed activities so that there is no duplication or overlap. They also identify events or activities they intend to work together on so that these can be documented in their respective plans.

This is the *ideal* model – one where all NSU-contracted providers are open with each other, plan strategically, and consistently document their approaches in their respective health promotion plans. However, there has been no evidence that subcontracted parties to lead providers or NCSP regional services have been involved in any shared discussions, strategising or planning.

In other regions, there are other examples of regional relationships, including:

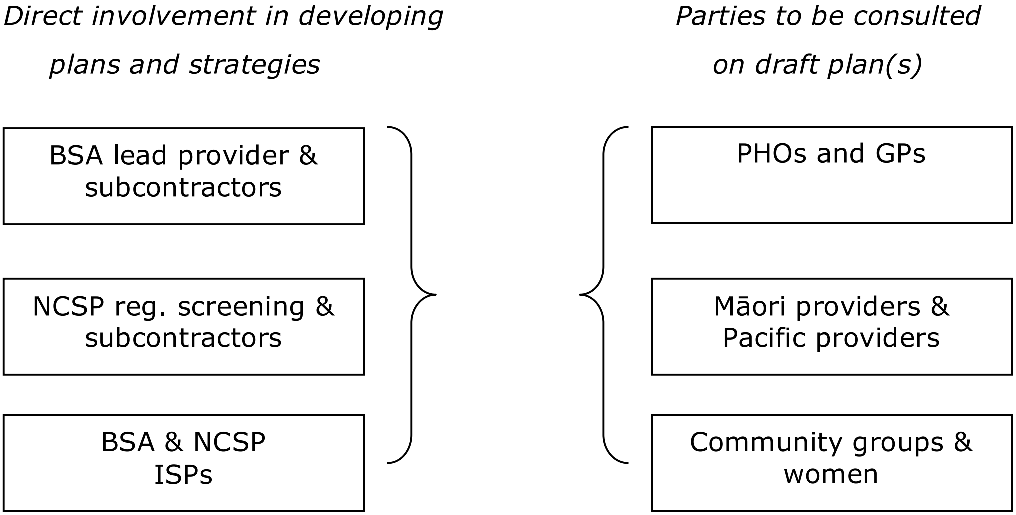
- BSA lead providers and BSA ISPs working together, but without NCSP regional screening service involvement
- NCSP regional screening services working with NCSP ISPs, sometimes with the involvement of some local smear-takers
- Māori ISPs working with other Māori health (and sometimes Pacific) providers, as well as other Māori organisations
- Pacific ISPs working with other Pacific providers.

In some regions these relationship models operate simply as informal meetings to look at what each provider is doing, rather than robustly analysing data and information from the region together and developing complementary health promotion plans. It was also noted in the original 2004 baseline process evaluation report that some BSA ISPs had difficulty with BSA lead providers having the title of ‘lead provider’, which implied that ISPs were somehow subservient to lead providers or of lesser importance. In a couple of examples the ISPs felt that their local lead provider was behaving like a leader of all BSA providers in the region, and trying to exert influence and control over ISP services.

None of these regional relationships formally include PHOs or general practices, or other smear-takers, in terms of consultation or involvement for the purposes of developing BSA and NCSP health promotion plans. However, often it is impractical to undertake substantial consultation on an annual basis for health promotion plans, and sometimes the NSU-contracted providers have not had any useful data on which to base their plans. They have not had data to share with other providers to help encourage collaboration and awareness of the low rates of screening for many women.

It would seem evident that the *ideal* model for regional relationships that link strongly to planning and implementation of BSA and NCSP health promotion services in a region should include the features summarised in Figure 4.

Figure 4: The ideal model for regional relationships



5.6.3 Screening workforce capability

A competent and capable screening workforce is essential for ensuring the benefits of screening programmes to the population (NSU 2003). However, there appear to be substantial difficulties for providers to recruit and retain staff in health promotion services. Some new kaimahi may have cultural or language skills but not health promotion, planning or evaluation competencies. Alternatively, providers may employ experienced health promoters, but they may not have cultural and language skills, or have any experience working with Māori and Pacific women.

New kaimahi therefore find it difficult to put their actions into plans because they are accustomed to being ‘hands on’ in their communities, and are not accustomed to conducting needs analysis, writing health promotions plans, understanding BSA or NCSP policy and quality standards, documenting activities or meetings or events, or evaluating their work. Some may not have any health sector experience let alone health promotion experience. On the whole, though, they are *great* front-line workers who operate well with women and families in their communities, and are able to support many women to engage in the programmes.

Tikanga and te reo Māori as well as proficiency in Pacific languages are key areas of expertise in screening health promotion in order to effectively work with Māori and Pacific women, particularly to reduce inequalities (Public Health Advisory Committee 2006), and these skills should be recognised for the value they have in attracting women in the priority groups. On the other hand, experienced health promoters may be good at the theory of promotion, but are not as good at engaging with Māori and Pacific women in their communities or developing the right networks.

Induction training for new kaimahi is only offered once a year by the NSU for new workers. There is no follow-up training, and any kaimahi employed in the immediate period after the annual induction training has to wait until the following year’s training to receive the full orientation. From feedback provided by providers in the process evaluation, the orientation training is good for forming networks with other kaimahi, gaining a general understanding of the NCSP and BSA programmes and screening issues, and meeting NSU staff. However, managers and kaimahi have suggested improvements to the way the NSU supports kaimahi, including the following.

