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An impact evaluation: Healthy Messages Calendar (Te Maramataka Korero Hauora).

A thesis presented in partial fulfilment of the
requirements for the degree of
Master of Arts
In
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Abstract

A health promotion intervention the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' was produced by a collection of community groups and provided free to every household in Tairawhiti. The purpose of this study was to conduct impact evaluation to determine if this calendar was an effective health promotion tool for the dissemination of health information and promotion. The researcher was interested in discovering what selected people in the community thought of the calendar, what improvements could be made and how the calendar was of benefit to them. Consistent with impact evaluation, a documentation review was carried out on the Maramataka calendar file held at the Public Health Unit in Gisborne. As well, qualitative data were obtained from five focus groups: four focus groups from selected cohorts in the community and one of stakeholders or key players in the development of the calendar. The data were analysed using a general inductive approach. From this information, an assessment was undertaken to determine if the project objectives were met. In addition, all data collected were used to assess if Maori health needs were met using the whare tapa wha model of Maori health as the assessment tool.

The results highlighted the positive link between health promotion practice and meeting the health promotion needs of a local community. From this study it was determined that the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project was a valuable social marketing tool that fitted into the context of New Zealand society. The focus groups feedback indicated an overwhelming positive community response for the calendar. The local production of the calendar and the use of the children's artwork to promote the messages were identified as being important to the acceptability of the calendar. However, there were areas of improvement identified mostly around the calendar design and funding for the calendar. Greater involvement of Maori at all levels was also identified as a need. Therefore, the information gained from this study provides useful information that not only improves the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project but can also be utilised to plan future health promotion programmes.

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Ethical approval for this study was sought and granted by submitting detailed ethical applications to the Massey University, Albany Campus, Human Ethics Committee (MUAHEC) and the Tairawhiti Regional Ethics Committee.

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Chapter One: Introduction

1.1 Introduction

Community health promotion programmes have the ability to address the broader, non-medical determinants of health (Judd, Frankish & Moultin, 2001). With this in mind there is an increased emphasis on the importance of evidence and knowledge about what works as a basis for the development and implementation of health promotion interventions (Thorogood & Coombes, 2000; Waa, Holibar & Spinola, 2000). The purpose of this study was to determine the impact of a community health promotion intervention: the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' on the people to whom it was given. The calendar was produced by a collection of community groups in Tairawhiti for three years prior to 2005, and provided free to every household in Tairawhiti (17,186 households in total).

Impact evaluation with a strong qualitative approach was chosen to underpin this study in order to provide rich descriptive data whilst allowing an increased sensitivity to the project experience for all those involved. The reason behind this approach lies with the belief that community health promotion programmes work with individuals, groups and communities for change (Waa et al., 2000). The information gained has the potential to provide the evidence and knowledge to enable decisions to be made as to whether to continue with the production of the calendar in the future. The study also provides information as to what processes enabled the development and implementation of this intervention that could possibly be used for future health promotion innovations in the Tairawhiti community. A Maori cultural advisor for the research was sought to guide the cultural safety of the study. The cultural advisor also functioned as group facilitator during the focus group interviews.

This chapter begins with an outline of the researcher's interest in the study followed by the study's significance, aim and research question. The background offers a brief overview of the New Zealand Health Strategy before setting the scene for the health promotion needs of the Tairawhiti community as identified from the socio-demographic statistics for this region. This is followed by the Treaty of Waitangi and the relationship

of the Treaty to health promotion. A brief presentation of the history of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' has also been provided. It was deemed important to consider this history in order to gain a greater understanding of the processes used in the development of this health promotion project. The chapter concludes with an overview of the thesis.

1.2 The Researchers Interest in the Study

My nursing history includes sixteen years as a public health nurse. During this time I experienced many frustrating moments working with families where very little prevention/promotion occurred, not only at a personal or local level, but also at a national level. Empowering people with information enables early identification of health issues. By having the available knowledge individuals and communities are encouraged to change health practices.

My interest in health promotion stems from my recent clinical experience in well child health promotion for public health. As a public health nurse the opportunity to participate in health promotion interventions is far greater than working in other clinical settings. From this experience I have developed a strong belief in a health promoting approach to the health of communities. My interest in the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project evolved from my own involvement in the initial and ongoing development of the calendar.

1.3 Significance of the Study

A commitment to health promotion practice not only means a commitment to good planning, but also to robust evaluation (Hawe, Degeling & Hall, 1995). The significance of this study to nursing is in the increased understanding of health promotion evaluation. Evaluation breaks the division between research and practice by applying research methods to improve the organisation of health care (Ministry of Health (MOH), 2003a). However, nurses are unaware or poorly equipped to carry out evaluation effectively (Beanland, Sneider, LoBiondo-Wood & Haber, 1999). A dearth of information

pertaining to qualitative health promotion evaluation by nurses reinforced the need for nursing research to be undertaken in this area.

The importance of this study is in the evaluation of an intervention that promotes health. Health is a crucial social and personal resource that needs investment. If we invest in ways to promote health, we also bring about benefits for the whole country (Peersman, 2001). However, successful health promotion programmes are not instinctive and not all health promotion programmes are successful in achieving their aims and objectives (Nutbeam & Harris, 2004). Evaluation needs to be incorporated into the processes of any health promotion project at the early developmental stages. Health professionals also have an ethical obligation to evaluate all aspects of their health promotion practices (Ovretveit, 1998). Evaluation is about trying to find out whether what you are doing could be done better while accommodating the complex nature and the long-term impact of the health promotion intervention (Hepworth, 1997; World Health Organisation (WHO), 1998).

An impact evaluation of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' determined the effectiveness of the project while also considering the associated costs. Further, the concept of efficiency and cost effectiveness is central to the development of new initiatives (Molloy & Cribb, 1999; Ovretveit, 1998; Thorogood & Coombes, 2000; Watson & Platt, 2000). In the current economic climate with a limited health dollar and increased public scrutiny, practitioners need evidence from evaluation to support what they do and the amount of money spent doing it.

With ever-increasing health care costs the financial considerations of any project are real issues. For the calendar project these considerations included both direct costs, as in the printing and distribution of the calendar, as well as indirect costs. Indirect costs are often overlooked but include the allocation of resources necessary to implement the programme, for example staff time (Nestor, 2001). It is necessary also to consider opportunity costs, these are the benefits that resources would possibly achieve if used differently (Conner, 1981). Because of the costs associated with the production of the calendar, careful considerations for future calendar productions must be made. If the programme is identified as being valuable, then the money is well spent. Value is considered the foundation of any evaluation process (Guba & Lincoln, 1981). This

evaluation research can assist in determining that value from a community perspective. Therefore, from this evaluation, the information gained can be used to determine if the project met the project objectives.

1.4 Aim of the Study and the Research Question

The aim of this study was to conduct impact evaluation research on the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'. Information sought related to what the community and stakeholders liked and disliked about the calendar, what improvements could be made to further its value to the community and what other health promotion interventions might be useful in meeting the community's health promotion needs. Also, information were sought to ascertain if the project objectives were met and what the relationship of the calendar to the whare tapa wha model of Maori health was. The information gained can be used as a basis for planning future projects. The research question guiding the study asks:

Is the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' an effective health promotion tool for the dissemination of health information and promotion?

1.5 Background

This section begins with an overview of the New Zealand Health Strategy that, according to the Minister of Health Annette King (2000), sets the platform for the Government's action on health, including health promotion in New Zealand.

1.5.1 The New Zealand Health Strategy

The New Zealand Health Strategy identifies the Government's present priority areas to ensure that health services are directed at those areas that will deliver the highest health benefits to the New Zealand population, with particular focus on tackling inequalities in health (King, 2000). What this means for people working in Tairawhiti is that the principles of this Strategy must guide health promoting practice. Even in the most affluent countries people with less wealth experience more illnesses and a shorter life

expectancy than those with greater wealth (Wilkinson & Marmot, 2003). With the gap between the health status of the rich and poor widening, special consideration needs to be given to disadvantaged population groups (Howden-Chapman, 1999; Reid, 1999). Inequalities in health become unfair when avoidable (National Health Committee, 1998; Wilkinson & Marmot, 2003); addressing inequalities improves public health (Oliver & Peersman, 2001).

Addressing inequalities is a major priority that requires an ongoing commitment across all levels of health providers (King, 2000). The strategy identifies that health service providers must work cooperatively towards common goals to improve the health of communities and provide the highest quality care for people who are sick or disabled. This includes collaborative health promotion and disease and injury prevention by all sectors. This inter-sectoral approach focuses on population needs with an emphasis on community and health service user's involvement at every level, and improves coordination across the health sector (King, 2000). An inter-sectoral approach was evident with the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' that saw many organisations working together on a common goal.

Included in the New Zealand Health Strategy is The Primary Health Care Strategy (MOH, 2001b). A strong primary health care system is considered vital to improving the health of the people of New Zealand particularly in tackling inequalities (King, 2000). Primary health care nurses therefore have a huge role to play in this strategy and in health promotion. This move towards a greater population focus and emphasis on a wider range of services requires well-educated primary health care nurses (MOH, 2001b); nurses that are educated in health promotion and health promotion evaluation.

There are thirteen population health objectives proposed by the Ministry of Health to assist in the reduction of existing inequalities. These objectives are:

- Reducing smoking
- Improving nutrition
- Reducing obesity
- Increasing the level of physical activity
- Reducing the rate of suicide and suicide attempts

- Minimising harm caused by alcohol and other drug use
- Reducing the incidence and impact of cancer
- Reducing the incidence and impact of cardiovascular disease
- Reducing the incidence and impact of diabetes
- Improving oral health
- Reducing violence in interpersonal relationships
- Improving the health status of people with severe mental illness
- Ensuring access to appropriate child health services including well child

(King, 2000).

The New Zealand Health Strategy helps guide health promotion practice in New Zealand with the thirteen population health objectives determining the health promotion issues to be addressed. This information helped guide the development of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'. In addition, the fact that Tairawhiti has a relatively high Maori population and poorer health statistics than most of the rest of New Zealand clearly supports the need for health promotion input into this community.

1.5.2 Tairawhiti

Population

In 2001 there were 43,971 people living in the Tairawhiti Health District region (Statistics New Zealand, 2006) with a relatively high Maori population of around 42.4% (Tairawhiti District Health (TDH), 2004). This is three times higher than in the total New Zealand population and is the highest proportion of Maori for a District Health Board. Consistent throughout New Zealand, Maori in Tairawhiti have a younger population structure than non-Maori due to the higher birth rate and lower life expectancy. This population is expected to increase by 6.9% in the next ten years. The region has a small but growing population of Pacific peoples (1.1%) and a relatively large percentage of older people, and people aged 45 years to 65 years compared with New Zealand overall (TDH, 2004).

Health Status

Tairawhiti has a significantly higher overall mortality rate, as well as lower life expectancy when compared with other parts of New Zealand. Those most affected are Maori who have the highest needs of any ethnic group for this region. As well, rural populations tend to have higher health needs and are currently under serviced with low numbers per capita of general practitioners (GP's), nurses, dentists, pharmacists, and Maori Health Providers (TDH, 2004). While the infant mortality rate is similar to other parts of New Zealand, the child hospital admission rates for unintentional injury are higher. Sexual and reproductive issues are of significance with the teenage fertility rates nearly double the national average. Poorer health statistics are evident in all other areas of health with diabetes, cancer, asthma and cardiovascular disease rates showing a higher death and hospital admission rate compared to the rest of New Zealand. In addition, injuries, alcohol and drug problems, and suicide are also higher than the national average (TDH, 2004).

Socio-demographic information

In New Zealand socio-economic inequalities in health have not decreased over the past two decades. People in the lowest socio-economic groups tend to consistently have the poorest health (National Health Committee, 1998; Howden-Chapman, 1999). The case linking socio-economic disadvantage to poorer health is identified in the New Zealand Maori health statistics (Health Funding Authority, 2000; Reid, 1999; TDH, 2004). Overall, the Tairawhiti region depicts a more deprived socioeconomic picture than the rest of New Zealand with lower levels of education, lower average incomes, higher unemployment rates and higher benefit use (TDH, 2004).

The Tairawhiti district is comparatively isolated being situated on the East Coast of the North Island (Appendix 1). People living in Tairawhiti are less likely to own their own home, have a higher number of solo parent households, have more people living in overcrowded conditions and are more likely to have no access to a phone or vehicle compared to the New Zealand average. This deprivation is not evenly spread with some areas showing a combination of marked deprivation, rural isolation, transport and communication difficulties and a relative lack of health services compared to other parts of New Zealand. Within the city itself there are also several areas of marked deprivation (TDH, 2004). The relatively high Maori population of Tairawhiti, the poor health status

of this region and the low social-demographic makeup of this community suggest this population have high health promotion needs.

To improve the overall health of New Zealanders particular attention must be paid to those with the poorest health. The current evidence suggests that those with the poorest health are Maori and Pacific people. For Maori, historical decisions such as the Treaty of Waitangi and subsequent land confiscations have had a significant impact on the present socio-economic status with the resulting poorer health patterns (Howden-Chapman, 1999). Despite the New Zealand Government's committed to fulfilling its obligations as a Treaty partner and the guarantee of equity in the Treaty (Reid, 1999); the profile of the Tairawhiti community identifies that inequalities exist between Maori and Pakeha. An overview of the Treaty of Waitangi and how it relates to health promotion practice is offered next.

1.5.3 Treaty of Waitangi (Te Tiriti o Waitangi)

The Treaty of Watangi is an important part of New Zealand constitution (State Services Commission, 2005); often considered the founding document of this country (Kingi, 2006). Signed on the 6th February 1840, the Treaty is an agreement between the British Crown and representatives of Maori, Iwi and Hapu (State Services Commission, 2005). Essentially the Treaty transferred sovereignty from Maori to the British Crown (Kingi, 2006) in return for a guarantee of the authority of chiefs and the protection of Maori land and resource rights. The intent was to extend the same rights and privileges to Maori as that of the British (State Services Commission, 2005). Both English and Maori versions of the Treaty exist, the text of which differ significantly in meaning and with quite different expectations (Durie, 1998; Health Promotion Forum, 2002). The chiefs who signed this Treaty expected to enter into a partnership with power sharing; however this was not to be the case (State Services Commission, 2005).

One of the main intentions of the Treaty is to protect the well-being of the Tangata Whenua (Maori) of New Zealand (Health Promotion Forum, 2002). As well, Maori claim health is a taonga and therefore entitled to protection under the Treaty (Durie, 1998). Central to the Treaty relationship is an understanding that Maori will have an

important role in implementing health strategies for Maori, and that the Crown and Maori will relate to each other in good faith with mutual respect, cooperation and trust (MOH, 2001a). Therefore, for health promotion to be successful in New Zealand, there needs to be an understanding of the application of the Treaty of Waitangi in health promotion practice (Health Promotion Forum, 2002).

The Health Promotion Forum of New Zealand is a national umbrella organisation funded by the Ministry of Health to provide leadership and support for good health promotion practice consistent with the Treaty of Waitangi and the Ottawa Charter. It became an incorporated society in 1988; two years after the Ottawa Charter became the international guiding principles of health promotion practice (Health Promotion Forum, 2006). The Health Promotion Forum (2002) have utilised the Maori text of te Tiriti o Waitangi to inform the TUHA-NZ document as discussed next. Te Tiriti is considered to be strongly associated with perspectives on health and well being as identified in the three articles of te Tiriti discussed in the TUHA-NZ document (Health Promotion Forum, 2002).

Article One: Kawanatanga – Governance.

Kawanatanga outlines the Crown's obligation and responsibilities to govern and protect Maori interests. It provides for the Crown's right to make laws ensuring adequate provision of services to all New Zealand citizens. This then applies to all agencies that draw their authority from the Crown and includes public health services. What this means for health promotion is that Maori participation at the decision making and management level of health service provision is a high priority. Maori are in the best position to advocate and strategise for Maori health advancement. For Maori health advancement to occur Maori participation needs to be comprehensive, active, consistent, responsive, and encompass a community development approach. There is also a need for rigorous research for Maori by Maori on all areas of public health in order to advance Maori health gains (Health Promotion Forum, 2002).

Article Two: Tino Rangatiratanga - Maori Control and Determination

Tino Rangatiratanga gives to all people of New Zealand, especially those who identify as Maori, full chieftainship over their lands, their villages and all their possessions, including governance over their health. What this means in health promotion is that action for the achievement of Maori health aspirations be determined by Maori. Maori

health aspirations relate to the goals, desired outcomes and vision Maori have for their own health. There is strong support for the development of the Maori health promotion workforce in both mainstream and Maori health environments (Health Promotion Forum, 2002).

Article Three: Oritetanga – Equity.
Oritetanga gives Maori the rights of protection and guarantees legal equity or fairness with other citizens of New Zealand. The implications from this give Maori the right to experience equity in the enjoyment of all the benefits of New Zealand citizenship including health. This provision requires the Crown to protect and reduce disparities between Maori and non-Maori. What this means for people working in the area of health promotion in New Zealand is that there is a priority for action to bring about improvement in outcomes for Maori. There is a need to remove the health disparities that currently exist by addressing the causes of poor health and by considering the underlying determinants of health (Health Promotion Forum, 2002). Programmes that operate at multiple levels are most likely to address the range of determinants of health problems in populations (Nutbeam & Harris, 2004). The history of the Healthy Messages Calendar (Te Maramataka Korero Hauora)' project will now be presented.