Orientation

Include a thorough description and understanding of the BSA and NCSP standards, and the expectations of the NSU in terms of their activity and documentation.

Include a thorough description and session on the health promotion cycle, as promoted in section 5.1.1 of this report, particularly in the needs analysis and planning phases. This needs to come from a kaupapa Māori perspective and allow integration and discussion of different philosophical models.

Emphasise the need for kaimahi to retain documentation in order for them to evaluate what they are doing, and to contribute to future planning.

Emphasise the importance of regional relationships and what the NSU expects in terms of developing, sustaining and documenting these relationships.

Provide training on the use of the resources and how best to disseminate these to have the greatest effect.

Provide training on cultural issues related to working with Māori and Pacific women, and in particular how providers are expected to address inequalities. Feedback from the impact evaluation report can be used to inform kaimahi about what barriers women face when thinking about screening. Cultural competencies need to be valued, along with tertiary qualifications for public health action.

Follow-up annual training

Include refreshers and feedback on the above topics, allowing managers and kaimahi to discuss the challenges they face and promote successes.

Provide instruction on how to use the NSU screening data and conduct self-analysis for planning and monitoring purposes. It is recommended that this be carried out by regional data managers, who know what data is available and what reports can be requested, as well as teaching kaimahi how to read the data properly.

Include NSU feedback on planning processes and audit programme outcomes (what is being learned from audits that other providers can benefit from).

Pacific Screening Workers Conference

There has been positive feedback about the content, focus and approach to this conference. Any staff from a provider who works with Pacific women is able to attend this conference and this inclusive approach supports kaimahi from around the country in ways to increase screening rates for Pacific women.

Kaimahi hui

There has been significant feedback on restricting the kaimahi hui to Māori kaimahi only, and the fact that this presents a barrier for non-Māori kaimahi who work with Māori women. Ultimately the issue is whether the kaimahi hui is focused on improving screening rates for Māori women (in which case all providers who deal with Māori women should be involved, like the Pacific workers fono), or whether it is an initiative solely for kaimahi for networking and information sharing. The majority seem to feel that both needs can be met by planning the three-day kaimahi hui better so that kaimahi have a chance to discuss their own workforce-related issues via a Māori caucus, while kaimahi from all providers (regardless of ethnicity) working with Māori women should be involved in discussing and improving the screening rates for Māori women. Some kaimahi who had attended the Pacific workers fono complimented their focus on the screening needs of Pacific women, rather than having an internal perspective on their own needs.

There has also been a suggestion of scheduling a day of the kaimahi hui for lead providers, regional screening services and interested PHOs to attend, so that there can be a broader focus from all providers of the screening sector on improving screening for Māori women.

In conclusion, the NSU should allow:

- more time for kaimahi to share experiences and discuss issues they are facing in all areas of the screening pathway, including anecdotal feedback they may be receiving from women.
- a separate time slot for kaimahi to discuss further issues such as workforce development via a Maori caucus
- Māori providers to send any of their non-Māori staff who work in BSA or the NCSP, if they so choose, and allow a Māori caucus to convene during the hui if desired.

5.6.4 Data

The process evaluation highlighted difficulties among providers in obtaining regular screening data from the NSU, yet they were aware of being measured on screening rates by the NSU. Providers have all called for regular dissemination of data, and for help in interpreting and analysing the data. On some occasions, particularly with NCSP data, the data has been inaccurate and some providers have begun to mistrust the data and have stopped using it for planning and monitoring purposes.

Problems with obtaining data, and then accurately interpreting and analysing the data, have undoubtedly affected the planning and monitoring capacities of providers. There is a need to remedy irregular data dissemination and to provide more training to enable the providers to use the data consistently and accurately

5.6.5 Resources

The independent review of resources identified specific issues related to Māori resources, and so these are not reported again here. However the process evaluation did identify a lack of resources for Pacific women. Providers who target Pacific women called for an improved range of resources targeted at the different ethnic groups of Pacific women in their own languages.

5.7 Reducing screening inequalities

5.7.1 The extent of the priority focus

The NSU's Strategic Plan specifically outlines how it will meet the New Zealand Health Strategy's goals and objectives, in particular reducing inequalities in health status and ensuring accessible and appropriate health care services. The Strategic Plan acknowledges that Māori, Pacific, low-income and disabled women, and those who are geographically isolated, are most likely to require additional services and attention (NSU 2003).

The focus of health promotion for Māori and Pacific women is to reduce inequalities, which means that providers should directly target the inequalities in their regions. The process evaluation has identified that there is still a range of health promotion activity that serves *all* women and does not have a specific enough focus on Māori and Pacific women, and in particular on reducing inequalities within providers' respective regions. According to the coverage and participation rates, and the NSU strategy, no activity should look at health promotion services that target European women where there are no inequalities affecting European women. Similarly, where Māori and Pacific women are not suffering inequalities in any part of the region, the providers' efforts need to shift to where they *are* being affected by inequalities. The evidence suggests that some providers – Māori, Pacific and mainstream – are still either spreading their approach across their entire populations or are targeting Māori and Pacific women, either wholly or partially, but not directing this to very specific geographic areas of inequality.

The aim of the health promotion services should be to reach the:

- hard-to-reach women
- hard-to-find women
- unconvinced women
- uninformed women
- under-screened women
- undecided women.

An example of a positive shift towards the priority groups is one lead provider using the evidence to direct their workforce to *solely* focus on priority population groups of Māori and Pacific women and to cease spreading their resources (human, physical and financial) across the entire eligible population. They have decided to direct their entire focus on addressing inequalities. Another provider has maintained a minor generic focus on the whole eligible population, but the majority of their efforts are on Māori and Pacific women. Another provider has decided to structure their team to have one member focus on improving participation rates by recruiting un-enrolled women into the programme, while other workers focus on maintaining current participants in the programme to sustain coverage.

Currently there may be a focus on Māori, and sometimes Pacific, women, but across the board it is not a targeted inequalities focus in which geographic/demographic areas are targeted and unique, specific and innovative strategies are used in these communities. It appears that health promotion is often targeted at those who already go, or those who would go with some additional support. Not enough health promotion activity works with the hard-to-reach, hard-to-find category of women where the real inequalities exist.

This can be attributed to:

- the general absence of robust needs analysis, including effective use and analysis of NSU data, by *all* providers across the country
- the variable quality of health promotion plans that target needs
- the need for more innovative approaches to reach women where there are inequalities – there have been positive initiatives arising from providers over the years, but providers need to move beyond 'doing what they always do'
- the absence of formal evaluation and the use of documented evidence
- inconsistencies in regional relationships and regional planning approaches
- some workforce development needs in the area of needs analysis, planning and evaluation.

If the number of Māori and Pacific women participating in screening is to achieve the targets of both the BSA and NCSP programmes, then these programmes must ensure the focus of health promotion is on identifying un-enrolled priority women, while the NSU focuses on ensuring all providers:

- ensure women have a positive screening experience, either for a smear or mammogram, so that they return
- maintain an effective and assertive recall and reminder system for all registered women (including PHOs and BSA).

According to the New Zealand Cervical Cancer Audit, any activities implemented by the NCSP should not *increase* disparities between Māori and non-Māori (University of Auckland 2004). The NSU have concentrated on the needs of Māori and Pacific women and a number of providers have had their health promotion plans sent back (identified in the 2004 baseline visits) for not having a specific enough focus on these priority groups. From that initial feedback and focus by the NSU, the 2006 evaluation has identified that some providers have made a number of successful changes; for example, an ISP hired a wahine kaimahi, a BSA lead provider re-oriented its services to focus entirely on inequalities and ceased other generic activity. They also identified specific recruitment and GP liaison roles. BSA South has been successful in using robust needs analysis, data analysis, regional and collective planning, regional relationships and a workforce that represents its target women to achieve successful results in their region.

For Pacific women the majority of providers do nothing specifically for this target group, with only a minority having an identifiable focus. The usual response – or excuse - is 'We don't have a big enough population to do anything specific for Pacific women'. This type of response demonstrates a lack of targeted needs analysis and focus on inequalities by these providers, and a general lack of understanding about who their Pacific populations are, where they live and what Pacific networks they can tap into to help them. It is only through comprehensive needs analysis could this decision be made, and providers should be able to document where these Pacific women are and how they will meet their needs rather than dismissing them altogether.

Overall, the results show that some providers are taking action to really target Māori and Pacific women to reduce inequalities, and that these are the ones who implement the *ideal* elements of health promotion outlined in this report:

- alignment with the health promotion cycle (see 5.1.1)
- appropriate and real regional relationships with other providers, including shared planning approaches
- a focused workforce
- effective use of NSU data and analysis
- effective use of resources
- good documentation for planning, design and evaluation of initiatives and plans
- targeting the hard-to-reach communities and not doing the 'same things they have always done'

Regrettably the other providers – who include both ISPs and mainstream providers – are in the majority and do not undertake these necessary activities. Although these providers are without doubt committed and passionate about improving inequalities for Māori and Pacific women, much of their efforts and activities are anecdotal and there is a lack of evidence to show that they are indeed meeting each of these criteria.

6. WHAKAMUTUNGĀ – CONCLUSIONS

As defined by the NSU, the objectives of the **process evaluation** were to provide information about:

- the range of activities and approaches used by health promoters to reach the target population, including the resources used and developed
- the links and processes that the health promotion teams have established with other relevant service providers (GPs, practice nurses, hospitals and other health promoters)
- any changes the service providers may have made to their activities and approaches over time, why these changes were made, what impact the changes have had and the results of the changes.

The objectives of the **impact evaluation** were to determine the possible effects of the targeted programmes in terms of:

- increasing the target groups' participation in the screening programmes at both the national and local levels
- ascertaining the extent to which the programmes may have contributed to changes in the knowledge, attitudes and behaviour of the target groups.

The findings and analysis from the evaluation led us to the following conclusions in line with the objectives of these evaluations.

Objective 1: Provide information about the range of activities and approaches used by health promoters to reach the target population, including the resources used and developed

We explored each of these areas in terms of the health promotion cycle, as depicted in section 5.1.1, and our conclusions are made in respect of each of the five phases of this cycle and the model underpinning this process.