1.5.4 History of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'.

The concept for the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project arose from the observations of a Tairawhiti District Health public health nurse Joan Painter (Personal Communication, 11th December 2003). This public health nurse had noticed that many clients with rheumatic fever who received monthly penicillin injections did not have a calendar in their home. This made keeping their monthly appointments difficult and possibly contributed to the high did not arrive (DNA) appointment rates. After some discussion with the well child team it was thought that this could be a barrier to health service access that was a community wide issue; especially with Tairawhiti having a low socio-economic population in comparison to other parts of New Zealand. Low socio-economic groups have less buying power and therefore are less

likely to receive a free commercial calendar from a commercial firm than their wealthier counterparts.

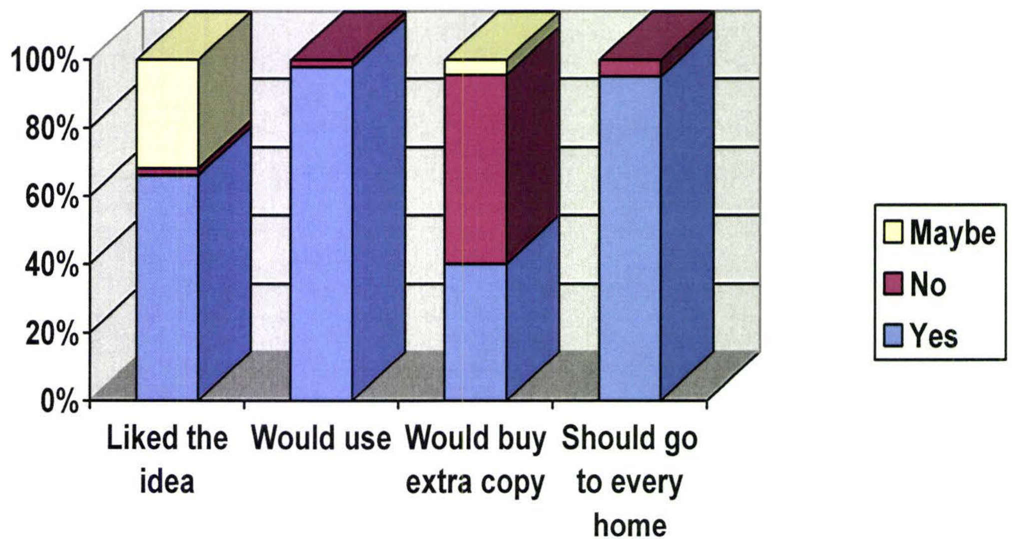
From these observations, members of the Public Health Unit health promotion team, in conjunction with representatives from health related agencies in the community, joined together to produce the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'. The Public Health Unit representatives in particular, wanted to access low socio-economic persons often considered the 'hard to reach'. The 'hard to reach' are known not to access health services either for wellness checks or when illness is in the early stages (Howden-Chapman, 1999). In addition to the health messages, key health contact details and space to write in appointments were also provided by way of this innovative health promotion tool.

A needs assessment was conducted in order to provide a comprehensive picture of what was happening locally. A needs assessment gathers as much information about the target or priority group, not only demographic data, but more subjective perceptions of people themselves (MOH, 2000). The needs assessment revealed that the targeted populations were dispersed throughout the community both in rural and urban areas, including the East Coast. It was also discovered that it was a similar price to produce a calendar for every household in Tairawhiti as it was to produce a lesser number and seek out those who would benefit most from receiving and displaying the calendar in their home. Hence it was decided that this calendar would be provided free to the entire Tairawhiti region, including businesses.

The design of the calendar was based on one similar produced by the Upper-Hutt City Council. The Upper-Hutt City Council was contacted to see if an evaluation had been undertaken. Paul Addison from the Upper-Hutt City Council did indicate that while no formal documentation was available, verbal responses from ratepayers suggested that lower water consumption and higher recycling had occurred (Personal Communication, March 11th, 2000). Mr Addison believed that the calendar they produced was more effective than brochures and leaflets had been in the past.

It was thought that the information in the calendar needed to be provided in a variety of ways to meet the various learning needs of the population. A pre-test was undertaken on the proposed calendar design and health topics prior to the calendar production to ascertain community acceptability. The purpose of this was to determine what the people of Tairawhiti thought of the calendar concept and to assist in the identification of key health messages relative to this community. Key health messages most identified were drug and alcohol, smoking, children's health, healthy eating and injury prevention. Respondents included work colleagues, clients and the general public from off the street. The results indicated 50% of the respondents were Pakeha, 47% Maori and 3% Pacific Island, 70% were female with the remaining 30% male. Age range varied with most 20 years of age and under (Robertson, 2000). The results (provided in the next section) from this pre-test determined the format and contents of the first and subsequent calendars.

Graph 1.1: Key Results from Pre-Test Survey

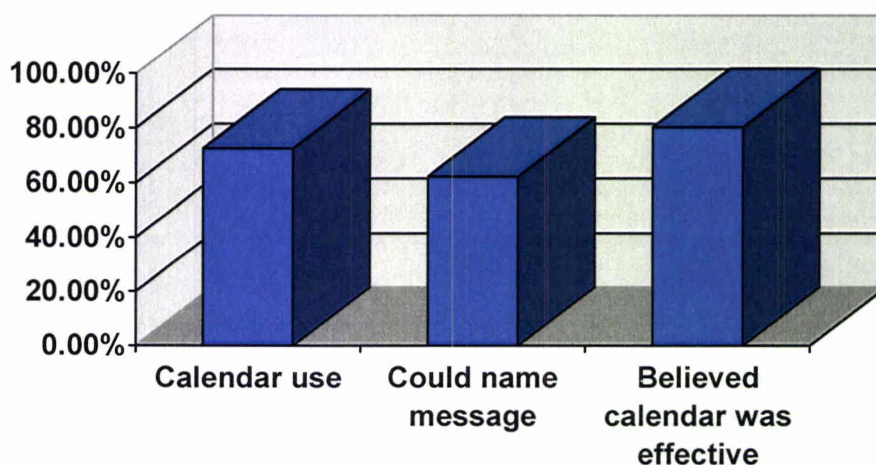


A sample page of the 2004 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' has been included in Appendix 2.

1.5.5 Previous Evaluation Information on the Project

The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project has been evaluated previously, the outline of which will now be presented. The Public Health Unit sponsored a local firm of consultants to undertake a quantitative evaluation. The results indicated a sample of 314 households was contacted to undertake a phone survey. Only 50% of the respondents could recall receiving a calendar but of those 157 respondents 72.6% were using the calendar. The main reasons given for having the calendar in use were "it's a good calendar", "needed calendar", "spare calendar", "good messages on the calendar" and "just put it up" (APR Consultants, 2002).

Graph 1.2: Results - APR Consultants



Another evaluation was undertaken after the first calendar was produced. Drug Free Schools, part sponsors of the 2002 calendar and part of a larger drug free campaign, undertook an evaluation of their entire drug free campaign. Of the 100 contacted in a telephone survey (it took 119 calls to get the 100), 100% of the recipients had put the calendar up and were using it and these 100% indicated they would like another calendar next year.

Substantial anecdotal evidence has also been gathered over the previous two years. The most recent anecdotal evidence obtained from the 2003 calendar indicated an increase in pre-school dental enrolments from children not enrolled with a well child provider. There was also an increase in appointments made for children under 5-years of age with local well child providers. In addition, the feedback from the community has been very positive. The local Public Health Unit has received many calls from people in the community thanking them for the calendar and commenting on how useful it was. Phone calls were also received from people out of the district and from other local agencies wanting a supply of the calendar to distribute to their clients. There was also an increase in the number of organisations wishing to be part of the 2004 calendar (Maramataka Committee, 2003). Public health nurses had also observed the large number of households and businesses who had the calendar up on display in their residences and places of work. With the knowledge that all this information provided there remained a need to increase this knowledge to find out what people in the community thought of the calendar; a need for qualitative in-depth data to determine what the calendar meant to the population to which it was given.

1.6 Overview of the Thesis

Chapter one: This chapter introduced the researcher's interest in this study, the study's significance, and the aim of the study and research question. The background provided information on the New Zealand Health Strategy, the health status of Tairawhiti, the Treaty of Waitangi, and the history of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'. Previous evaluation of the calendar project was also presented in this chapter.

Chapter two: This chapter presents a review of the literature relevant to the study in order to ascertain what information and research is currently available. Literature sought related to health promotion and health promotion evaluation, health education, mass media, social marketing and branding/packaging as well as community development and empowerment.

Chapter three: An outline of theoretical processes that were utilised in this study has been provided. It includes an overview of the method/methodology utilised, the selection of participants and justification for this selection. Ethical and cultural considerations are also explained. A general inductive approach by Thomas (2004) was used to analyse the qualitative data extrapolated from the five focus group interviews.

Chapter four: The key findings from this study are presented in this chapter that begins with a review of the documentation of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project files. This is followed by the results of the demographic data that was collected from each of the four community groups that participated in the focus group interviews. Next the findings from the five focus group interviews are presented under the headings: improvements, messages, health promotion tools, the pictures, sponsorship, keeping it local, community involvement/relationships and what people think of the calendar. Also included in this chapter is an examination to determine if the project achieved the objectives set out in the project plan. This examination extended further to assess the project relationship to the whare tapa wha model of Maori health.

Chapter five: This chapter begins with a discussion around the improvements to the calendar as offered by the focus group participants. The calendar as a health promotion tool via the health messages is discussed next, along with suggestions made from the focus group participants of other potential health promotion activities. From the results it was identified that the ethics of health promotion sponsorship caused debate amongst the stakeholders, and created much discussion within the community focus groups. Keeping it local was another common theme that emerged; this is followed by the significance of community involvement and relationships as they relate to the results. The whare tapa wha model of Maori health assisted in determining the calendars responsiveness to Maori. To complete this chapter the contribution to nursing knowledge, research, and practice has been presented, as have the limitations of the study and recommendations, before finishing with a concluding statement.

1.7 Summary

The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' was produced by a collection of community groups in Tairawhiti, and provided free to every household in Tairawhiti. The purpose of this study was to conduct impact evaluation to determine if this calendar was an effective health promotion tool for the dissemination of health information. The researcher was interested in discovering what selected people in the community thought of the calendar, what improvements could be made and how the calendar was of benefit to them.

This chapter has provided an introduction to the thesis. It began with an outline of the researcher's interest in the study and the study's significance, as well as the aim and research question. The background provided an overview of the New Zealand Health Strategy, Tairawhiti statistical health data and the Treaty of Waitangi. A historical overview of the calendar development, as well as an outline of previous evaluation undertaken on the 'Healthy Messages Calendar (Te Maramataka Korero Hauora) project, was then provided. The chapter is completed with an overview of the thesis. The following chapter presents the findings from the literature review undertaken in order to ascertain current information, relevant research and evaluation research tools.

Chapter Two: Literature Review

2.1 Introduction

A literature review is intended to provide an analytical and critical appraisal of relevant literature, as well as link a proposed study to the context of previous research (Minichiello, Sullivan, Greeenwood & Axford, 1999). It is important to understand what previous research has been undertaken and to determine where the current research fits within a body of knowledge. An extensive search of the literature since 1990 was sought. Qualitative health promotion evaluation is relatively new, therefore any research earlier than this date was considered too old to be of relevance to this study.

Printed material was accessed through the University library, the Public Health Unit library, Ministry of Health and related websites as well as health promotion, commercial marketing and nursing journals. Search engines included EBSCOhost, CINAHL, MEDLINE and Web of Science. Selection criteria for the search included key words and material related to social marketing and health promotion, health promotion media advertising and evaluation research. In addition, literature was also sought on commercial advertising, evaluation and research. To broaden the range of inquiry the search was then extended to include health education, print media, mass media, community development and empowerment as well as the ethics of health promotion and advertising. The development of health promotion evaluation significantly increased in the last two years enabling sufficient published material to be sought.

The characteristics of the literature indicated an apparent abundance of research on health promotion, empowerment and the quantitative evaluation of health promotion programmes. There was however, a dearth of literature relating to the investigation using a qualitative approach of health promotion, social marketing and print media. This dearth of information was also apparent in the absence of nurses having a role to play in health promotion evaluation.

The first section of the literature review explores health promotion and health education. There are a range of activities undertaken by health promotion practitioners (Nutbeam &

Harris, 2004), health education being one of those activities. Other activities relative to this study and included in this literature review, are mass print/media and social marketing. Branding and packaging have also been included as they are relative to the social marketing model of health promotion. An exploration of community development and empowerment, the cornerstone of the health promotion paradigm, completes the literature search.

2.2 Health Promotion

Health promotion is a process of enabling people to increase control over, and improve their health (WHO, 1998). Health promotion is about changing the environment to enable behaviours to change (Health Promotion Forum, 2002; Jones, 1998; Oliver & Peersman, 2001; WHO, 1986). The concept of health promotion has evolved over the later half of the 20th century (Falk Rafael, 1999), and has developed from a mix of positivist (medicine, epidemiology & behavioural psychology) as well as constructivist (community development) disciplines (Watson & Platt, 2000). With strong foundations in public health, health promotion is fundamentally directed towards improving population health (Nutbeam & Harris, 2004). In health promotion, health is viewed as a positive concept that emphasises social and personal resources, as well as physical capabilities (WHO, 1998).

Good health is an active process empowering communities to deal with their own health issues, reinforcing the notion of greater control and self-direction (Moewaka Barnes, 2000; MOH, 2000; Durie, 1993). The implementation of this definition requires that health promotion initiatives should not only be empowering, but also participatory, holistic, inter-sectoral, equitable, sustainable, as well as multi-strategic (WHO, 1998). Health promotion demands co-ordinated action by all concerned including governments, voluntary organisations, local authorities, industry and the media. Combinations of strategies as described next in the Ottawa Charter for health promotion (WHO, 1986), are likely to have the greatest effect.

2.2.1 The Ottawa Charter

Health Promotion Action as directed by the Ottawa Charter on health promotion (WHO, 1986) means:

1. Build Public Health Policy

This puts health on the agenda of policy makers in all sectors at all levels, directing them to be aware of the health consequences of their decisions. Health promotion policy combines diverse but complimentary approaches, including legislation, taxation, financial resource, and organisational change. The aim must be to make the healthier choice the easier choice.

2. Create Supportive Environments

The link between people and their environment is the basis for a socio-ecological approach to health. We need to take care of each other, our communities, and our natural environment. Health promotion generates living and working conditions that are safe, satisfying, stimulating and enjoyable. It includes the protection of our natural resources.

3. Strengthen Community Action

Health promotion is working with communities to achieve health for all. This involves the empowerment of communities, their ownership and control of their own future. Community development utilises the existing human resources in a community to enhance self-help and social support, and strengthen public participation and direction in health matters.

4. Develop personal skills

Health promotion supports personal and social development through the provision of information, education for health and enhancing life skills. By doing this increases the options available to people to exercise more control over and choices for their own health.

5. Reorient Health Services

The prerequisites of health cannot be ensured by the health sector alone (WHO, 1986). The role of the health sector must move beyond providing curative and clinical services, towards health promotion. Individuals and communities need to be supported to enable a healthier life. Channels need to be opened between the health sector and the broader social, political, economic and physical environment that affect health. This can be achieved through health research as well as changes in professional and organisation education and training. There is also a need for an increased focus on the total needs of the individual as a whole person.

There has been considerable debate over the definition, nature and social function of health promotion (Piper & Brown, 1998). The term health promotion is commonly interchanged with health education and disease prevention. A similar conceptualisation of health promotion is also evident by nurses and in nursing literature (Falk Rafael, 1999; Whitehead, 2003a). Health promotion is often used to describe disease prevention or lifestyle change and is more focussed on aspects of local and national structural change. On the other hand, health education is orientated towards the individual and involves some form of health-related learning (Piper & Brown, 1998). Most nurses work within a health education framework (Whitehead, 2003a; Piper & Brown, 1998). Progressive health education and health promotion programmes acknowledge the interface of both approaches as mechanisms for improving health (Whitehead, 2003a). A more detailed examination of health education follows next.

2.3 Health Education Programmes

The origin of health education dates back to the early nineteenth century at the time of the cholera epidemics, when leaflets were produced to inform people on safeguards against this contagious disease (Sidell, 1998). Health education essentially is a form of communication that aims to give people the knowledge and skills to make choices about their health (Jones, 1998). Traditional education activity was behaviourally focused with a medical preventative approach to practice (Whitehead, 2003a). Health education programmes were often about telling people what to do rather than empowering them to make their own decisions (Jones, 1998).

A health promoting approach to education requires an understanding of education and learning techniques in which the recipient is seen as an active education partner. This is supported by the results from an evaluation of a health education programme for osteoporosis run over two and a half years in the United Kingdom (Whitehead, Keast, Montgomery & Hayman, 2004). The processes involved assessment of a preventative osteoporosis service by way of group meetings involving all research participants; made up of senior clinical medical staff and education practitioners from a range of disciplines such as nurses, physiotherapists and occupational therapists. These group meetings were supplemented with unstructured personal reflective diary accounts from each participant. The findings indicated a shift from a medical model of health towards an enabling preventative model. Both clients and staff supported the prevention model and participants felt empowered and motivated by the response to the programme. These results offer a future for health education in nursing in a predominantly medical oriented health service where little funding is provided for such programmes.