Model/philosophy

There are only two models used by providers to underpin their health promotion activity:

the Ottawa Charter and Te Pae Mahutonga.

Only one provider has been given approval to use Te Pae Mahutonga as a planning model (this excludes the three formative providers). The remaining providers have used the Ottawa Charter as this is the model that underpins the NSU planning template.

Although the NSU developed a Te Pae Mahutonga framework it has not been widely implemented.

Despite the above, many providers (both mainstream and Māori providers) have shown a strong interest in using a kaupapa Māori model. In the absence of an identified Pacific model, the Pacific providers have accepted the Ottawa Charter as the foundation for their approach.

Providers generally use a combination of population-based and one-on-one approaches:

- *population based health promotion* – involves utilising broad-ranging activities such as radio promotions, events, public meetings, media, advertising/branding on the BSA mobile unit
- *one-on-one health promotion* - which tends to work with an individual woman and perhaps her whānau, or other small groups, to provide the key messages and encourage screening.

For priority women a combination of these two approaches is utilised – *holistic health promotion* – which can combine:

- NCSP and BSA health promotion at events for women, even if delivered by different providers
- NCSP and/or BSA health promotion with other well-woman topics or events, such as contraception, maternity or parenting
- well-woman topics with other family health topics, such as female health and male health issues.

The evaluation indicates that one-on-one holistic health promotion works better for recruiting Māori women to both programmes because it is more effective at informing women and encouraging them to make a decision to proceed with screening.

For Pacific women, a population-based approach works to raise awareness at a broader level, but targeted health promotion is needed in small groups to tailor information for the different ethnic groups.

Pacific women prefer to use written resources in their own languages after receiving oral messages.

Once women are enrolled they can generally be retained in both programmes through a combination of:

- continued awareness from population-based health promotion
- having positive experiences from the screening (mammography or smear)
- a robust recall/reminder system that constantly prompts them to return.

All three factors help to maintain coverage of priority women, but all three must work well to be successful.

A positive experience in both programmes that does not put women off returning is vital. Despite the good work of health promotion and recall systems, a less than positive screening experience is likely to deter a priority-group woman from remaining in the programme, thereby undermining coverage.

Needs assessment

Providers have used a number of sources to identify the needs of eligible women, including:

- NCSP/BSA screening data
- opinions and views from key women
- other data (eg, census or deprivation data)
- anecdotal feedback
- community consultation
- formal needs analysis and evaluations.

The effective use of NCSP and BSA data has been limited by its inconsistent provision and accuracy.

Few providers use formal processes for conducting needs analysis, and the majority use anecdotal evidence that is often not documented.

Some providers are combining their approaches for Māori and Pacific women. However, the evaluation has shown that these two priority groups have different needs and should be treated separately.

The majority of efforts at meeting the needs of Māori are done on the basis of informal and anecdotal feedback from networks and key Māori women in the community. It was difficult to ascertain from the documented evidence whether the same key women were being approached each year or whether the network was being expanded and diversified to incorporate a broader perspective each year. Public consultation with Māori women and their whānau is not widespread.

The evaluation has identified that, for Pacific women, health promotion should recognise the individuality of the seven main Pacific nations, yet there is currently a tendency to treat Pacific women as one population group. Only three providers formally undertake needs assessment to identify the needs of Pacific women as a distinct population group. The majority of providers use the reason – or excuse – that their Pacific population is too small for them to undertake any specific activity.

Effective needs assessment involves a combination of quantitative and qualitative data being used to target the providers' efforts to specific population groups and geographic areas in their regions, and in particular to inequalities that exist in their regions.

Health promotion planning

- As indicated above, providers have on the whole prepared their health promotion plans on the basis of the NSU template and therefore the Ottawa Charter.
- Most plans are developed internally by health promoters and/or their managers.
- Planning that includes external parties, and in particular other NCSP/BSA providers in the region, is not common. A small handful of providers proactively get together each year to undertake regional planning, and follow up by sharing their draft plans with each other before they submit them to the NSU.
- Currently, the annual health promotion plan covers the rationale (basis for health promotion) and activities. The philosophical service model is often not defined and interpreted in terms of how it underpins the approach.
- Future plans would benefit from more reference to the health promotion model and a stronger rationale, supported by the qualitative and quantitative evidence outlined under 'Needs assessment' above.

Consideration should also be given to encouraging providers to develop three-year plans with annual targets, which would assist providers to think more strategically about their needs assessment information and to plan ahead for improving participation and coverage. At present the transaction costs for the NSU and providers appear to be relatively high for the health promotion plans.

Delivery of health promotion activity

The health promotion activities that providers are utilising to reach Māori and Pacific women fall within the three areas of the NSU Health Promotion Framework: community development, communications and health education. Often providers use a combination of all three components, as they all need to be interdependent to be successful.

Community development – providers have used very innovative approaches to access hard–to-reach women. It is evident that hard-to-reach women do not come to health events or presentations that are solely about breast and cervical screening. As a result, providers have used smear parties, ladies nights, fashion shows, photographic exhibitions and sports tournaments as a way to attract priority women who do not generally access their information from routine health promotion approaches. The use of role models or 'champions' has been a successful approach for this group.

Communications – providers use a range of Māori and Pacific media, magazines and newsletters. Communications activity often occurs around an event such as the movements of the BSA mobile unit or a free smear clinic in the area.

Health education – providers use the NCSP and BSA programme resources to provide education, either working in small groups (eg, with a woman and her whānau, or groups of women in settings that have been initiated by the community development approach).

In addition to the above approaches, activities used to further address inequalities include:

- referring to female smear-takers or free/low-cost smear services
- providing transport
- using interpreters
- support to services.

The most effective approaches for Māori women appear to be where role models are used and personal stories are shared. Screening within a Māori setting (eg, at a marae or Māori health provider) is also successful for Māori women.

The most effective approaches for Pacific women are those that are ethnic-specific and allow first languages to be spoken, stories to be shared and a safe atmosphere that allows open discussion.

Evaluation of health promotion programmes

Providers use a wide range of methods to evaluate what they are doing, ranging from informal evaluation, to formal evaluation that is usually activity specific.

Providers generally use feedback forms following specific events, and some have conducted formal evaluations to measure their effectiveness. Over the three-year period of this evaluation there has been a greater emphasis on formally evaluating activity and using the results for planning.

Revision of health promotion plans

When providers develop their annual plan, the majority are relying on the previous year's plan and additional anecdotal evidence, often gathered internally among the health promotion team and management. Sometimes the rationale has not changed from year to year, and it is clear that assessment of needs has not been updated to revisit targets and amend activities accordingly.

There is no common and consistent approach taken by all providers to evaluate activity and link it to future health promotion plans. Once these links between evaluation and planning are established by all providers nationwide, the quality and standard of planning and approaches will be enhanced.

Associated workforce issues

Providers face substantial difficulties recruiting and retaining staff with the right cultural, language and health promotion skills in health promotion services. This problem is further exacerbated by a lack of career pathway for many health promoters to aspire to, associated with a demand across the sector for trained health promoters.

High staff turnover in some providers has led to disruptions to services because of the time it takes to recruit and train new health promoters. Strategies such as placements with other providers can help to establish networks, as well as build competencies.

Induction training for new kaimahi is only offered once a year by the NSU for new workers. There is no follow-up training for kaimahi, and any kaimahi employed in the immediate period after the annual induction training have to wait until the following year’s training to receive the full orientation. Managers and kaimahi have suggested improvements to NSU support for kaimahi that include improved orientation topics such as:

- BSA and NCSP standards
- the health promotion cycle
- the importance of documentation
- the importance of regional relationships
- the use of resources
- cultural issues related to working with Māori and Pacific women (including a reducing inequalities focus).

Two suggestions are for follow-up annual training to include refreshers and feedback on the above topics, and for training in data analysis to be provided – how to use the NSU screening data and conduct self-analysis for planning and monitoring purposes.

Kaimahi have requested more time to share experiences and discuss issues they are facing in all areas of the screening pathway. They also wish to have a greater say about the agenda of the kaimahi hui, and many are advocating for the inclusion of non-Māori staff who work in BSA or the NCSP, and to allow a Māori caucus to convene during the hui if desired.

Providers have supported the organisation and agenda for Pacific Screening Workers Conferences because participation involves representation from all providers working with Pacific women. The inclusiveness of the conference and the focus on the specific needs of Pacific women have received positive feedback.

Objective 2: Provide information about the links and processes that the health promotion teams have established with other relevant service providers (GPs, practice nurses, hospitals and other health promoters)

Regional provider relationships are variable across the country.

In some regions the NSU-contracted ISPs, BSA lead providers and NCSP regional screening services work together very effectively. This includes sharing data and plans, and identifying areas of need within the region. However, there has been no evidence that subcontracted parties to lead providers or NCSP regional services have been involved in any shared discussions, strategising or planning.

In other regions there are other examples of regional relationships, including:

- BSA lead providers and BSA ISPs working together, but without NCSP regional screening service involvement
- NCSP regional screening services working with NCSP ISPs and sometimes with the involvement of local smear-takers
- Māori ISPs working with other Māori health and sometimes Pacific providers, as well as other Māori organisations
- Pacific ISPs working with other Pacific providers.

None of these regional relationships formally include PHOs or general practices, or other smear-takers, in terms of consultation or involvement for the purposes of developing BSA and NCSP health promotion plans.

Ideally the model for successful relationships should include:

- those who need to have direct involvement in developing plans and strategies (BSA leads and subcontractors, NCSP regional screening services and subcontractors, and NCSP and BSA ISPs)
- parties who should be consulted on draft plans and strategies (PHOs and GPs, Māori and Pacific providers in the region, community groups and women).

There is evidence that sometimes the structure of providers may have a positive or negative influence on providers and the effectiveness of health promotion services along the screening pathway. For the purposes of this report the structural models have been categorised into two groups:

- *successful models*: those that support the integration of health promotion with the screening pathway, such as BSA providers that combine health promotion with mammography and the call centre, or NCSP services that subcontract local ISPs and other Māori or Pacific providers for health promotion and/or smear services in order to access women for cervical screening
- *challenging models:* those that impact on the ability to integrate health promotion with the screening pathway, such as regional NCSP services having

difficulties linking with PHOs, or private laboratories subcontracted by BSA services for mammography who have no awareness of, or relationship with, health promotion services covering their community.