The following evaluation of a health education programme examined the influence of health education on mother's treatment seeking behaviours and their children's malarial fever, conducted in Central America (Cropley, 2004). Three types of educational material were used in this programme: a pamphlet, a poster and a malarial post sign. The results indicated that some health education interventions did appear to have a positive impact on fever and malaria beliefs and attitudes on positive treatment seeking behaviours.

Further in support of the benefits of health education the following study examined the difference of health education on the sun smart practices of outdoor workers in Israel (Shani, Rachkovsky, Bahar-Fuchs & Rosenberg, 2000). Using experimental 'objective' tools for data collection the results suggested a significant difference between the groups that indicated the education group were better protected from the sun than their counterparts that did not receive the education. The authors concluded by supporting the use of both health education and engineering (structural), and enforcement approaches for addressing public health problems.

Shani, Ayalon, Abu Hammad and Sikron (2003) suggest that in disadvantaged communities, a multifaceted approach to health promotion is required. This suggestion

arose from a comparative evaluation of a visual one-session health education burn prevention programme on 12 to 13 year-old children in Israel. The results indicated that health beliefs and demographic characteristics were more powerful in predicting the effect of the intervention rather than the medium used.

However, health education programmes used in conjunction with other interventions in an attempt to change behaviour often makes it impossible to separate the effects of the various interventions as this next piece of research shows. Steenhuis et al. (2004) undertook an evaluation of a combined health education and environmental intervention project in Dutch worksite cafeterias in an attempt to evaluate the separate influences. The aim of the programme was to increase fruit and vegetable intake and reduce fat intake by not only increasing the availability of low fat products, fruit, and vegetables in the worksite cafeterias, but also by offering educational information and labelling of the fat content of food. The educational component consisted of brochures, table tents and self-help manuals and posters with an initial focus on increasing awareness that later focused more on increasing self-efficacy and teaching skills. Results indicated a minimal effect as a result of this programme in behaviour change, although the data showed a beneficial effect from the labelling programme on total fat intake.

What the literature suggests is that health education on its own is effective in providing information regarding a health issue. However, as a health promotion approach, health education is more powerful when combined with other activities such as a policy change to have a long-term impact (Shani et al., 2000). In addition, the differentiation between a health education campaign and a media campaign is not always clear. This next section of the literature review examines mass media campaigns.

2.4 Mass media

Media messages are endemic in our society from exposure to television, radio, movies and advertising via newspapers and magazines (Wakefield, Flay, Nichter & Giovino, 2003). Considered a powerful communication agent, mass media can reach a large number of people (Katz & Peberdy, 1998). Media campaigns are now commonly used to influence public knowledge, attitudes and opinions as part of a more comprehensive

strategy that places media campaigns within a wider repertoire of interventions (Brown, Zavestoski, McCormick, Mandelbaum & Luebke, 2001; Nutbeam & Harris, 2004; Wimbush, MacGregor & Fraser, 1998). The appropriateness of mass media as a means to influence behaviour within the new millennium is considered even more relevant given the technological advancement in global communication systems (Whitehead, 2000). It has also been suggested that mass media is often able to reach groups of people who are otherwise difficult to communicate with, for example young males (Katz & Peberdy, 1998). However, the messages need to be conveyed in the language, cultural values and imagery of the intended audience (Bond, Bowden-Proctor, Wallis & Woll, 1997; Robinson, 1992).

Advertising, in particular, works by reminding consumers about the product or service. The service or product may be remembered months or even years after the original advertisement was run (Blythe, 2000). Blythe proposes that four elements are important in the effectiveness of advertising: awareness, liking, interest and enjoyment. The effectiveness of written education materials is determined by the ability of the client to read them (MOH, 2000). In addition to the readability of the target population, is the content and design characteristics to enhance the effectiveness of the information (Griffen, McKenna & Tooth, 2003; Keller & Brown, 2002). For those people unable to read, the advertisement relies on visual communication, the image or picture relating the message. Print advertising especially, contains sought and unsought communications. Sought are those that are actively looked for by consumers, unsought are what the consumer is not looking for at the time but may activate the need for the sought later on (Blythe, 2000).

Substantial debate has occurred in recent years as to whether the media has any effect on viewers at all (Catford 1997). If this is the case then what is the nature of these effects? Due to the complexities and cost of conducting scientific evaluation on this type of health promotion, many programmes have relied on self-reported data to track their effects. The large-scale nature of the intervention makes it difficult to assess in isolation from other societal variables (Keller & Brown, 2002).

Despite the debate, mass media appears to be an especially useful medium for teaching young people about reproductive health. This is particularly apparent if articulated in a

young person's language and terms that won't embarrass them (Keller & Brown, 2002). Mass media is also a useful medium in influencing adolescent's attitude towards alcohol. A study that investigated the impact of alcohol advertising on teenagers was undertaken in Ireland (Dring & Hope, 2001). The findings strongly suggested that alcohol advertising had a strong attraction for Irish adolescents as it portrayed lifestyles and images that were part of their social setting. Because of this, alcohol advertising promotes and reinforces the use of activities that this age group aspired to engage in and enjoy.

Mass media also appears to be effective in influencing smoking behaviour. Wakefield et al. (2003) conducted a review of empirical studies on cigarette advertising and promotion in movies, on television, the music media and news coverage. The authors concluded that media does shape and reflect societal values about smoking by providing observational learning from models that teenagers emulate. The findings from this review suggest media messages about smoking do provide direct reinforcement for smoking or not smoking. What this identifies is that media messages to improve health should be equally as effective as those that promote unhealthy behaviour.

This is also supported by health communication research that indicates messages targeted to specific populations are more effective in promoting human immunodeficiency virus (HIV) risk awareness. As part of a five-year study funded by the Centre for Disease Control and Prevention, the Philadelphia Health Management Corp developed its own HIV prevention pamphlets specially targeting women living in a Philadelphia community (Bond et al., 1997). One major strategy was to create special print materials called role model stories to communicate the information. The evaluation was still underway at the time this thesis was printed but early findings suggest the level of exposure to the stories was quite high with 45.5% of targeted women indicating they had seen the role model stories. Bond et al. (1997) suggests though that the study did not evaluate behaviour change.

Behaviour change is dependent on multiple complex interrelated factors. It is awareness that is created before the change of behaviour occurs (Sidell, 1998). A change in knowledge and attitude does not mean behaviour will change (Peberdy, 1998). The success of a campaign is therefore dependent on the campaign objective or what it sets

out to achieve. Behaviour change was evaluated in the following evaluation of a national mass media walking campaign in Scotland involving 40 television advertisements and a telephone help line (Wimbush et al., 1998). The campaign impact was assessed in terms of awareness of the campaign, pre and post campaign knowledge and beliefs about walking as a good form of exercise. The findings showed that at a population level, the campaign had a positive impact on knowledge about walking as a form of exercise but it had no impact on walking behaviour, thereby challenging the use of the media on its own as a behaviour change strategy.

Media campaigns included as part of a multiple health promotion strategy are shown to be effective (Friel, Hope, Kelleher, Comer & Sadlier, 2002; Smith, Ferguson, McKenzie, Bauman & Vita 2002; Svanstrom, Welander, Ekman & Schelp, 2002). Svanstrom et al. (2002) evaluated a mass media campaign that made considerable progress in reducing bicycle related injuries in Sweden over two decades. At an operational level, all methods of data sources were utilised in the programme and included surveillance of injuries, provision of information and advice, training and supervision, as well as product improvement and legislation. At a sustained level of input, these multiple strategies were considered effective in this health promotion project.

Further in support of combined mass media and health educational strategies was a pilot oral health programme that was developed in Ireland aimed at improving dental health and knowledge amongst school children aged 7 to 12 years (Friel et al., 2002). The programme comprised of a television campaign that ran for a 6-week period concurrently with a dental nurse delivering an interactive talk with pupils. Impact evaluation was undertaken to assess the school pupil's dental health knowledge and reported behaviour using an experimental control pre and post design. Results indicated an increase in the dental health knowledge and improved dental health behaviours of school children after the intervention.

Conversely, not all health education campaigns are effective neither in changing behaviour, nor in increasing awareness as suggested by the following study. A randomised-controlled trial to assess the effectiveness of health education leaflets in reducing sunburn was undertaken in England (Dey, Collins, Will & Woodman, 1997). The study population consisted of holidaymakers travelling by air from North America

and Jamaica to Manchester Airport in 1993. Before boarding, health education leaflets related to sun safety were placed in the seat pockets on the return flights of passengers exposed to sunburn in the intervention group but not in the seats of the control group. Passengers, who had not yet departed and therefore not exposed to sunburn, also completed the questionnaires. There was no significant difference between the three trial group responses.

Further, the impact of the media might have a limiting affect according to Brown et al. (2001). A research project that examined the role of print media in disputes over the environmental causes of breast cancer was undertaken as part of a larger project that examined contested illnesses. The authors defined contested illness as those that involve scientific dispute and public debate over the environmental causes of breast cancer, Gulf War-related illnesses and asthma. General media sources included both specialised scientific periodicals and non-scientific articles such as women's magazines and other non-specialised news publications. What was looked for was the frequency of the reporting of the environmental causation of breast cancer, how it was reported and headlines for reporting, the scientific context of the articles and the images that accompanied the articles. The study revealed there was very little coverage of breast cancer in the media. Of that coverage, the reporting of the environmental causation of breast cancer was both minimal and limiting. The authors concluded the media has a significant positive or negative communicating influence over public understanding and social action.

In addition, contradictions in health media messages were evident from the following study undertaken in Australia by Hesketh, Waters, Green, Salmon and Williams (2005). The study aimed to elicit child and parent views regarding social and environmental barriers to healthy eating, physical activity and child obesity prevention programmes. The findings indicated that children and parents were generally well informed about the health value of different foods and could identify what was healthy and unhealthy. Parents believed their children knew which foods were healthy but suspected they did not fully understand the consequences of eating unhealthy foods. However, contradictions in messages children received were reported to be a barrier to a healthy lifestyle. These contradictions across population prevention programmes for obesity need

to be prevented and consistency in communication in prevention programmes need to be ensured.

To improve the effectiveness of health promotion campaigns, more health promoters are turning to commercial marketing strategies. Social marketing has a systematic planning process similar to health education (Neiger, Thackery, Barnes & McKenzie, 2003). The next section of the literature review examines the health promotion theory identified in this study as the social marketing model, using the strategies of commercial marketing with the principles of health promotion.

2.5 The Social Marketing Model

What separates social marketing from media campaigns is its multi-phased, systematic planning process involving the assurances of market analysis, attention to the marketing mix, exchange positioning and pre-testing (Neiger et al., 2003). Social marketing evolved as a health promotion technique in the 1970's (Neiger et al., 2003; Nutbeam & Harris, 2004). While social marketing is flourishing it appears there is confusion as to what it is, what it does, and how it should be applied to health promotion.

Social marketing is a social change tool that can influence attitudes and behaviours on social and personal issues by promoting desirable attitudes and by encouraging positive behaviour change (Health Sponsorship Council, 2001; Lefebvre, 1997; Nutbeam & Harris (2004). Social marketing acknowledges the unique characteristics of the population to be served, as well as the inherent opportunities and challenges, assessment of capacity and the identification of preliminary areas of focus (Neiger et al., 2003; Nutbeam & Harris, 2004). Market research and evaluation is used to assist and improve marketing decisions (Hague & Jackson, 1999). Social marketing campaigns succeed by appealing to the fundamental values, attitudes, and motivations of the target audience (Nutbeam & Harris, 2004).

As with marketing strategies that are multi-factorial, social marketing is generally based on a mix of four major inputs commonly referred to as the four P's: the Product, the Price, the Promotion and the Placement. The product is the vehicle by which the

messages are delivered to the community. The price signifies the relationship between the costs and benefits of the product. The promotion includes the wide range of techniques used for the message delivery. The placement, the final step to success, is in finding the high access points for the priority population (Nutbeam & Harris, 2004).

Traditionally marketing has been linked to the concepts of profitability. However, social marketing is non-profit marketing with the skilful use of the media and promotion of the product (Hague & Jackson, 1999; Zimmerman, 2003). The benefits are to the community as opposed to the marketer (Nutbeam & Harris, 2004). The motive is not financial, the moral base completely different, and the marketing techniques more complex. Nutbeam and Harris (2004) stress it would be a mistake to imagine social marketing simply involves the utilisation of marketing strategies from the commercial sector and applying them to achieve health goals.

A social marketing model was utilised to offer a health promotion intervention to general practitioners in the United Kingdom (Lock, Eileen & Kaner, 2000). The 'Drink Less' intervention programme was designed for use by general practitioners with help from practice receptionists to opportunistically identify and briefly intervene for excessive drinking in primary health care. The promotional strategies used to facilitate the dissemination of the programme involved postal marketing, telemarketing and personal marketing. The study took place in general practices across the Northern and Yorkshire Regional Health Authority. Of the practices eligible, 52% took the programme, 41% considered doing so, and 23% went on to use it. Analysis of the three promotional strategies indicted the personal marketing strategy was the most effective. However, telemarketing was more cost effective. Findings indicated the marketing approach was positive in not only promoting the benefits of the programme, but also in encouraging uptake.

Further support for social marketing comes from a 12 month marketing campaign that was run to promote active transport for a selected cohort of health service employees working in a health care facility in Sydney Australia (Wen, Orr, Bindon & Rissel, 2005). An evaluation of the campaign indicated a reduction in the proportion of participants who drove to work 5 days per week and a decrease in trips travelled by car on weekends. In addition, there was a high awareness of the intervention amongst participants and an

increase in their understanding of the concept of active transport. The results suggest social marketing was effective in changing the behaviour of the target audience.

Some interesting results were found from an investigation to ascertain the extent and nature of food advertising during Australian children's television viewing hours (Neville, Thomas & Bauman, 2005). The purpose of the study was to determine whether confectionary and fast food restaurant advertisements were more likely to be broadcast during this time than adult viewing times. Data were purchased from an international market research company that detailed all television advertisements broadcast during children's television viewing hours. Confectionary advertisements were three times more likely and fast food advertisements twice more likely to be broadcast during children's programmes than adult's programme. It was concluded that foods most advertised during children's viewing hours are not those foods that contribute to a healthy diet. What this study identifies is the negative influence of commercial marketing on health. Social marketing strives, using similar practices, to have a positive influence on health and health practices. However, health promoters have been criticised for using techniques of persuasion in an attempt to improve health, suggesting these techniques are in conflict with the values associated with health promotion (Jones & Cribb, 1998).

It is argued that marketers often intentionally use inappropriate manipulative techniques in fear appeals when communicating with their target audience (Duke, Pickett & Carlson, 1993). Fear appeal is when a negative consequence from a given behaviour may cause fear. This fear or threat motivates audience action (Duke et al., 1993). The appropriateness of using fear tactics when delivering health messages could be considered a concern if intended to elicit negative and/or unhealthy responses in consumers. The intended outcome of the advertising is to change behaviour so that societal and personal benefits far outweigh the detriments of increased anxiety. High fear appeal advertisements are most likely to be acceptable when most stakeholders' benefit from the actions promoted in the advertisement, for example seat belt use (Duke et al., 1993).

Whether having a positive or negative influence on health, advertising in social marketing, relies on the strategies of commercial marketing. As with commercial

marketing strategies, the branding and packaging of a social marketing product is important to the products acceptability.

2.6 Branding/ Packaging

Branding is an accumulation of a range of activities across a whole marketing mix that leads to a brand image (Blythe, 2000; Howard, Kerin, & Gengler, 2000). Branding allows a product to be easily recognisable and conveys a set of messages to the consumer (de Chernatony, 2001). Branding is a sign of ownership and differentiates the product from other similar products, acting as a functional device conveying an image of quality and expected performance (Blythe, 2000). It is a symbolic and strategic device that maintains and builds on added value and therefore the product remains distinctive (Blythe, 2000; de Chernatony, 2001; Kelly, Slater & Karan, 2002).

The main purpose of packaging is to inform consumers. The colour is also important, for example, the colour purple formally associated with royalty now confers an upmarket image (Blythe, 2000). Labelling is used to denote the information printed on the packaging and is an important part of the marketing communication. It helps the consumer identify the product and the products content. When evaluating the packaging there is the need to determine if the product stands out (Blythe, 2000).

To illustrate the power of brand image, a study by Kelly et al. (2002) was undertaken using an experimental design. The purpose of the study involved viewing either image or tombstone (without image) advertising to ascertain the attitude towards an advertisement, its brand and the visual image content in advertisements on the perceptions of the desirability of beer, cigarettes and soft drinks in adolescents. Results indicated that image-oriented visuals were found to directly produce a more positive attitude towards advertising, branding and attitude towards the product category, than advertising with no photographs or drawings. The authors concluded that the image content of advertisements do influence the desirability of cigarettes and alcohol in adolescents.

Further in support of the power of branding was a field experiment undertaken to determine how brand source confusion varies as a function of confusingly similar brand

names and consumer's degree of care when they examine brands (Howard et al., 2000). Three identical pre-tests were conducted on the brand name for drain cleaner and car wax. Results indicated that brand name similarity has a significant influence on judgements of common brand origin, but the information used to make that judgement differs by the level of involvement. Under high involvement conditions, consumers made inferences on the basis of shared meaning between brand names. Under low involvement brand names that sounded similar were most likely to result in common source inferences. The use of identical labels had a strong effect on brand confusion. However, brand name has special importance to consumers when they make judgments regarding the origin of the goods.