The challenge for the future is for all parties involved in the screening pathway to have a greater awareness of each others' role to ensure that maximum benefit is gained from the activities each perform and to reduce the likelihood of gaps occurring in the screening pathway.

Where service integration can be promoted through co-location, this has shown benefits in terms of BSA lead health promoters being able to respond quickly to enrol women where they are located with the call centre. Also, BSA lead health promoters are able to have a greater influence on ensuring radiographers are culturally responsive for Māori and Pacific women. Conversely, for BSA ISPs, the fact that they are not located with the call centre or the radiographers means it is more challenging to take advantage of an opportunity to enrol. It therefore relies on a positive relationship with the BSA lead provider.

For health promotion services within NCSP regional screening services, it is virtually impossible to co-locate with smear-taking services that can enrol women opportunistically. NCSP ISPs that have smear-taking and health promotion services co-located have the advantage of being able to provide a successful screening episode. Their additional benefit is that smear-taking services provided within an ISP are usually more culturally appropriate for Māori and Pacific women because they can be delivered in a suitable setting.

Because GPs have a strong influence on participation and recall, both BSA and NCSP health promotion have identified the need to tap into GPs, primarily through working with PHOs. Some providers have gone to the extent of employing GP liaison roles to perform this function at a local level. All providers would be well supported by the NSU working with the Ministry of Health to influence PHO contracts at a national level that encourage and reward positive relationships between the PHO and BSA/NCSP services.

Objective 3: Provide information about any changes the service providers may have made to their activities and approaches over time, why these changes were made, what impact the changes have had and the results of the changes

We analysed the changes in terms of the health promotion cycle, as depicted in section 5.1.1, and our conclusions are made in respect of each of the five phases of this cycle.

Model/philosophy

At the baseline survey all providers were using the Ottawa Charter. At the time of the final survey one provider was using a kaupapa Māori model – Te Pae Mahutonga.

Throughout the three-year evaluation providers have become adept at tailoring their approach to reach priority women. These approaches may be a combination of population-based health promotion, one-on-one health promotion and holistic health promotion.

For BSA, some health promotion services have demonstrated a growing influence on the cultural responsiveness of mammography services (eg, through providing cultural training). Similarly for NCSP, some health promotion services are providing cultural training to mainstream smear-takers or are supporting Māori and Pacific nurses to become smear-takers.

Needs assessment

There have been no demonstrable changes or improvements in the use of data. A large part of this is due to the inconsistent availability of accurate and user-friendly data. Another reason is the difficulty that some providers have in interpreting and utilising the data.

Despite this, providers are increasing their use of other quantitative data, such as census or deprivation data, as well as qualitative data through feedback from their networks and experiences.

Increased use of providers' own formal evaluations is evident, although not to the extent that would be expected of national programmes.

Health promotion planning

In the last three years providers have increased their focus on priority women and on reducing inequalities, and this has been evident through more specific activity outlined in their health promotion plans.

Although significant and exciting improvement have been made by some providers to investigate and respond to inequalities, regrettably this is not a standard approach across the board. Those providers who have utilised robust qualitative and quantitative information coupled with strong regional relationships appear to have made more gains than others in the area of reducing inequalities.

Similarly, some providers have acknowledged the need to collaborate with other NCSP and/or BSA providers in their region to develop a shared approach to reaching priority women. This has included targeting geographic areas, sharing plans and data, and looking at events and activities they can collaborate on. Again this is not a standard approach across the board.

Delivery of health promotion activity

Since the baseline survey in 2004 there appears to have been a shift in the application of the health promotion framework away from a dominant health education approach. There is now a greater community development focus, which supports long-term behaviour changes and participation in the pathway. This finding aligns with the Health Promotion Framework document, which describes the benefits of community development (NSU 2004c).

By having a stronger community development focus, providers are able to maximise the effectiveness of the other two components of the framework.

The focus on community development has introduced more options for providers to be creative in their efforts to build on their networks, relationships and successes.

Evaluation of health promotion programmes

As mentioned above, providers have increased their use of formal evaluation as a method to improve their service delivery. More providers are now planning for evaluation rather than just planning an event and thinking about evaluation at the end.

Evaluation is not yet built into all providers' planning across the board.

Revision of health promotion plans

This is another area where there are no significant improvements nationwide in terms of it becoming normal practice for providers to link their evaluation activity to future plans. There is still a propensity to use last year's plan and anecdotal evidence to develop the annual health promotion plans.

Objective 4: Determine the possible effects of the targeted programmes in terms of increasing the target groups' participation in the screening programmes at both the national and local levels

We analysed the effects of the targeted programmes in terms of increasing participation in screening programmes, and our conclusions are drawn from both the process and impact evaluations. It should be noted that the impact of targeted programmes on increasing screening rates has not been ascertained through this evaluation by comparing activity with actual screening data. This was to be achieved through a national telephone survey, but was removed from the evaluation methodology to address the NSU's concerns about the lack of a face-to-face approach.

Instead, the findings relate to describing how health promotion services have aimed to address participation and coverage in the context of the screening pathway The conclusions are as follows.