As identified from the previous two studies, branding and packaging greatly influences the results in a social marketing programme. Important in commercial marketing, branding and packaging holds the same importance in the promotion of health through social marketing strategies. This importance is noticeable when competing with commercial advertisements that promote cigarettes or alcohol consumption. The next section of the literature review examines community development and empowerment, often considered the cornerstone of the health promotion paradigm. Community development and the empowerment of individuals and families were identified as key elements of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project.

2.7 Community Development

Effective health promotion strategies are best developed by engaging, not only individuals but also communities, in the issues to be addressed (Nutbeam & Harris, 2004). This aligns with strengthening community action. Strengthening community action is about the empowerment of communities, their ownership and control of their own future (WHO, 1986). Community development utilises the existing human resources in a community to enhance self-help and social support, and strengthen public participation and direction in health matters (Nutbeam & Harris, 2004). Lindsey, Stajduhar and McGuiness (2001) identify four components of community development that include citizen action, voluntary participation, co-operation and collaborative problem solving, empowerment and the focus on holistic community-wide outcomes.

Understanding communities, community structures, social systems and the different organisational settings in which people live their every day lives and how these systems can be mobilised for health is considered essential (Nutbeam & Harris, 2004). By mobilising communities there is potential for an increased emphasis on tackling the determinants of health.

Valid endpoints for community development projects might include non-health-related outcomes such as sense of community, community empowerment and community competencies that impact on social, cultural, economic, environmental and the political determinants of health (Watson & Platt, 2000). The following study illustrates a community- wide environmental regeneration programme and the impact on people with a mental illness.

An in-depth qualitative study was undertaken in London to investigate the impact an urban regeneration programme had on the everyday functioning, coping and recovery for people with mental illness (Whitely & Prince, 2005). This regeneration programme included housing repairs, renovation of a community centre and library, a new sports centre, public landscaping, and public security. What this evaluation showed was that interventions that improved community safety were by far the most important in affecting everyday coping and functioning and that the interventions that improved the quantity and quality of shared community facilities had a positive but milder effect on mental health.

Community action to improve public safety is again illustrated in this next study that alludes to co-operation within a community to achieve a common goal. An evaluation of a regional community action intervention in New Zealand to reduce access to alcohol from off-license premises by minors was undertaken by Huckle, Conway, Casswell and Pledger (2005). The initiative was established to encourage inter-sectoral collaboration and cooperation in reducing alcohol related harm focussing on monitoring alcohol sales made without age identification from off-licenses. Data were obtained before and after intervention. Media items were monitored and included pre and post intervention phases. Interviews with key enforcement staff and a documentation review was also undertaken post intervention. Purchase survey data indicated a significant decrease in sales of alcohol made to young people without age identification both pre and post intervention.

This study is an example of how a community worked together to overcome a community-wide health issue.

Further in support of the effectiveness of the community working together on community driven strategies, a pilot community injury prevention project based on the WHO Safe Community Model, was established in selected small communities in New Zealand (Simpson, Morrison, Langley & Memon, 2003). The project was monitored for three years and externally evaluated using process and impact evaluation. Results suggest it was unlikely the project had any impact on the community rate of injury. There was however an increase in awareness within sectors of the community who in turn could influence known injury risks. The authors concluded projects such as this need to be within the community's capacity to effect change as is also illustrated in this next example.

Communities can unite to address local issues as identified in this community driven response that was initiated by concerned residents in a popular beach and holiday resort in New Zealand (Conway, 2002). Following an escalation of alcohol related incidents in this community; a coalition was formed involving community and statutory stakeholders to successfully implement a local communication strategy. A case study was undertaken using document analysis, key informant interviews, a small survey and participant observation to evaluate the intervention comprised of alcohol bans, traffic checkpoints, publicity using local radio and print media: posters and flyers. The results indicated that inter-sectoral collaboration and multiple level strategies through policy, promotion and enforcement activities that enabled this community to successfully reduce alcohol related harm. This community driven project indicates effective community development by not only identifying the issue, but also finding and implementing the solution.

Community development has huge potential for Maori as suggested in the following evaluation by Masters (2000). A formative evaluation was undertaken of the 'Hapai Te Ora' project in Tairawhiti. With a strong community development focus, this project targeted health gains for Maori by encouraging the adoption of healthy lifestyles with the use of ancient and modern water sports for whanau and communities. The evaluation indicated that while recognising the programme was still in its developmental stage, the

future for community involvement, community development and the sense of ownership was positive for Maori.

The principles that are effective in health gains for Maori through community development also have the potential to effect change within schools as shown with this example of a school food programme offered by the Heart Foundation of New Zealand (Carter & Swinburn, 1999). The programme aimed to improve the health of the school community by increasing children's access to foods that are nutritious, safe and sufficient in quantity. An outcome evaluation undertaken concluded the programme had a positive impact in influencing healthier school environments by improving healthier food choices.

This was also supported in an evaluation of a school-based programme that was piloted to prevent obesity in children in the United Kingdom (Warren, Henry, Lightowler, Bradshaw & Perwaiz, 2003). The programme was comprised of three trial groups consisting of a nutrition curriculum, physical activity and a group that received both the nutrition and the physical activity curriculum. Children's growth, nutrition knowledge, diet and physical activity were assessed at baseline and at the end of the intervention. Significant improvements in nutrition knowledge were seen in all children and especially in the nutrition and combined nutrition and physical activity group, and indicated that the school setting may be suitable for the promotion of healthy lifestyles in children.

What these studies suggest is the powerful potential of an inter-sectoral approach to health promotion and the health of communities. However, the level of financial resources is not always available to match the needs of disadvantaged communities. This is especially so when these disadvantaged communities are fundamentally different from privileged communities. The financial and social support within these communities is often greatly limited (Boyce, 2002).

In addition to the financial and social support within community development there is a gap in evidence as to what constitutes success in a community development programme (Germann & Wilson, 2004). Germann and Wilson (2004) identified that this challenge exists in an evaluation designed to explicate key elements that contribute to organisational capacity for community development. The authors suggest the long-term

nature of a community development programme is not amenable to traditional measures of evaluation. Qualitative data that measures the success and nurturing of capacity building needs to be acceptable to the decision-makers. Defining the measures also need to be agreed upon by all members of the community development team. In addition, confusion exits as to what community development means and that it is often confused with community-based planning. In community-based planning it is the health organisation that often identifies the issues to be addressed.

Other authors who have studied community development approaches also reiterate the confusion over what the findings mean; the term community development suggests different things to different people (Ritchie, Parry, Gnich & Platt, 2004; Robinson & Elliott; 1999). To illustrate this confusion community development has been linked to terminology such as community-based initiatives, community mobilisation, community capacity building, and citizen partnership (Ritchie et al., 2004). This is exemplified in the following qualitative study that evaluated an initiative aimed at producing a shift in community norms towards the non-toleration and non-practice of smoking in a low-income area in Scotland. Findings indicated a disjunction between the respondent's conceptions of the programme as a community development programme and the translation of the programme into practice. Partnership representations were unequal and that left some community agencies feeling disempowered. The perceived low level of input from the community members as well as the lack of consensus as to what constituted a community raised a question mark over whether smoking was a priority for this particular community. The authors concluded that it is crucial community organisations and agencies feel they have ownership of a programme. It was also identified that participating groups need to be on board with the programme at an early stage in the programme development (Ritchie et al., 2004).

Partnerships can positively influence a community's health status but in order to be effective they require the sharing of power, effective planning and long-term planning from both the government and the local community (Boyce, 2002; Germann & Wilson, 2004; Heenan, 2004). A case study of a partnership approach to health promotion in Northern Ireland suggested long-term vision is required to prevent a haphazard way of working. It was also identified that staff needed training in the community development approach and need to be supported by senior management. Many of the difficulties

encountered related to different expectations for the different groups who had formed this partnership. Interestingly, the statutory body claimed they had actively promoted user involvement, while the community groups suggested that most of the power and control had remained with this statutory body. This resulted in tensions within the partnership. The authors concluded that local communities could be empowered by a community-based health promotion project if the difficulties identified are addressed. Community development is based on the concept of empowerment, the empowerment of communities. The final section of the literature review will examine empowerment.

2.8 Empowerment

One of the cornerstones of the health promotion paradigm is the concept of empowerment (WHO, 1986). Empowering communities involves community ownership and control over their priorities as well as participation in policy, planning, implementation and promotion (Public Health Commission, 1995). Empowerment facilitates the building and strengthening of communities to increase that community's potential to act as a resource for health. Included in the empowerment partnership are multidisciplinary collaboration, capacity building, equity and sustainable development (Judd et al., 2001).

On an individual level, empowerment enables people to increase control over and to improve their health (Peersman, 2001; Sidell, Jones, Katz & Peberdy, 1997). Empowerment claims to attribute responsibility to people for finding a solution to a problem (Oliver & Peersman, 2001; Sidell, 1998). Empowerment is an approach used to optimise the impact of health promotion (Watson & Platt, 2000). Tones (1997) suggests that ethically and practically the main goal of educational endeavours should be empowerment. On a more personal level, self-empowerment can be achieved by promoting informed choice (Pearman, 2002; Tones, 1993). Self-empowerment is illustrated in an evaluation of a health promotion resource designed to encourage empowerment in children undergoing chemotherapy introduced in an English hospital (Pearman, 2002). The health promotion resource involved was a storybook developed to assist children cope with chemotherapy-induced nausea and vomiting. The storybook was designed to encourage children undergoing chemotherapy to use distraction

techniques to enable them to gain control over their nausea and vomiting. A questionnaire was randomly distributed to nine members of a multidisciplinary team working on the bone marrow transplant ward. The storybook was considered an effective health promotion resource, as indicated by the seven replies received. The study also identified the need for the parents of these children to also be involved in the evaluation in establishing the effectiveness of this resource. This study supports Tones (1997) suggestion that the empowering function extends to the utilisation of health services by helping patients interact with practitioners.

The review of the literature supports the findings from Pearman's (2002) study that promotes empowerment to enable positive health practices. The outcomes of a further four studies, most of which related to improving nutrition and physical activity substantiates the positive influence of empowerment. An online weight loss programme was evaluated using a short-term qualitative evaluation that examined participant recruitment, website usage, satisfaction and self-reported health risk appraisal records (McCoy, Couch, Duncan & Lynch, 2005). This 10-week interactive programme enabled participants to voluntarily complete an online health risk appraisal and develop diets and exercise plans to suit their personal needs and goals, as well as guide them on the maintenance of lifestyle behavioural change. Results indicated a high level of satisfaction from participants with 56% agreeing the programme helped them achieve their goals. The authors concluded from these preliminary findings that the Internet delivery for a weight loss programme for diabetes has the capacity to raise the public's awareness of health, wellness and illness prevention, as well as motivate participants to act on their awareness.

A further example of empowerment at the individual level is the Pick the Tick programme of the National Heart Foundation in New Zealand. It provides a framework for co-operation with the food industry to improve nutrition labelling and to develop a healthy food supply (Young & Swinburn, 2002). The impact of this was evaluated by outcome measures. Results indicated the Pick the Tick programme effectively reduced the salt content of commonly consumed foods by influencing the food industry to reformulate existing or new food products. This was achieved by signposting to consumers an increasing range of foods with reduced salt content without affecting

product taste or quality. The outcome for this project was empowerment at an individual level, empowerment to make the right choice the healthy choice.

To further support the concept of empowerment the following study examines capacity building (Smith, Coveney, Carter, Jolley & Laris, 2004). Capacity building is included as a component of empowerment (Judd et al., 2001). A capacity building programme, the 'Eat Well SA' project, aimed to increase consumption of healthy food by children, young people and their families was developed in South Australia (Smith et al., 2004). Methods used to create this awareness included a campaign promoting fruits and vegetables, dissemination of pamphlets and newsletters, a conference, a cookbook, a literature review and a research study. Coalitions with agencies from health, education and community groups were formed to develop and implement the programme. Results demonstrated that the 'Eat Well SA' project developed a useful model for undertaking sustainable, collaborative work, to promote healthy eating that can also be used by other providers to address nutritional issues.

An increased awareness about the capacity building effects of health promotion projects provides clarity about outcomes, planning and evaluation methods (Salmon et al., 2005). In support of this Salmon et al. (2005) undertook a randomised-controlled trial to evaluate a 'Switch Play' programme developed to prevent unhealthy weight gain among 10-year-old children. The children participated in lessons that focussed on mastery of six skills: run, throw, dodge, strike, vertical jump and kick. The results indicated that most aspects of the interventions were successfully delivered to the majority of children participating in the 'Switch Play' programme (Salmon et al., 2005).

2.9 Summary

The literature reviewed for this study focussed on the evaluation of health promotion interventions. The salient points relating to health promotion and health education were presented. This was followed by an exploration of mass media. The literature suggests a debate exists as to how effective advertising and the media is in improving health. However, research did indicate that this form of communication could be effective if used correctly. Social marketing was also examined. Based on commercial marketing

strategies, social marketing has the potential to influence health. Branding and packaging was then explored to support the social marketing model of health promotion. Considered important in the commercial world, branding and packaging helps the consumer to identify the 'product'.

According to the literature, community development empowers communities to identify their own health needs and to determine possible solutions to overcome the issues. Community development is the empowerment of communities. From this it was determined empowerment strengthens a community resource to enhance the health of its community and the people within. It became apparent during the literature search that many of the terms used in health promotion were interchangeable; for example capacity building and empowerment. Mass media and health education was also difficult to separate in some of the literature. This is consistent with confusion relating to health promotion as suggested by Sidell et al. (1997). As mentioned in the introduction, there was a dearth of literature relating to the use of qualitative methodologies to evaluate health promotion programmes. This dearth of literature was extended to include the noticeable absence of nurse involvement in health promotion and health promotion evaluation. The following chapter presents a detailed account of the research processes used in this study. The rationale for the research processes is also presented.

Chapter Three: Theoretical framework

3.1 Introduction

The previous chapter explored the literature on recent health promotion research and evaluation. This chapter presents the theoretical framework utilised to answer the question under investigation: is the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' an effective health promotion tool for the dissemination of health information and promotion? The chapter begins with a description of the methodologies and methods used for this evaluation. This is then followed by the specific details of the processes undertaken to answer the question, including the ethical and cultural considerations of the study. The data analysis made use of a general inductive approach, as offered by Thomas (2004), and provided the framework for the coding and sorting of data. To conclude this chapter the rigorousness of the study is discussed.

3.2 Method/Methodology

The data collection method chosen for answering a question should be made after considering the resources available, as well the existing knowledge in the area of interest (Minichiello et al., (1999). The methodology refers to the theoretical assumptions that underlie the decisions made when choosing the method to answer the question or generate knowledge (Roberts & Taylor, 2002). The paradigm of health promotion research is based on information, methodologies and research models originating from several different scientific disciplines that contribute to health promotion knowledge (Lahtinen, Koskinen-Ollonqvist, Rouvinen-Wilenius, Tuominen & Mittelmark, 2005; Oakley, 2002). Therefore, as with any research, evaluation research requires a formal evaluation design and procedure that will systematically collect and analyse data in order to understand the mechanisms that underlie successful interventions (Morse, 1994; Nestor, 2001).

Health promotion evaluation fits with the principals of marketing research in identifying and anticipating consumer requirements, as well as measuring customer satisfaction with

the product (Hannagan, 1992). Evaluation literally means to place a value or to quantify worth and to give sound information about a project (MOH, 2000). The danger is that the evaluation will measure what is easily evaluated and ignore what is valuable (Thorogood & Coombes, 2000). A qualitative approach was chosen to capture the evaluation information sought.

3.2.1 Qualitative Research

With health promotion there are a wide range of methods that can be used to gather the information for the evaluation (Alcohol & Public Health Research Unit, 2000). The decision on what method to use is dependent on what type of information is sought. For this study a qualitative approach was considered the most appropriate exploratory tool to discover what selected people thought of the calendar and how it was of benefit to them. A qualitative approach is inductive as opposed to deductive. When undertaking inductive research the researcher moves from the observations to theory generation, as opposed to deductive where the observed data fits the predictions of the theory (Davidson & Tolich, 1999). Qualitative data is more likely to lead to findings that have a vivid meaningful flavour, a source of rich description (Beanland et al., 1999; Davidson & Tolich, 1999; Hague & Jackson, 1999; Miles & Huberman, 1994). It is the people and their experiences that are valued in the qualitative research process (Roberts & Taylor, 2002). The focus is to discover the nature of the phenomena as humanly experienced (Minichiello et al., 1999).

An understanding of what the community and stakeholders thought of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' was sought from this study. It is considered important to involve those members of the community whose health is being addressed in the evaluation (Gomm, Needham & Bullman, 2000; Oakley, 2002). From this an understanding was gained that provided an explanation of the community perspective. Also included were the stakeholder views that have traditionally been ignored (Guba & Lincoln, 1989). Including the stakeholder views allows the opportunity to build a broad picture of what is being evaluated (Guba & Lincoln, 1989; Ovretveit, 1998). For the purposes of this research, impact evaluation was chosen to evaluate the 'Healthy Messages Calendar (Te Maramataka Hauora)' project.

3.2.2 Impact Evaluation

Impact evaluation tests the theory or causal chain of events that has been postulated about a programme (Hawe et al., 1995). Impact evaluation refers to the immediate or short-term effects of the programme, usually corresponding with the project goal (Hawe et al., 1995; Nutbeam & Harris, 2004), as opposed to outcome evaluation that is concerned with the longer-term effects of the project. The difference between these two types of evaluation does not depend on what is measured but is defined more by the sequence of measurement (Hawe et al., 1995).

Impact evaluation, in particular, examines the extent to which the programme objectives have been achieved and by the strategies that were put in place to achieve them (Alcohol & Public Health Research Unit, 2000; Waa et al., 2000). This type of evaluation looks at what the intended and unintended effects the project has had (Alcohol & Public Health Research Unit, 2000). This evaluation method also includes any changes in knowledge and is concerned with establishing programme participants feedback on their perceptions about a programme (Alcohol & Public Health Research Unit, 2000; Thorogood & Coombes, 2000). Impact evaluation is considered particularly useful for print media reviews (Wurzbach, 2002). It was for these reasons that impact evaluation was used to evaluate the 'Healthy Messages Calendar (Te Maramataka Hauora)' project.

The types of information that can be collected when undertaking impact evaluation include:

- Establishing people's perception of the programme and health promotion issues.
- Collecting data on short-term changes in knowledge attitudes and behaviour of people who have been involved in the programme and for whom the programmes were designed to benefit.
- Assessing the positive or negative effects of the programme.
- Short term changes in the environment directly affected by the programme
- Reviewing process evaluation information through a documentation review (Alcohol & Public Health Research Unit, 2000).

A documentation review was included as part of the information gathering. Consistent with an evaluation of an injury prevention project in New Zealand by Simpson et al. (2003), and mentioned earlier in the literature review on community development, the present study sought minutes from meetings, official and unofficial reports, letters, archival material such as correspondence and background material from the commencement of the project. The data from this review, as well as the results from the focus group interviews, were then used to determine if the programme objectives were met. Included as part of the present study, is an assessment of the project against the whare tapa wha model of Maori health. As a means of ensuring the 'Healthy Messages Calendar (Te Marmataka Korero Hauora)' project's commitment to the Treaty of Waitangi, the whare tapa wha model was used to determine if the calendar was responsive to Maori health needs.

3.3 Sample Process

Purposive sampling was chosen to select the most appropriate people to gather the qualitative data. A purposive sample is one that provides a clear criterion for the selection of participants (Ezzy, 2002). It is when the researcher deliberately seeks certain types of elements because they are typical of some case of interest to the researcher (Davidson & Tolich, 1999), there is no random selection process (McGivern, 2002).

The study population identified for this project comprised of two groups of people. Firstly, the stakeholder population was specifically sought not only because they are the users of the evaluation, but also because they have in-depth knowledge of the calendar processes. This is supported by Guba and Lincoln (1994). Stakeholders are groups that have a stake in the evaluation (Chenoweth, 2002). These stakes may take the form of power, money, status or opportunity, the stakes ranging from large to small depending on the stakeholder input (Conner, 1981). The utilisation of stakeholder input can be valuable and therefore time and energy must be expended to identify the stakeholders and interact with them sufficiently to understand their concerns, claims and issues. This process is considered vital to true evaluation (Nestor, 2001).

The stakeholder population was defined as those with financial sponsorship and who were actively involved in the development and production of the 'Healthy Messages Calendar (Te Maramataka Hauora)' project. They were the active members of the Maramataka working committee. Recognition also needs to be given to the many other people who could be considered stakeholders, defined as those who had a financial interest in the calendar or who contributed towards a page. However, they were excluded for the purposes of this study, as they were too numerous to include.

The second study population was drawn from adults (over the age of 16 years) who were using the calendar, living in Tairawhiti, and available to be interviewed. From this prospective population, forty people were sought to make up four focus groups. The four focus groups were defined by cohort: kaumatua from the East Coast (mainly Maori over the age of 55 years), parents whose children attend a play centre, parents whose children attend a kohanga reo and rangatahi (youth 16 to 25 years). These groups were chosen to provide a range of age groups as well as a variation in socio-economic groups. They were also easily accessible.

3.4 Recruitment Process

One of the major tasks in securing participation of people in any research project is to establish a relationship. This begins when the researcher gains acceptance as a person interested in the participant perspective. Once this acceptance is gained it is then more likely that the participants will willingly participate in the research project (Minichiello et al., 1999). In this study, the sample were sought through community contacts known to the researcher who first approached the person in charge of each of the selected groups to invite participation. The person in charge then offered participation to members of this group and provided them with the participant information sheet. The researcher followed up a few weeks later to answer questions about the study and confirm the most suitable time for the interviews to take place.

This participant recruitment cycle occurred with four of the potential focus groups with the exception of the kaumatua from Ruatoria on the East Coast who were invited to partcipate by the cultural advisor. The cultural advisor, as mentioned in the introduction,

was the person consulted with to guide the cultural safety of the study. The cultural advisor was known to and respected by this group. It was decided in consultation with the cultural advisor and the Maori Health Manager at TDH, that the cultural advisor was the most appropriate first point of contact for the kaumatua group. Generally recruiting participants through a third party can be problematic according to Minichiello et al. (1999). Fortunately in this instance it proved beneficial. The cultural advisor discussed the study with all the kaumatua; the researcher then met with the participants at Ruatoria prior to the focus group interview to confirm details and answer questions.

Exclusion criteria from this sample population included those who did not use the calendar and those not wishing to participate. A different play centre than the one interviewed was initially approached and invited to participate in the study. However, only one parent had the calendar up in their home. Because of this another play centre was required. Also excluded were those persons who had an immediate connection to the stakeholders, defined as an immediate family member, work colleague or personal friend of any of the stakeholders. Inherent in any research is the demand for the protection of human subjects (Minichiello et al., 1999). The following section presents the ethical issues that were addressed when considering the ethical implications of this study.

3.5 Ethical Considerations

This research conforms to the ethical requirements of standard scientific inquiry. Ethical approval for this study was sought and granted by submitting detailed ethical applications to the Massey University, Albany Campus, Human Ethics Committee (MUAHEC) and the Tairawhiti Regional Ethics Committee (Appendix 3 & 4).

3.5.1 Participant Rights

The researcher discussed participant risks with the participants and written consent was obtained prior to each interview (Appendix 5). All participants at each interview were advised that the interview would be audio-taped and were made aware of their rights in relation to this. All participants were given the opportunity to ask any clarifying questions at any time throughout the interview. A unique ethical consideration for focus

group participants lies in the fact that what the participants say to the researcher, they are sharing with other group participants as well. They may reveal personal information about their lives, information that may be unknown to family and friends or school/work colleagues (Babbie, 1992). To minimise this, ground rules were set at the beginning of the focus group interviews as to the need to maintain confidentiality once the interviews had concluded.

To ensure subject safety and anonymity, all names were removed from the questionnaires and recordings, and replaced with pseudonyms. This pseudonym, chosen by the participants themselves, was then the only name used for the transcripts and written report to ensure anonymity.

3.5.2 Risk of Harm

Nurses have relatively easy access to the community, often without much explanation (Beanland et al., 1999). More so with public health nurses who, during the course of their normal work, are very much part of their community. By acknowledging this privileged relationship with the community, the researcher ensured all ethical processes were adhered to. In addition, any intrusion in people's lives disrupts the subject's regular activities (Minichiello et al., 1999). They are inconvenienced by their attendance, have the potential to be judged by their surrounds as well as their involvement in their community group.

The researcher was an experienced registered nurse, trained in facilitation, with the ability to detect discomfort. Should any person have experienced discomfort they could withdraw from the study without consequence. Participants were also given the opportunity to have the audio-tape turned off at anytime during the interview.

3.5.3 Stakeholder Risk

In a sense stakeholders are at risk in any evaluation as their stakes may be placed in jeopardy by the evaluation if there is a negative finding (Guba & Lincoln, 1989). There is the possibility the feedback from the community could be negative and could impact

on their self-esteem or the working relationship with their organisation. Furthermore, evaluation research involving stakeholders provides the opportunity for the evaluator(s) to exercise power over the stakeholders. This power has the potential to injure self-esteem, damage reputations and stunt careers, if these people are not able to defend their own interests (Conner, 1981). The stakeholders were informed of this potential ethical risk prior to their consent being obtained. It was ensured that no stakeholder, nor his or her supporting organisation would be identified at any time during the study. All comments were written to ensure anonymity. However, as with any evaluation, if honest feedback is sought then it is part of that risk and was accepted by the stakeholders who were themselves seeking honest feedback on the project.

3.5.4 Data Storage

Documents, including consent forms, taped interviews and transcriptions will be kept for a minimum period of ten years by the researcher's supervisor. All computer files are protected by a password and will be deleted after the same ten-year period. A delegated person from Massey University will then destroy all documentation. This next section discusses cultural considerations.

3.6 Cultural Considerations

Evaluation needs to acknowledge the diversity of different groups as part of the evaluation. There was a high probability Maori would be included as participants in the group interviews. Because of this, cultural considerations were considered paramount and Maori input was actively sought throughout every process of the research. The protection of Maori included individual and collective Maori rights, cultural data, cultural concepts, values, norms, practices and language. Every attempt was made to ensure the cultures of Maori and others were respected and all protocols adhered to. Each focus group began and ended with karakia, kai was provided and a koha given.

As identified earlier, a Maori cultural advisor was sought to guide the cultural safety of the study. The cultural advisor also served as group facilitator and therefore was present during the interviews to maintain cultural sensitivity. The cultural advisor was a

respected trustee of Te Runanga O Ngati Porou, president of Ngati Uepohatu Maori Women's Welfare League and executive president of Ruataupare ki Tuparoa Marae. The cultural advisor had a good understanding of the Maori language and was available for translation if the need arose. In recognition of te reo as the official language of New Zealand, if requested, participants could respond in Maori. The transcriber was also able to translate the information if it was necessary. It is acknowledged that some of the comments might not be able to be translated into English if the true meaning of what was said is not to be lost. To acknowledge and respect this, key Maori phrases were included in the written dialogue. In addition to the language, consultation and communication is considered a necessary part of being responsive to Maori (MOH, 1997).

Consultation was also undertaken with a Kaumatua Tohunga of the Ngati Uepohatu Tribal Authority. Ongoing involvement from these key people occurred throughout the entire project. The kaumatua were also kept informed regularly of the progress of the project to ensure correctness of procedures was maintained. The proposal was also given to the Tairawhiti District Health Maori Health Manager for approval prior to commencement. Consistent with Maori consultation, information was shared with all the participating groups at the end of the project. A copy of a summary of the results was provided to all the groups participating.

3.7 Sample Size

In qualitative research, the sample size depends on the scope of what the researcher is trying to explain (Minichiello et al., 1999). Smaller groups offer more opportunity to share ideas and are considered more appropriate if a high level of participant involvement is sought (Morgan, 1997). The five focus groups provided an adequate amount of information for analysis to occur.

Participants for this study ideally were typical of the target group to benefit from the calendar namely the elderly, rangatahi and young parents. The Maramataka committee participants interviewed were to be seven, however five participated. A similar number was sought for each of the four focus groups: ten people were invited to participate in the hope six or seven participants would attend the group interview. This number is what is

recommended for group interviews (Hawe et al., 1995; Robinson, 1999) and was achieved in all but one of the community group interviews where there were five participants.

3.8 Data Collection

A review of project documentation was carried out on the files held at the Public Health Unit in Gisborne. This is consistent with the processes of impact evaluation. In addition and consistent with a qualitative approach, further data was collected by face to face semi-structured focus group interviews using open-ended questions. It was thought open ended-questions would prompt recall of the product, and encourage discussion on what participants thought of the calendar. There will invariably be a great deal of contextual material that does not get onto the tape such as non-verbal communications (Darlington & Scott, 2002). During the interviews for this study the researcher noted and documented the non-verbal actions and reactions of the participants. This note taking was both descriptive and reflective. Participants were informed prior to the commencement of the interview that note taking might occur.

For the community participants, the questions were based on the necessity of establishing participant understanding of the purpose of the calendar and the values of that calendar for them and their whanau. For the stakeholders, the questions were based on ascertaining the participant's perceived value of the calendar and their involvement in the project. The semi-structured interview questions/prompts and the justification for the inclusion of each question has been provided in Appendix 6, 7 and 8.

Included as part of the focus group process for the sample groups, was an individual written questionnaire to complete. Information requested demographic data relating to age, ethnicity, gender, socio-economic status, employed, unemployed or retired, and whether rural or urban (Appendix 9). It was thought this demographic data would enable comparison between different cohorts in the community. From this it can be determined if the calendar was of benefit to any particular social group. No demographic data were sought from the stakeholders to avoid identification of either them or the representing organisation.

3.9 Focus Groups

The method for obtaining the qualitative data was by way of a semi-structured focus group interview format. Focus groups have been commonly used in marketing since the early 1960's (Greenbaum, 1998), as well as in social research (Waldegrave, 2001). Focus group technique, otherwise known as group interview, was selected as it fits well with qualitative methodologies (Minichiello et al., 1999). Defined as in-depth, open-ended group discussions (Robinson, 1999), focus groups provide a powerful means to explore the variation, diversity, and consensus of both ideas and beliefs on a given topic within a social context (Minichiello et al., 1999; Robinson, 1999; Sudman & Blair, 1998; Waldegrave, 2001). The hallmark of focus groups is the explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group situation (Morgan, 1997). Interaction is encouraged to maximise the quality of the output enabling clarification and/or qualification of thoughts and ideas (Greenbaum, 1998).

The strength of focus groups as a method of data collection is in its ability to produce a concentrated amount of data on precisely the topic of interest (Morgan, 1997). This data can be collected in a shorter time frame than if individual interviews were carried out. This is both time and cost effective (Robinson, 1999). Focus groups can also give voice to groups that otherwise might not be heard (Morgan, 1997). There is allowance for literacy, language or cultural differences between the researcher and those being researched (Minichiello et al., 1999). This was considered important for this study, as it was thought some of the participants might not be able to read.

The disadvantages to this form of data collection are the potential for psychological factors and group dynamics to affect the group (Morgan, 1997). The greatest threat is 'groupthink' wherein the stronger participants may influence the ability of some members of the group whose view sways the responses from the other group members (Greenbaum, 1998; Hawe et al., 1995). This can severely limit the self-expression of some members (Minichiello et al., 1999) and less information is obtained from each respondent at the individual level (Sudman & Blair, 1998). The more homogenous the group the better participants relate to each other (Greenbaum, 1998; Morgan, 1997). To

provide for a secure social climate to encourage discussion and free expression, the researcher endeavoured to determine the homogeneity of the groups by age, social standing, ethnicity and subculture.

The number of groups was also the primary determinant of how much data the research produced (Morgan, 1997). As a general rule of thumb Morgan (1997) suggests three to five groups, any more seldom provides meaningful insight. For this study, four community-based focus groups were chosen and one representing the stakeholder group. The community focus group participants were also asked to complete a written demographic questionnaire (Appendix 9). Completing this was optional and did not negate their input at the interview if participants chose not to complete the questionnaire.

3.9.1 Conducting the Focus Groups

The five focus group interviews were conducted over a six-week period. The cultural advisor served as the group facilitator for all five groups. The researcher was present at each interview but not part of the group interview. This left the researcher free to make observations and take notes. This arrangement served as a back up in case of recording failure. The researcher documented what each person said to enable clarity of the conversation and identification of the speaker for the transcribing process. This was discussed with the participants prior to the beginning of each interview. The researcher was available at the end of the interview to answer any questions the respondents might have had about the calendar. After each of the four community group interviews, the respondents asked questions mostly relating to how their organisation could be involved in the next calendar production.

3.9.2 Environment

The group interviews took place in the natural setting, in an environment the participants were comfortable with. The kaumatua group interview was held on a local marae in Ruatoria, the kohanga reo and playcentre at their early childhood centre venue, the stakeholders at their usual meeting place and the rangtahi at a private home. This served to encourage a feeling of ease and to stimulate the flow of speech. The rooms while

suitable for the participants were not always suitable for the audio-taping. The scheduled time for interview was 60 minutes with an extra 30 minutes allowed for introductions, karakia and conclusions. This was a total of 90 minutes. Participants were seated around a table to facilitate discussion. The table also provided an object on which the audio-taping equipment could be placed. Two audio-tapes were recording throughout each interview to enable all the information to be captured. Refreshments were provided at the end of each interview. This allowed for socialising and to provide participants an opportunity to debrief should they wish to do so.

3.10 Data Analysis

Building in sufficient time to analyse the evaluation information is considered important (Alcohol & Public Health Research Unit, 2000). It takes time to bring together all the pieces of information and make sense of it once it has been collected. For this study the qualitative data were analysed using a general inductive approach.

A General Inductive Approach.

Qualitative data analysis involves a detailed examination, summary and interpretation of information that is collected by the researcher (Minichiello et al., 1999). Qualitative data analysis relies on an interpretive process requiring astute questioning of what the data means, a search for answers, active observation and accurate recall (Ezzy, 2002; Wolcott, 1994). The analysis in general is concerned with identifying patterns within the data and the different ways these patterns relate to each other (Bryman & Burgess, 1996; Darlington & Scott, 2002; Thomas, 2004). The process of piecing together data, of making the invisible obvious, of recognising the significance from the seemingly insignificant and of linking unrelated facts logically is required (Minichiello et al., 1999; Morse, 1994).