There is often a disconnection between health promotion and the screening pathway. It is clear that, in some areas, even if health promotion does an excellent job this work can be totally negated by a bad screening experience elsewhere in the screening pathway.

Where the pathway is controlled in its entirety by the NSU, as with the BSA programme, the chances of monitoring and enforcing quality and responsiveness are relatively high. The NSU control of the BSA database, appointments, data, recall, health promotion, mammography and audit of the services has a direct impact on the quality of the BSA programme.

Within the NCSP programme, however, the NSU does not have control of all smear-taking services and therefore cannot control the quality of smear-taking or auditing of GPs. Also, the NSU has little control over the quality and level of information provided to women by GPs to ensure that women are prepared appropriately.

The impact evaluation highlighted that GPs have a very strong influence over the majority of women in cervical screening. There is an increasing focus on working with PHOs in relation to un-enrolled, overdue and under-screened women.

The NSU has ensured that breast screening is free for all women within the age range, and this has a direct influence on health promotion services to encourage women to go in for screening. Health promoters cannot similarly promote a free service for smears, and this presents a barrier for both them and the women.

It is more difficult for providers to offer support to services for women to obtain a smear at their local GP, unlike the support they can provide for women attending the BSA mobile unit or fixed site for mammography.

There is a growing trend for providers to have a formal focus on *participation*, including designating roles for GP liaison. Generally, providers have self-defined three functions within the health promotion team: health promotion, GP liaison and recruitment, or a combination of all three.

In terms of *coverage*, health promotion services are more dependent on women having a positive experience elsewhere in the pathway and the programme operating an effective recall system.

This evaluation shows an emerging pattern of health promotion having a greater effect on participation than on coverage, because health promotion providers can influence women enrolling in the programme whereas they have limited influence on retaining women on the programmes, particularly if women have had a bad experience.

There are varying views among health promotion services as to whether their primary role is to raise awareness among women so that they can make an informed choice about screening, or to ensure a screening result regardless of whether a woman is fully informed of her options or not. Effective health promotion recognises that recruitment is an important aspect within a screening programme.

The NSU focuses on measuring health promotion services in terms of screening rates alone, and undervalues the providers' efforts to raise awareness and fully inform women about their choices. This may be resolved by the NSU recognising the three functions of recruitment, health promotion and GP liaison, and measuring performance accordingly.

Objective 5: Determine the possible effects of the targeted programmes in terms of ascertaining the extent to which the programmes may have contributed to changes in the knowledge, attitudes and behaviour of the target groups

The findings of the impact evaluation are limited by the methodology that was adapted to the NSU's requirement to conduct face-to-face focus groups instead of a national telephone survey, as was initially proposed. The findings of the focus groups are not quantifiable to the general population due to the relatively small sample size. The following information provides insight into the motivations of target women, and gives different possible reasons for the knowledge, attitudes and behaviour of the target groups.

In 2004 36% of women knew the age range for BSA but only 9% knew the age range for the NCSP. Some did not even know there was an age range for the NCSP programme. Most women thought the NCSP started at age 20 or when a woman had her first baby, or started on contraception. The majority of eligible women who participated in the 2006 focus groups knew where to go for a smear or mammogram, and this was aided by the recall letters that women receive once they are enrolled.

For both programmes, women rely on their GP providing information about screening, followed by TV promotion and then lead maternity carers for cervical screening, and family and friends for breast screening. In both programmes, health promoters and educators – from BSA/NCSP as well as other Māori and Pacific providers – feature as the fourth-ranked source of information.

Women who participate and enrol in screening have identified the key reasons for doing so.

For both programmes, the primary reason is making a positive lifestyle choice. Much of this can be attributed to effective health promotion informing women to make positive lifestyle choices.

For breast screening, reasons included:

- there is a family history
- being referred by the GP
- encouragement from family and friends
- having a free service.
- For cervical screening reasons included:
- there is a family history
- it was suggested by the GP/Family Planning.

The reasons for women *continuing* to participate are:

- for breast-screening:
- the free service
- the recall/reminder system from BSA
- having a prior positive experience at the mammography
- for cervical screening:
- fear of cancer
- a history of abnormal smears meaning they feel at higher risk
- a recall/reminder system from their GP.

Women identified that they do *not* participate in cervical screening because of the following reasons:

- embarrassment / whakama / shyness
- male doctor doing the smear
- cost of smears – too expensive
- fear of the result (cancer)
- pain and discomfort
- not knowing what to expect.

Women identified that they do *not* participate in breast screening because of the following reasons:

- fear of the unknown / scared of the screen and the result
- cost (outside age range)
- pain and discomfort
- embarrassment / whakama / shyness – usually of body image
- too busy
- better not to know if it is cancer.

Women were asked to provide ideas about how best to encourage non-participating women to attend for screening. For health promotion services, a key recommendation is that more information be disseminated about the stages of cancer development and the importance of early detection. There is a view that many women who fear cancer may not be aware that if they get in early they can be treated. The fear of cancer has led to many women just not wanting to know anything – and preferring *not* to know. However, this could be because they are misinformed about the stages of development of anything potentially cancerous, and the benefits of early detection.

TĀPIRITANGĀ – APPENDIX

The following table outlines the health promotion providers included in the evaluation, and the region in which they provide their services.