Qualitative data analysis involves a number of systemic procedures and techniques that engages with the complexity of analysing human action in terms of meanings (Ezzy, 2002; Thomas, 2004). Qualitative analysis is a dynamic process that is influenced by the

aims and objectives of the study, the study sample, and the type of questions asked (Ezzy, 2002; McGivern, 2002).

For this study, a general inductive approach was utilised to analyse the data obtained from the focus group interviews. A general inductive approach provides an efficient, straightforward way of analysing data (Thomas, 2004). The general inductive approach is a method of working with qualitative data and uses systematic procedures culminating in the identification of common patterns and themes (Thomas, 2004). The underlying assumptions of this approach are that the findings are derived from both the research objectives outlined by the researcher and the findings that arise directly from the analysis of the raw data. The primary mode of analysis is the development of categories from the raw data into a framework that captures key themes; the findings are shaped by the assumptions and experiences of the researcher (Thomas, 2004).

3.11 Coding Procedures

Coding is a central process that assists the researcher to sort the data and uncover the underlying meanings in the text (Darlington & Scott, 2002). Coding is the process of disassembling and reassembling data by breaking them into lines, paragraphs or sections. The data is then reassembled to produce a new understanding that explores similarities and differences across a number of different cases. This coding process allows the researcher to move beyond a pre-existing theory to gain new interpretations and understandings of the data (Ezzy, 2002).

3.11.1 Preparation of Raw Data Files

In order to be systematically analysed the audio-recorded data was transcribed. The transcribed data were printed onto size A4 paper to allow for multiple readings of the results. The transcripts were checked for accuracy. The importance of confidentiality was stressed with the transcriber and a written agreement for confidentiality was obtained.

3.11.2 Stages Utilized in Creating the Data Driven Categories

The audiotapes were listened to several times until familiarity had occurred. The transcripts were also read and re-read many times. The researcher made the decision about what was more important or less important in relation to the data. The data extracts were then sorted into their thematic files. As the categories or themes began to emerge from the data they were named and highlighted using a different colour for each of the nine original categories. This process was repeated for each transcribed document from each interview.

3.11.3 Categories

Categories are frameworks, developed in order to summarise the raw data and to convey the key themes that emerge (Thomas, 2004). These categories can then be broken down further and a system of coding applied (Edwards & Talbot, 1999). When undertaking a general inductive approach, Thomas (2004) refers to the identification of upper and lower level categories or themes. Upper level categories are more general categories or themes that are most likely to be derived from the research aims. Lower level categories are more specific categories that are derived from the multiple readings of the raw data. Both upper and lower level categories are created from the actual phrases used in specific texts.

Nine initial categories were found in the data and include the health messages, health promotion tools, the pictures, colours, sponsorship, keeping it local, community involvement/relationships, improvements, and what people thought of the calendar. Once the original categories were identified the nine categories were reduced down to eight categories.

The extracts that comprised the robust categories were looked for and segments of the text were grouped according to a category by a process of cutting and pasting into a table format. This table then allowed comparisons and contrasts to take place between the data from the different groups as to what the similarities and the differences between them were. The following table is an example of the coding and categorisation of the data.

Table 3.1: Coding and Categorisation of Data

Label for Category	Description of Category	Text associated with category Rangatahi Interview (4)
Pictures	The artwork drawn by local children to provide the messages	Frank: Oh its good how one of the kids used the Alzheimer's Support (p2) Maui: They wont read it (p4) Carmen: It wont get the children involved with it after they're doing stuff they wont recognise it p4 Fac 2: What do you like about the calendar? (p5) Maui: They're all done by children (p5) Jaz: Yeah and they show they're interested (p5) Carmen: Getting the children to do it helps them promote so I like that about the calendar cause that's getting the children in to it – healthy living (p5)
Colours	Colours used in the calendar to provide the messages and highlight important health related events e.g. Mana Wahine week	Jaz: Its bright (p4) RnB: Its colourful (p4) Maui: Its beautiful (p4) RnB: The blue highlight, the blue highlight spoils, the I think its Breast Feeding Week its blue and the writing inside the blue boxes is blue (p5) Maui: Maybe having a different colour inside of the blue box (p5)

The key to understanding the verbatim excerpts in the results chapter is as follows: the individual's anonymous name is given, followed by an interview number that relates to the group that they aligned to. Interview 1 = kaumatua, Interview 2 = stakeholders, Interview 3 = kohanga reo parents, Interview 4 = rangatahi, Interview 5 = play centre parents. The page number refers to the transcribed interview page, for example: (Frank, Int4, p4).

3.11.4 Overlapping Coding and Un-Coded Text

As is common in qualitative analysis a single text segment may fit into more than one category (Thomas, 2004). Where this occurred in this study, each colour that related to that category was applied to the text. This process was repeated with each interview. Likewise some of the text may not be assigned to any category as it may not be relative to the research objectives (Thomas, 2004). This did not occur very often in this particular study, as the interview questions were specific to the calendar project.

3.11.5 Continuing Revision and Refinements of the Category System

The robustness of the categories were tested with all transcripts by a continual revision and refinement of the category system. What were looked for were relationships between categories, the overlap of categories, contradictory points of view and new insights. The revision and refinement processes were continued until the researcher was comfortable with the results. There is no overt sequence to the categories although they were closely linked and comparative with each other. Thomas (2004) suggests procedures for assessing the trustworthiness of the data analysis include a coding consistency check, clarity of category check and stakeholder checks

3.12 Rigorousness of the Study

One of the difficulties with qualitative research is persuading others as to the authenticity of the information gained and the interpretations drawn from it (Guba & Lincoln, 1981; Strauss & Corbin, 1998). Ezzy (2002) believes qualitative research provides a sophisticated understanding of the issues as the participants see them. As with most qualitative research there is a higher interest in the validity of this study rather than the generalisability in order to obtain a more meaningful whole of the text (Emden & Sandelowski, 1998). What this means is that while the results might not be generalisable to other locations and populations, the results accurately reflect the opinions of the people in the study (Minichiello et al., 1999).

Ezzy (2002) believes qualitative research demonstrates trustworthiness when the researcher has demonstrated that they have worked to understand the nature of the participant's interpretations and meanings. The results depend on disciplined conceptual processes and on ensuring that these processes reveal the understanding of their participants (Ezzy, 2002). The rigorousness of this study will be discussed using the headings: credibility, audibility, fittingness and confirmability (Beanland et al., 1999).

3.12.1 Credibility

Credibility refers to the truth of the findings as judged by the participants and others within the discipline (Beanland et al., 1999). Claims to credibility can be strengthened by involving the respondents in the interpretation of the data obtained by audio recordings during the interviews. For this study, because of the difficulty in gathering the focus group interviewees, as well as the geographical location of one of the groups, the transcribed data derived from each interview was given to the cultural advisor to confirm or challenge the themes the researcher had identified. As mentioned earlier, the cultural advisor facilitated each focus group interview. It was thought that the cultural advisor was an ideal person to undertake the task of identifying common themes as she already had an understanding of the context of the interviews. The cultural advisor was given no prior indication of what themes the researcher had established until after this process had occurred. For the cultural advisor, most of the categories that emerged from the raw data were common to those identified by the researcher. Credibility is also achieved if there is recognition of the phenomena when reading the research report (Roberts & Taylor, 2002). It is hoped credibility will be established with the dissemination of the research results.

3.12.2 Auditability

Auditability is established when the adequacy of the information leads the reader from the research question and raw data through the steps of analysis to the interpretation of the findings (Beanland et al., 1999). This was achieved in this study from the description of all the processes described in full detail in chapter three of this thesis. The rationale for the methodology and method have also been provided.

3.12.3 Fittingness

Fittingness is being faithful to the everyday reality of the participants. It includes describing in enough detail so that others in the discipline can evaluate the importance of their own practice, research and theory development (Beanland et al., 1999). Research reflects the interests and experience of the researcher; hence the term bias is often avoided. Researchers should make known their personal stance in relation to the subject under investigation as well as their relationships with the participants (Fade, 2003). The potential for coercion by the researcher in obtaining the desired feedback is a very real threat (Guba & Lincoln, 1989). The researcher in this study acknowledges a potential conflict of interest in this study having been part of the original and continuing Maramataka Calendar Committee. This however could be seen as positive in that a good knowledge and understanding of the history, management and production of the calendar by the researcher was advantageous in eliciting the information that was required.

3.12.4 Confirmability

Confirmability is achieved when the findings reflect the implementation of credibility, auditability and fittingness have been demonstrated (Beanland et al., 1999). The researcher proposes that in this study, credibility, auditability and fittingness were demonstrated.

3.13 Summary

This chapter presented an overview of the research design for this study. Impact evaluation using a qualitative methodology was utilised to evaluate the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project. Information was sought to ascertain if this project achieved the objectives it set out to achieve and to discover the meaning of the calendar for respondents, as well as suggestions to improve the calendar for selected members of the Tairawhiti community. Data were collected through a review of documentation as well as from five focus group interviews. A purposive sample was chosen to also include the stakeholders from the Maramataka calendar committee, as well as four community groups in the interviews. Demographic data were collected from

each of the four community group participants to determine the cultural and social makeup of each focus group. All this information was then utilised to assess if the project objectives were met and if the project incorporated the whare tapa wha model of Maori health.

Ethical approval was sought and granted from the Massey University, Albany Campus, Human Ethics Committee (MUEHEC) and the Tairawhiti Regional Ethics Committee (see Appendix 3 & 4). To incorporate the principles of the Treaty of Waitangi within this evaluation cultural advice and approval was also sought. A cultural advisor assisted the researcher throughout the project ensuring cultural safety. A general inductive approach was used to analyse the qualitative data. Chapter four will present an overview of the results of the documentation review followed by the results of the demographic data and qualitative results from the focus group interviews.

Chapter Four: Results

4.1 Introduction

The chapter begins with a presentation of the documentation review of the Maramataka calendar files held at the Public Health Unit in Gisborne. This is followed by the results of the demographic data collected from each of the four community focus group participants. This data provided useful insight into the makeup of these focus groups. Some of this background information is then used to present the qualitative results from the focus group interviews. Thomas (2004) suggests that when reporting findings from inductive analysis, categories are often used as main headings. The sequence used in the inductive analysis begins with a category label with the author's description of the meaning of the category. This is then followed with appropriate quotes selected to illustrate the essence of these categories. The presentation of data in this study includes conversations between members of the focus groups. These opinions served to provide more meaning to the data obtained.

This chapter also includes an analysis that determines whether the calendar project met any or all of its objectives. In addition, the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project was also evaluated against the whare tapa wha model of Maori health to determine project responsiveness to Maori health needs and the project partner's commitment to the Treaty of Waitangi. Each of the four components of the whare tapa wha model is outlined followed by a discussion of how the calendar project incorporated the principles of this model.

4.2 Review of Documentation

Consistent with impact evaluation was a documentation review of the files kept at the Public Health Unit in Gisborne. The information sought included minutes from meetings, official and unofficial reports, letters, and archival material such as correspondence and background material from the time of the commencement of the project. The purpose of this documentation review was to identify the processes used to establish the project, as well as to determine whether the achieve objectives set were achieved. The data obtained

provided valuable insight into the development of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project.

With the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project, the project plan formed the template for the entire project. The project plan was first written early in 2000, at the beginning of the concept of the calendar project. It has been updated annually to allow for improvements, refinements, and new timelines, as well as to address fiscal considerations. The project plan met the requirements of the prescribed Public Health Unit project plan format (TDH, 2000). A copy of the Maramataka project plan has been provided in Appendix 10. Timelines were clear. Coverage was identified as every household in Tairawhiti. There were approximately 17,186 copies produced to cover an estimated viewing audience of 46,000 people. After the production of every calendar, debriefs were held with the Maramataka committee members to look at processes used and what could be done better. The project plan was then upgraded to include any suggested improvements. Evaluation processes were clearly outlined. Reports were generated as required, including a postponement report that identified why the decision was made to postpone the production of the calendar for the 2001-year. Financial reports identified from whom money was sponsored and how the money was spent.

Meetings were held on a regular basis for the four years leading up to 2005. Prior to each meeting an agenda was distributed to people who had indicated an interest in being part of the calendar project. Meetings were held at the various participating community organisation venues. The subject of the meetings included where to access funding, the funding obtained, the determination of key messages, publicity and deadlines. The distribution of the calendar was a continuous agenda item. Letters were sent out each year to invite broader participation in the committee. This process provided a second chance for community organisations to become involved. As the calendar progressed each year more organisations came forward to be part of the project.

Copies of all communications are kept on file at the Public Health Unit in Gisborne. Publicity about the calendar was included as part of that communication process. The initial publicity campaign aimed to gather community involvement and support for the calendar financially, physically and socially. Once the calendar was produced, the

publicity was about informing the community of the calendars imminent arrival in their letterboxes. It provided the community with information as to the reason why the calendar was produced, the story of its development and who was involved in its production. Both the documentation review and the following demographic data provides useful background information to the focus group feedback that is presented later in the chapter.

4.3 Summary of Demographic Questionnaire

A written questionnaire was given to each member of the community group participants to complete just prior to each group interview and after written informed consent was obtained. A copy of this questionnaire has been provided in Appendix 9. The opportunity to complete the questionnaire was voluntary. If participants chose not to complete the questionnaire they were still able to be part of the group interview. All but one participant completed the questionnaire. This may have been due to their arriving late and leaving the interview early for another appointment.

Demographic data were sought in order to gain an understanding as to the socio-cultural status of each group. This was considered important knowledge as the calendar was developed predominantly for rangatahi, young parents and Maori. Household income was not requested, as these groups were known to have limited income in Tairawhiti as identified in the Tairawhiti demographic information offered in chapter one. This was applicable in view of the strong evidence that social, cultural and economic factors are the most important determinants of good health (Durie, 1994a; Howden-Chapman, 1999; Reid, 1999). The information gained could potentially support future funding applications to enable the continuation of the project.

The questionnaire was not given to the stakeholder group for several reasons. The most important reason being that from the information it would make it easier to allow identification of the stakeholder participants. Stakeholders are at risk from the evaluation if the findings are negative (Conner, 1981; Guba & Lincoln, 1989). If the identity of stakeholder was obvious, not only could it potentially cause issues for the stakeholder, but would also allow for the identification of their contributing organisation. From this, the reader could make assumptions that the views of their aligned organisation were

expressed rather than the views of the stakeholder. It is reinforced here that it was the stakeholder as an individual that participated in the interview and not the views of the organisation they were aligned to. Secondly, it was not considered essential for the purposes of this study.

The results indicated that most respondents were female, Maori, with a variety of ages and occupations. The majority of respondents were retired, beneficiaries, students or homemakers with only one respondent indicating they had a professional occupation. The key findings are provided in table 4.1 as provided below that offers a summary of all the information collected. Income per household was not requested. However, from the information gained from the occupation and housing status, an assumption could be made as to the suggested wealth of the respondents. Within this context, and with the knowledge of the socio-economic status of Tairawhiti, including the East Coast, it can be assumed the income for the majority of respondents was not above the national average.

Table 4.1. Demographic Information Summary:

Questions relating to:		**Kaumatua**	**Kohanga Reo**	**Rangatahi**	**Playcentre**
Gender	Male	2	1	1	
	Female	6	5	4	8
	Did not specify				
Age	16 to 24		2	5	1
	25 to 29		1		
	30 to 34		1		3
	35 to 39				2
	40 to 44		1		2
	45 to 49				
	50 to 54				
	55 to 59	2	1		
	Over 60	6			
Occupation	Retired	5			
	Student			5	
	Homemaker				6
	Trades				
	Beneficiary	4			1
	Professional		2		
	Other		1 Truck driver 3 Kaiawhina		1 Retail 1 Homemaker/ Volunteer

Ethnicity	NZ Pakeha/ European			1	7
	NZ Maori	8	6	4	2+1 identified as both
Housing	Rented	1	2	1	2
	Owned	6	4		6
	Did not specify	1		4	
				4	2
	Town/City	4			
	Country	4	6	1	6
	Did not specify				

(Important – please note the numbers do not necessarily add up to the number of participants from each focus group. The reason for this is that some respondents identified themselves in more than one category, for example they have identified themselves as both retired as well as a beneficiary).

Returns Completed Per Group

1. ***Kaumatua Group***

100% completion of the questionnaire = 8

2. ***Rangatahi Focus Group***

100% completion of the questionnaire = 5

3. ***Kohanga Reo Focus Group***

85% - 6 out of 7 completed the questionnaire

4. ***Playcentre Focus Group***

100% completion of the questionnaire = 8

Interestingly, an original focus group selected to be one of the groups interviewed, was a play centre in Tairawhiti determined by their decile rating as in the higher socio-economic bracket. One of the conditions for participating in the focus group was to have the calendar in use in their home. Because of this condition there were not enough participants from this play centre to participate in a focus group. The reason suggested is

that they received calendars from other sources. Not only are they more likely to receive a free calendar because of their buying power from businesses they were customers of, but because of this greater buying power these people could afford to purchase a calendar of their choice. This could imply that those of higher socio-economic status did not 'need' the calendar. This is supported in the literature that suggests those most experience greater levels of health (Howden-Chapman, 1999; National Health Committee, 1998; Oliver & Peersman, 2001; Reid, 1999).

4.4 Focus Group Results

This next section presents findings from the five focus group interviews that were derived from the multiple readings of the raw data. Each category is used as the main heading followed by the results. To begin, the suggested 'improvements' to the calendar as offered by the focus group respondents are presented. This is then followed by the 'health messages', a common theme that came through from the focus group interviews. Other 'health promotion tools' to promote health messages were identified by the focus group participants. The 'pictures', the medium used to promote the messages in the calendar, then follow. The 'sponsorship' of the project is presented next before 'keeping it local', a theme that appeared of great importance to all participants as were the 'community involvement/relationships'. To conclude this section and the chapter, 'what respondents think' of the calendar is then presented.

4.4.1 Improvements

One of the key aims for this research study was to uncover suggestions as to how the calendar could be improved should it continue in the future (see section 1.4). Suggestions for improvements provided by both the community respondents and stakeholders appeared very similar throughout. The participants themselves also easily identified how these issues could be addressed.

Lack of Space/Clutter

The calendar being too cluttered or too busy was a common theme amongst the community groups as this example shows:

> *When I look at it I just, I think it sort a looks a little bit like it's really busy, like cluttered (Petal, Int.5, p. 4).*

Because the calendar was so busy and full of information, there was limited room for people to write their own notes and appointments on the calendar, as some people like to do. It did not appear to be an issue with the rangatahi group though, most of whom thought it a good idea to make use of that space to advertise health, be it with a phone number or a website. While this lack of writing space was an issue for some, one person from the play centre group thought the date boxes were large enough:

> *I like the way the boxes for each day are big enough for you to actually write things in yourself as well and the numbers (Sally, Int.5, p. 3).*

As identified from the documentation review, the squares with the numbers in were sold to other organisations to help pay for the calendar. Most of the stakeholders realised this was an issue. However, it appears this was necessary to finance the calendar to enable the project to go ahead. The focus group participants themselves, while identifying with the lack of space as an issue, also offered solutions to overcome the problem of having no room to write on the calendar, as this example illustrates:

> *Or maybe the possibility of where you've got your logos on some of the days on the calendar, maybe putting those again at the top. And just maybe a brief message to go with the days that you're focussing on, the possibility of that. Or maybe just adding on a note a portion adding notes on the end of it where we could have that room. Maybe if there's no possibility of changing the logo*

and the message to have a notes area where I can write my messages (No 4, Int.5, p. 5).

The feedback from one of the stakeholders was very similar. One of the suggestions to overcome the cluttered look that came from the community respondents was to have a bigger calendar. The main reason people wanted it bigger appears to be so that all the information can remain on the calendar but have room for their own comments. While some wanted the calendar bigger, several respondents from the play centre parent group did not want it too much bigger. One of the rangatahi, while in support of the idea, thought the larger size would cause problems with the delivery of the calendar. Other suggestions from the rangatahi group, to go with the bigger theme and overcome the delivery problem, was to make the calendar lighter, especially if it is made bigger and have a clip for hanging it. To go with the bigger theme several respondents from each of the community groups thought the lettering and numbers should be bolder. When the participants were asked what they thought of a June through to June calendar to match in with the Maori year the participants were in agreement, especially the kaumatua group.

Colour

Colour was used in the calendar to promote the messages, as well as highlight important health related events such as Mana Wahine week. The colours used in the calendar created a lot of discussion with the community groups. For some, it was the colour schemes that attracted their attention, for others, the colour was simply attractive:

The colours are ataahua beautiful, eye catching (Liz, Int.5, p. 9).

Some interviewees enjoyed the colour, while for others it caused enormous difficulty. Those most affected were the kaumatua group, all over the age of 55 years, with most over the age of 65 years. For one particular person it was the focus of their discussion throughout the interview:

Yeah. Sometimes background, aye background, some colours don't go together, one of them is this ah this purple. You can change the colour of purple or change the white (Tawhaki, Int.1, p. 9).

This colouring of the special highlighted weeks also caused a problem for one of the respondents from the rangatahi group, the issue identical with the person from the kaumatua group, although not to the same extent. The kaumatua and rangatahi group respondents offered suggestions as to how this problem with the colours could be addressed. This was related mainly to the highlighted weeks such as well child week where a background colour, in this case blue, was used to highlight the whole week. The stakeholders, kohanga reo parent group, or play centre parent group did not have an issue with the colours used.

The respondents were asked if they thought the pictures were the best medium to promote the messages. Most were in agreement. A question was asked of the respondents whether photos would be as effective. Some respondents from the kaumatua group approved of the photo idea, another interviewee thought a balance between photos and drawings would be nice as long as both were local and it was a good photo. Another suggestion was to include the phases of the moon. This idea created a lot of discussion in the play centre group:

> *The calendar could actually have the basic phases of the moon on it too. I know when we buy a calendar that's very important to us because my partner gardens and fishes by the moon (Liz, Int.5, p. 13).*

Distribution

The community group participants identified there was an issue with the distribution as the following excerpt suggests:

> *I don't think that all households got this calendar last year so maybe agencies, kohanga's they could be issued to them (Petal, Int.3, p. 8).*

The Maramataka calendar committee paid a distributor to deliver to every home in Tairawhiti. Unfortunately in the three years the calendar had been in production there had been pockets in the community that never received a copy. Some of these delivery

hiccups were a direct result of the people paid to deliver not delivering. Both the documentation review and stakeholder focus group interview revealed the distribution issue was common knowledge with the stakeholder group:

> *The only other thing that I've heard about is that people haven't known what it was and thrown it away without opening it properly. So that's one extreme, but I've also heard of some people also not getting them because they've been stolen by kids so they're either a treasure or a trash depending on which way you look at it (Camellia, Int.2, p. 11).*

It was suggested by one of the stakeholders that the calendars were heavy and this may have been one of the reasons they were not delivered. There were also reports that there were occasions when the calendars were stolen from letterboxes and sold to unsuspecting customers. Another suggested distribution issue identified was the fact that the calendar was also delivered just prior to Christmas and may have got caught up in all the Christmas flyers and accidentally thrown out. The calendar committee tried to find another source of delivery. It appears the options were limited in Gisborne. The calendar committee invited people to submit a tender for the distribution by advertising for expressions of interest. While there are documents recording the expressions of interest, no one person or organisation submitted a written tender offering a price for delivery. This process appeared very time consuming and thus never eventuated. The committee had to make a decision to use the previous year's distributor as delivery day approached.

Publicity through the local newspaper occurred in each of the three years the calendar was produced informing the people of Tairawhiti that the calendar was on its way. It was through these newspaper articles that people were asked to phone the local Public Health Unit if they had not received a copy of the calendar. Many people did phone in and were then able to receive a copy of the calendar. Those that did not know of this option or who did not have access to a phone therefore missed out. The distributor was also informed of the issue and requested to correct the matter.

4.4.2 Health Messages

The delivery of key health messages was one of the aims of the calendar. The calendar was about being creative in the delivering of messages and developing a product that had the potential to bring about change. The calendar was an opportunity for people to have daily reminders of the key messages. Multiple messages were presented on each page with a key theme for each of the twelve months of the year (see Appendix 2). The focus group interview questions sought to discover if the participants were easily able to identify these key messages and how relevant these messages might be for them. The community group participants were easily able to identify what the key health related messages were. These key messages were recalled consistently throughout each interview as evident from the following excerpt:

> *The calendar shows people how to live healthy, gives people ideas how to live healthy through the messages in the calendar (Carmen, Int.4, p. 1).*

Some members of the kaumatua group commented that Maori people don't read books; they prefer to look at the pictures as this example illustrates:

> *Ae, ko te Maori hoki, kare read pukapuka (yes, Maori are visual learners rather than readers of books), they just look at the pictures, and ah, and ah, me too, and, If I've been to an important hui, he aha ranei, pehea ranei (meeting of some kind) or any book of some sort, I look at the pictures and I can see the background. What's going on so therefore I think of the kaupapa, hauora, health, with the health and I look at the picture and it could say (Rangahau, Int.1, p. 1).*

The target audiences for the health messages were, on some pages, age or gender related. For example pages supported Alzheimer's and cervical screening. Immunisations and dental checks were encouraged to promote children's health. The health message also related to the Ministry of Health contracts held by the various stakeholders working in their individual area of health. The calendar provided a tool with which the individual

involved could fulfil their Ministry of Health contracts. Again it related to having knowledge of their target audience, as well as their need to disseminate information. The influence of the stakeholder contracts and output responsibilities were evident in the stakeholder interview:

> *Um as part of the Ministry of Health contracts, it's actually one of the things is to disseminate information to the public and in terms of all the different types of ways you can do that um, say through newspapers or pamphlets. It's been shown that way of disseminating information isn't actually a good way to get out to the general public and especially with the sort of low reading age that we have in Tairawhiti. Most people's reading is around the age of a ten-year old, um, and the calendar is a good way to get messages out to the community. They look at one message for a whole month and it can actually become a discussion point within families (Abby, Int. 2, p. 1).*

Within the stakeholder group there was much discussion around health messages and how effective they were in inciting a change of behaviour to improve health:

> *The other thing in terms of key messages in this sort of format is unless they're telling you to do something, unless they're actually asking you to incite a behaviour of some sort they're not actually. The message isn't going to be that useful. Like um, if there's just a picture of something or, um can't give a good example. Just a phone number for an organisation, phone numbers asking you to ring someone because your child needs a Well Child check. Um that's actually trying to incite behaviour, which is a good (Abby, Int.2, p. 14).*

These comments caused discussion from the other stakeholders over the effectiveness of these messages being repeated throughout the calendar. Not only did children's art deliver information to the people of Tairawhiti, but also many of the dates on each page

supported a message. Dates used in this manner were seen as having both positive and negative effects for the calendar from the community groups.

4.4.3 Health Promotion Tools

Providing the right medium for the delivery of a health related message is essential for the success of any health promotion project. Respondents, including the stakeholders, were asked what suggestions they had apart from the calendar to get health-related information out to the community. While it was the calendar that was under evaluation, the focus groups provided an opportunity for respondents to offer alternative options that could replace or be additional to the calendar. A diary was offered as a suggestion in the play centre group with another four people in this group agreeing with this idea. They wanted a small one similar to the diary offered to clients by a local chemist. A wall chart, a year planner, and a height chart were also offered as alternative health promotion tools. Some participants liked the idea of a wall chart, while others commented that a wall chart was too big and wouldn't get used, whereas a calendar, they stated, is useful and usually kept handy.

Discussion took place in two of the community groups as to what age the information was targeted at, children or parents? If the information was targeted towards children then a height chart was considered suitable by one of the respondents from the play centre group. Videotapes were also suggested; however one of the rangatahi proposed people would get bored with a video. A billboard was also offered as a suggestion in more than one focus group. Gisborne had a billboard up in the main street advertising alcohol. The rangatahi group in particular discussed this billboard. One member of this group suggested it should be taken down and a health promotion message put up. The other group members agreed with this suggestion. They realised this type of advertising would be expensive though.

Discussion arose about the use of the Internet to promote health messages. Some respondents did use the Internet for information. However, most respondents realised that many homes in Tairawhiti did not have Internet access. The stakeholder group also identified this lack of access as an issue in this community. One person from the

stakeholder group thought that a web site could be used to further supplement the calendar. The advertising of health websites already placed strategically on the calendar to match up with the message promoted was noticed by one of the rangatahi:

> *Like for health websites if you need to go have a look and get some information about like healthy women and stuff, the website is in the box (RnB, Int.4, p. 3).*

Another suggestion, this time from the kohanga reo parent group, was to put out a fridge magnet. There were pros and cons for this type of promotion. Delivering the information through schools was also offered as a suggestion from the kaumatua group as a way of getting messages into the community and into the home. There was a concern raised by another member from the kaumatua group that the schools are already overloaded with information. The use of pamphlets as a means of promoting healthy messages was also discussed by more than one of the focus groups. On the whole pamphlets were not considered effective in getting information to people:

> *And a leaflet is not really effective because people throw them out (Frank, Int.4, p. 14).*

The kaumatua group preferred to stay with the calendar as a means of getting health-related information into people's homes. It was visible, you look at it every day and it was also useful:

> *But the calendar you always put it on the wall (Cracker, Int.1, p. 14).*

The stakeholder group reiterated this theme and had a strong belief that the calendar was a very good medium for the delivery of their messages. This knowledge stemmed from feedback they had received from their community about the calendar.

4.4.4 The Pictures

The producers of the calendar made use of children's artwork to promote the key health messages to attract attention. It was through these pictures and the colours used that the calendar appeared to have impact and appeal:

> *The pictures are capturing (Crickey, Int.1, p. 1).*

> *I see the picture and the picture is sort of reminding us. Some health ranei (otherwise), what health is, don't forget it's, you know, some education is something maybe we're not aware of at that point and time. I look at the pictures, which are the first thing I look at. (Huinga, Int.1, p. 2).*

The children's pictures created much discussion amongst all of the groups, and there was a general agreement that it was effective in promoting the messages. The children's artwork was also a favourite with the stakeholder group as this excerpt suggests:

> *Um yeah I think my favourite part about it definitely the children's artwork (Abby Int.2, p. 4).*

One of the rangatahi made comment about one of the pictures with a suggestion that one of pictures had "angry bananas". That person thought this contradicted the kaupapa of the calendar. Despite this, the rangatahi group was in support of the children continuing to draw the pictures as this excerpt illustrates:

> *We wanna keep their pictures (Maui Int. 4, p. 8).*

The artwork not being technically correct was also commented on by a member of the stakeholder group, although this was seen as an advantage rather than a disadvantage:

> *I like the fact that the children's artwork isn't perfect and um that they sometimes accentuate things that we would probably think*

that wasn't terribly pc' (politically correct). You know like the one with the immunisation. He's just drawn great big dirty needles that the nurse is holding. But that's quite good to see it through the child's eye and the children have even got tears coming out of their eyes (Camellia, Int.2, p. 4).

These general feelings of continuing with the children drawing the pictures were similar throughout each of the other focus group interviews. Discussions took place as to what age group should be drawing the pictures, as in the 2004 calendar it was mostly primary school aged children. One person in the play centre interview suggested sharing it with another age group. Another person was interested to know how the children were selected to draw the pictures. She liked the involvement of the high schools as well.

There were comments made as to the additional value of the children's artwork apart from being aesthetical pleasing and eye catching. These comments came not only from the stakeholder group, but from several of the community groups as well. The advantages identified mostly related to the knowledge gained by the children from their involvement in the health-related drawings. Some of the respondents also thought these children, through their artwork, might encourage parents to take more notice of the messages, especially if their children understood the health-related messages. One of these comments is as follows:

Waking a few parents up too I think (Maurice, Int.3, p. 3).

The stakeholders identified the value in the pictures drawn by the children as the most appropriate medium to convey their messages:

I think that large parts of the community identify with because of the pictures which have been drawn by the children they seem to draw you in to want to make to want to look at it (Whangai, Int.2, p. 30).

Another issue identified by a parent from the kohanga reo group that wasn't mentioned by any of the others was lack of older persons in the calendar. Interestingly the kaumatua group did not make mention of this apparent lack of older person input. There was however a photo of an older person advertising Disability Awareness Week, the only feature page not drawn by children. The kaumatua did not comment on this.

The rangatahi group was able to identify quite clearly that the pictures and messages were linked, as was the main picture with the key theme that linked with the sponsor of the page. They were also able to link the messages throughout; the example shown is that motorcycle accidents lead to disability and disability had their logo throughout the calendar. Some respondents saw the pictures as more than just pictures. This, of course, was the intent of the producers of the calendar as a medium for the transfer of information. To sum up the advantages of using pictures, especially for Maori, is this comment made by one of the kaumatua:

> *The pictures, they tell you the story (Huinga, Int.1,p. 2).*

4.4.5 Sponsorship

The sponsorship theme arose from the discussion around who sponsored the calendar as well as who should be sponsors. The cost of the calendar was understandably discussed at length in the stakeholder interview. This cost was more than the financial cost from each contributing organisation, but the time cost of finding sponsorship. The stakeholders, while acknowledging these costs were large, believed the benefits to the community far outweighed the costs:

> *It's just such a cost-effective way of getting key messages out to such you basically well it is the whole community. There is I don't think there's actually any other way (Camellia, Int.2, p. 4).*

> *I'd say probably the biggest disadvantage, is time. It is a very time consuming process for the coordinator mainly, but also*

for the other people involved for all those reasons. I mentioned before each step of the process takes a lot of time (Abby, Int.2, p. 7).

With this financial and time burden, came the pressure from the hierarchy of each contributing organisation, in how the money was being spent. This lead to a discussion on whether the money should go into health promotion or should it be used on client care:

For me time, plus the shrinking dollar. For charitable and volunteer organisations, our committees and trusts are bearing down, wanting so see their money go into treatment and support than health promotion. Many organisations are having to look at the dollar and say; well others do that promotion (Survivor, Int.2, p. 7).

The rangatahi group in particular were very aware that the calendar was free to everyone in Tairawhiti. The other respondents in the other groups did not pick up this fact though:

I like that it's free for everyone in the Gisborne region (Frank, Int.4, p. 7).