Region	**BSA lead providers**	**Independent service providers**	**NCSP regional screening services**
Auckland	BreastScreen Auckland or BSAL. (*Previously BreastScreen Auckland and North or BSAN*)	Health Star Pacific (BSA) Te Ha o te Oranga o Ngati Whatua (BSA) Well Women's Nursing (NCSP) Pasifika Healthcare (NCSP) Te Whanau o Waipareira Trust (NCSP) *Raukura Hauora ki Tamaki (both NCSP and BSA and not included in this evaluation)*	
Northland	*BreastScreen North -- not included in this evaluation (Previously covered by BSAN)*	Te Hauora o te Hiku o te Ika – Hauora Whanui (joint venture – BSA)	Northland DHB
Bay of Plenty	BreastScreen Midland – BSM Waikato DHB)	Poutiri Trust (BSA)	Bay of Plenty DHB
Waikato		Raukura Hauora (NCSP and BSA)	Waikato DHB Raukura Hauora
Hawke's Bay (HB)	BreastScreen Coast to Coast (BSC2C)	Te Whanau Awhina o Waimarama (no longer a provider)	Hawke's Bay DHB

Manawatu/ Wanganui (MW)		Best Care Whakapai (BSA)	MidCentral DHB
Tairawhiti (TI)		Te Aitanga a Hauiti (BSA)	Tairawhiti DHB
Taranaki (TK)		Ruanui Health Centre (BSA)	Taranaki DHB
Wellington and Tasman	Hutt Valley DHB BreastScreen Central (BSC)	*(Mana Wahine both NCSP and BSA and are not included in the process evaluation)*	Hutt Valley DHB Regional Screening Services
Nelson-Marlborough	Breast Screen South (BSSL)	(*He Waka Tapu both NCSP and BSA and are not included in the process evaluation)*	Nelson-Marlborough DHB
Canterbury			Canterbury DHB
West Coast			West Coast DHB
Otago–Southland	Breast Screen Health Care (BSHC)		Public Health South

RĀRANGI WHAKAMĀRAMA - GLOSSARY

Aotearoa	New Zealand
Awhi	to help or support, embrace or foster
Āwhinatanga	to assist or benefit
Fanau	family unit (Samoan)
Fono	a meeting (Samoan)
Hapū	clan, section of a large tribe, secondary tribe
Hauora	health, spirit of life, vigor, fresh and healthy
He Korowai Oranga	Māori Health Strategy developed by the Ministry of Health
Hui	congregate, come together, meet, assembly group
Iwi	bone, Nation, People
Kaimahi	worker, employee, personnel
Kaimahi hui	an assembly of workers, ie: Health promoters
Kaitiaki	caretaker, custodian, guardian, handler, keeper, minder, protector, trustee
Kanohi ki te kanohi	face to face approach
Kapa haka	Māori culture performing group
Kaumātua	adult, respected elder of either male or female gender
Kaupapa Māori	relevance to general Māori foundations, thoughts, beliefs and values
Kawa	ceremony, etiquette,
Kōhanga reo	language nest, a place that fosters the language for young children
Kuia	older woman, mother or grandmother
Kura kaupapa	Māori language immersion school
Mana wahine	women's pride, influence, prestige and authority
Manaakitanga	to show respect and kindness, blessing, hospitality, homage
Māori	Indigenous people of New Zealand
Marae	courtyard, village
Matariki	Pleiades – the first appearance of which before sunrise indicated the beginning of the Māori year, this appears around the middle of June

Māuiui	sickly, wearied
Mirimiri	rub, soothe, smear in, massage
Mohio	to know or understand, recognize, be wise or intelligent, a knowing person
Moko	abbreviation of mokopuna – see below
Mokopuna	grandchild, reference to younger generations
Pānui	advertise, announce, article, a notice
Pasifika	Pacific culture
Rohe	boundary, area
Rūnanga	assembly, council, public meeting house, discuss in an assembly
Tainui	affiliating tribe to the Waikato region of New Zealand
Tairāwhiti	Provincial area – East Coast (North Island)
Taitokerau	Provincial area – Northland (North Island)
Tamariki	children
Taranaki	Provincial area – New Plymouth (North Island)
Tāua	older man or woman, ancestor or grandparent
Tautokotanga	support, supportive nature
Te ao Māori	The Māori world
Te Hui Ahurei	in reference to the Tuhoe Festival
Te Pae Māhutonga	Health promotion model designed by Mason Durie, based on the constellation of stars, The Southern Cross
Te Puni Kōkiri	The Ministry of Māori Development
Te reo	the language
Te Whare Roimata	in reference to a Community Health Day
Te Wheke	Health promotion model designed by Rose Pere, based on the tentacles of an octopus as each being an element of wellbeing
Tikanga Māori	Māori customs, conditions, conventions, culture, elements, ethics, etiquette, formalities and methods
Tuhoe	affiliating tribe to the Urewera, Ruatāhuna and Ruātoki regions of New Zealand (North Island)
Wahine	woman, lady
Waka ama	outrigging canoe paddling

Whakamā	ashamed, shy, bashful, embarrassed
Whakapapa	genealogical family tree
Whānau	family unit, offspring

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