There was a great deal of discussion on the financial sponsorship from Pub Charity. Pub Charity is a gaming machine society whose purpose is to relieve poverty, advance education or religion and benefit the community (Pub Charity, 2003). The funds are usually distributed to the area or region in which they were made. The calendar committee members sought a large amount of funding from Pub Charity. This created a huge ethical dilemma resulting in discord amongst committee members in terms of what they were promoting:

I'm sorry, I just want to add that one of my ethical dilemmas in this day's world is when we do something like this, we have to look at funding and much funding now comes from gambling, alcohol. And I know myself I have this huge moral dilemma that is

> *opposite, it's polarising what we're trying to do (Survivor, Int.2, p. 8).*

This discussion was also opened up to the community groups as well. Most of these respondents were aware of what Pub Charity signified. Most of them had an opinion on the use of Pub Charity money. For some initially, this was a conflict of interest with the calendar, this created much discussion.

> *It contradicts itself so are we doing that by accepting sponsorship from Pub Charity? (Frank, Int.4, p. 10).*

As the discussion progressed this use of funds was justified:

> *I think it's just a means to an end (Frank, Int.4, p. 10).*

> *Yeah but like Pub Charity being a gambling thing. And the people go there to put their money into the machines. This might be their kind of way of paying back to the community by sponsoring (RnB, Int.4, p. 11).*

Discussion also arose as to the use of the Pub Charity logo on the calendar. This was a requirement of the grant and was placed not only at the back of the calendar but also featured on every picture page. It was placed in the pinhole site. The rangatahi group was the only group of participants who noticed this logo in use:

> *It's in a spot where you put a pin through or something so you cover it up (Frank, Int.4, p. 12).*

Discussion also took place with the rangatahi group as to whether people would be willing to pay for the calendar:

> *I'm not sure. I don't think they would pay for it. Some people might because a lot of people like those calendars. But I don't think many people would want to pay for it (Carmen, Int.4, p. 11).*

Further discussion took place with the stakeholder group on who should or could sponsor the calendar. This included support for and against the use of a major funder or sponsor:

> *I would like to see the calendar have some major funders. I think if that happened, we could actually, maybe in terms of time, in terms of energy put into fundraising. That would be a very good thing and would probably ensure the survival of the calendar (Abby, Int.2, p. 12).*

> *A note of caution for major sponsors, every time we do this we lose I wouldn't say control, we lose our input. Every time you ask a major sponsor to do something you recognise that it'll have to be theirs that's in front because we do it on a shoestring and that's the positiveness of it. I don't want to see a major sponsor. I would just like to see the organisations that are involved see it as part of their budget (Survivor, Int.2, p. 12).*

The rangatahi group responses correlated with the behaviour of that particular age group, when they offered some good suggestions including selling dates for people to advertise their birthdays:

> *I think we should do that once people you know have their twenty-first birthdays (Jaz, Int.4, p. 14).*

After much discussion on this topic and after processing this thought a few problems were identified with this concept:

> *Well why if people are all trying to buy the same date then who does it go to first? (RnB, Int.4, p.15).*

4.4.6 Keeping it Local

Keeping it local was a theme that came through quite clearly throughout all the interviews. Most of the community participants related this to the children who drew the

pictures or the schools involved in the artwork. These children were known to some of the respondents. The sense of pride some of them felt indicated keeping it local was important:

> *Cool, because my nephew, my nephew had a picture in there and it was hey my nephew did that and it was like big smile (RnB, Int.4, p. 15).*

For the kaumatua group especially, local was seen as important beyond the children's artwork:

> *Local is good. Like seeing what we know, you know, local is good (Rima, Int.1, p. 12).*

There was also a sense of pride in the mention of local place names for the kaumatua group and in the advertising of local horse sports on one particular date on the calendar. Discussion arose as to how those place names were used. One of the kaumatua spent a great deal of time talking about the correct place names. This in itself identifies the value and input from the community for future productions of the calendar.

The schools that participated in the healthy message drawings were noticed by many of the community group respondents. Some especially enjoyed and believed in the value of the children having their name printed on their picture. This had an impact indicating that this was quite a powerful influence on the acceptance of the calendar. One participant from the kaumatua group felt proud with the drawings in this year and the last year's calendar as they had artwork from local Ruatoria schools from up the East Coast where she lived. She summed it up by simply stating:

> *I feel proud (Huinga Int.1, p. 11).*

The stakeholders also held a belief that a locally produced product was important. It was suggested that many of the Ministry of Health pamphlets and brochures failed to reach their target audience in Tairawhiti because they weren't local. Keeping it local was a

deliberate ploy on behalf of the Maramataka committee to assist in reaching their target audience:

> *Adding to that, one of the biggest benefits is showing the country that locally produced resources work far better for your organisation than do nationally produced ones. Not that I'm decrying them, but each provincial place, each region, especially provincial places such as rural the small urban outlook because we are a rural community. In this place you have to really get back down to your people and what they do and their view of things (Koru, Int.2, p. 6).*

The stakeholder group identified that individuals, as well as businesses, used the calendar. This appeared to be important to the stakeholder group. The calendar's distribution and use throughout the community was apparent to the stakeholder group participants.

4.4.7 Community Involvement/Relationships

Following on from the 'keeping it local' theme appeared a core category identified as community involvement/relationships. Part of the importance placed on relationships was, with the makeup of the population of Tairawhiti, the use of Maori translations throughout the calendar. It wasn't only the fact that the dates for example, were translated, it was also the type of translations used. The Maramataka committee made a concerted effort to get these translations correct. While the Maori language exists in its entirety there is a variation of words that, while it might be a word for one tribe, is not the word used in a tribe from a different region. It was because of this the Maramataka calendar committee sought advice from local kaumatua, and had the translations carried out professionally by a local translator. This use of Maori translations was commented on throughout each of the five interviews, and despite some suggestions for improvement in this, the response was overwhelmingly positive as this example illustrates:

Nga korero Maori nga mahi o nga tamariki hei apopo ka tu hei rangatira (The writings in Maori language, the work, encouraged and displayed, those of the children, so that tomorrow they will take their right place as leaders). There is your Maori there, those who are learning Maori can use that and read it from the calendar, the Maori language through um that's a good one. Kei te pai katoa (that is good) (Huinga, Int.1, p. 3)

The younger rangatahi group did not oppose the use of the older Maori translations. However, they did propose that the modern version also be present. This was most likely related to knowing what was taught at school and/or was familiar to them:

Maybe have the other Maori month maybe. As well as like Hanuere for January, instead of Poututerangi (Maui, Int.4, p. 8).

As identified in the project plan the stakeholder group deemed the bilingual messages as very important. It appears a lot of effort on their behalf went into making the calendar more acceptable for the people for which it was intended. It was about honouring the Treaty of Waitangi as well as encouraging the calendar to have more meaning for the people of Tairawhiti:

Ah the other thing for me was listening and watching people in my great age wanting it to have bilingual input and so when I work at a table sometimes of all Maori or pakeha middle class people with their organisations wanting to give the community that look of equality in some way in that calendar (Survivor Int.2, p. 5).

Several of the participants from the kohanga reo parent group identified the importance of the calendar as being for both Maori and non-Maori:

Ah well it says the Maori and the pakeha. Anyway it's all about tamariki yeah and health that is a big issue these days is the kids and the tamariki (Maurice, Int.3, p. 1).

Not only were translations seen as important, but also the Maori artwork/design. The documentation review identified that the Maramataka calendar committee, in the development and production of the calendar, actively sought community input. For some of the community groups this seemed to have been achieved, while for other groups more community input was required:

And it would be nice to have more community support in the calendar and I think with things like these focus groups and that, that could be achieved (No 4, Int.5, p. 4).

Maybe take it to the maraes – they can be involved then (Rangahau, Int.1, p. 16).

The community participants made suggestions as to how the community might further be involved in the calendar project most of which understandably related to their area of interest:

You may be able to choose one from each kohanga 12 months in a year. Select every kohanga that you have in Gisborne (Pepi, Int.3, p. 4).

The discussion included who were currently supporting the calendar and how this could be extended. One particular representative from the rangatahi group thought there needed to be more representation from the lower socio economic groups. When asked how the committee could access these people his answer was:

Just on the streets. Hang out at WINZ (Frank, Int.4, p. 17).

The spin offs for the stakeholder group in working together appeared to be extremely positive. The opportunity this project provided for networking, for strengthening existing networks and working together towards a common goal. The strengthening of networks, also identified as one of the projects objectives, was about working closely with other organisations as these inserts indicate:

And I think the next benefit of it was actually working together at ground level, We've done a lot of things together and each time we work together it can only strengthen our community and strengthen our resolve to get that working together push it further up the ladder (Survivor, Int.2, and p. 5).

And it really strengthened networks having a project that a lot of organisations were involved in it strengthened networks and therefore strengthens information sharing and services delivered to the community (Koru, Int.2, p. 5).

Along with the team approach, it was also about the sharing of information with each other:

Ah I think it's all that team approach you know together each achieves more and um for me I learnt a lot about what other organisations do through their contribution and I think we've made connections for other things that we've go onto do (Camellia, Int.2, p. 6).

4.4.8 What People Think of the Calendar

Another aim of this research was to identify the meaning of the calendar for, not only the community focus groups, but also the stakeholders who were part of the calendar development. Consistent with qualitative research is the attempt to capture the meaning or perspective of something (Minichiello et al., 1999). When asked what the calendar meant and how it was useful to each of the community groups the responses were varied and interesting. For some it related to the calendar purpose:

Most useful. Educational (Huinga, Int.1, p. 4).

Yeah its been useful cause you know what date it is and month and the Maori too and in te reo Maori too the days and the months (Maui, Int.4, p. 2).

The rangatahi group summarised the meaning of the calendar in a few words:

It's beautiful (Maui, Int.4, p. 4).

It's educational. It's insightful as well (Frank, Int.4, p. 4).

The kaumatua's summary of the meaning of the calendar was also expressed succinctly:

The calendar is nice (Crickey, Int.1, p.14).

The stakeholder's belief in the usefulness of the calendar was evident in their efforts to achieve their goal of the calendar being a tool to get health-related messages into the homes of most people in Tairawhiti. This desired effect was evident from the kaumatua group interview:

But the calendar you always put it on the wall (Cracker, Int.1, p. 14).

You see it every day. This here you look at it almost just about every day (Tawhaki, Int.1, p. 14).

The play centre parent group talked in terms of what they liked about the calendar and what they found useful:

I like how it's got the holidays in here, it's handy. Very informative and easy to read. I like the messages on each page with the pictures and I don't think I dislike anything. I like, I really like the calendar (Mary, Int.5, p. 5).

But I do love the colour and the community messages that are involved and it would be nice to have more community support in the calendar and I think with things like this focus group and that, that could be achieved (No 4, Int.5, p. 4).

Other accolades from the play centre parent group included the use of good quality paper, seeing the children who draw the pictures names included, and having the wording and letters big enough for people to read without their glasses on. The kaumatua group especially identified the calendar as an educational tool for children. It didn't seem to matter whether this learning was derived from drawing the healthy messages or the medium by which those messages were delivered:

> *You can start from here with the pictures. And the kids look at the pictures too. It's easier to teach kids, I think, by looking at the pictures than trying to teach them how to read (Tawhaki, Int.1, p. 2).*

For some respondents it was their children who enjoyed having the calendar up in their home:

> *Yeah this particular one here I've always had at my children's level rather than at adult height its at the child height. And they've even at times been taken off and put in the magazine rack and read or used so the children do refer to it a bit like a book (No 4, Int.5, p. 13).*

The usefulness and advantage of the calendar as a tool to deliver messages was evident in the request by the facilitator for a few words to summarise what they thought of the calendar. This is the feedback from the kaumatua group:

> *It is good – very good (Huinga, Int.1, p. 15).*

> *It is excellent (25, Int.1, p. 15).*

> *I would give it a 10 (Tawhaki, Int.1, p. 15).*

The sense of pride the stakeholders group had in their involvement in the production of the calendar was evident throughout their interview:

And I would say there is a certain amount of pride involved for all of us who were involved in putting something together and after three years seeing that its working (Koru, Int.2, p. 5).

The feedback the stakeholders have received from the community and their clients was on the whole positive. It was the reason behind their continual involvement in the calendar project:

Um, positive for my client base. We have had, because we cannot knock on the door and say what we do because of the grants, that we've had a lot of feedback from people who have seen the logo on the calendar and realise they could get in touch with us or ask somebody about it. So the feedback is, is been really positive about how they got to know things (Survivor, Int.2, p. 8).

I've had people say to me that they look forward to it coming each year because they've become accustomed to the format. And I think it is initially, for a lot of people, especially businesses that they are able to write in the squares (Koru, Int.2, p. 9).

I've heard that some of the Early Childhood Centres and the preschools like the fact that it highlights the special weeks of the year like Well Child week or some of the other weeks that we have. Mental Health week and things like that and they often use it when they know its coming up to fit things in to the curriculum for the children and plan for Well Child week (Camellia, Int.2, p. 9).

It wasn't only from the local people that the stakeholders received feedback. Most members of the Maramataka calendar committee aligned with health related organisations outside the district. The feedback they received from these national contacts were positive:

I've shown people this from other areas, other people who do the same work as me in other areas and they're just blown away by it.

They just want to know how we did it and are really quite jealous that we had such an amazing calendar to give the community and just wished that they could do the same as us (Abby, Int.2, p. 6).

For one of the stakeholders it was being part of something for the community that created the most satisfaction:

It gives you a feeling of being part of something. Part of the community because you know the people have done it or the children have done it the school that's done it you know you've been part of it (Survivor, Int.2, p. 3).

Another attraction for being part of this calendar team was related to providing something to the community in which they serve:

The fact that it was going free to the whole community even though it meant fundraising but the fact that it was going to be free to all those households there was no cost to them (Koru, Int.2, p. 2).

For another stakeholder it was the knowledge and skill she had gained from being part of a health promotion project, especially one on such a large scale as the calendar was:

For me one of the other benefits of being involved um certainly in the initial stages and for the next couple of years is just that its such a big learning curve being involved in producing a resource of this magnitude (Abby, Int.2, p. 6).

When the stakeholders were asked if they would be part of the calendar production again if it were to continue their responses reflected their belief in what they were doing:

I would definitely. Yep sure would (Abby, Int.2, p. 16).

Of course I would, it is such a good way to get information out there. I just love being part of something that is so useful and important to the community (Camellia, Int.2, p. 16).

The findings from the focus group interviews, as well as the processes identified from the documentation review provided the information to determine whether the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project achieved the objectives it set out to achieve. The assessment against the objectives follows next.

4.5 Calendar Objectives

Objectives are the more specific statements about what is to be achieved through a project, what the project intends to do and what opportunities the project will provide (TDH, 2000). An important feature of impact evaluation is assessing the extent to which the project met its objectives by the strategy put in place to meet them (Hawe et al., 1995). The health promotion project 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' under evaluation had clear and specific objectives as set out in the project plan. Each objective was written in the order they appeared in the Maramataka calendar project plan (Appendix 10).

4.5.1 Objective one: *To provide a vehicle for the delivery of healthy messages to the whole community especially those that are deemed to be 'hard to reach' – an all year round 'in the face' promotion.*

This was met with the calendar being delivered to almost every household in Tairawhiti. While it appears there were a few delivery hitches, considering the number of people who received the calendar, it can be assumed that the majority of people in Tairawhiti who could be considered 'hard to reach' received a copy of the calendar. The calendar was effective in the delivery of health messages as recognised in the focus group interviews. Participants were easily able to identify the health messages advertised. The calendar being in use in homes enabled 'all year round in the face' promotional health messages.

4.5.2 Objective two: *To involve community groups in the planning, production and design of the calendar.*

This objective was partially met. From the documentation review it was apparent a lot of effort went into inviting all health-related community groups to participate in the calendar project. Initially the uptake of this offer was minimal. As the calendar project continued each year, the number of community groups participating increased. The opportunity for further participation was evident by the advertisement at the back of the calendar inviting interest in the project for the following year. However, the processes used to invite community participation were not as effective as they could have been. This was evident with each community focus group indicating that had they known they could have participated in the project, they would have. While consultation occurred and participation actively invited, the number of Maori on the Maramataka committee was minimal. To the committees credit this lacking was recognised and advice and participation sought by other means, for example seeking of advice on the Maori wording. It was identified that a local Maori health provider was actively involved in the original committee for the first year of the calendar production. While this did not continue, it did allow for more Maori input in the initial designing of the project.

4.5.3 Objective three: *To provide an opportunity for members of the community to have a vehicle to deliver 'their' health message to the whole community.*

The calendar was the vehicle to deliver the message. The opportunity to partcipate was made available for any community group to advertise their message. This might not have been known as widely as it should have been, as identified under objective two.

4.5.4 Objective four: *To provide a forum for people to have ready access to important community health and social service contact details.*

The findings from the community group interviews indicated the calendar provided information as to how members of the Tairawhiti community could contact agencies should they need or wish to do so. For example, the school dental service advertisement included a phone number for people to phone in for an appointment. Along with contact details provided on every month there were prompts to encourage people to access these services. Anecdotal evidence given to the stakeholder group indicates improving access was one of the most successful outcomes of the calendar. On the second to last page of

the calendar key community contact details were provided for example, Relationship Services. All groups that were part of the project advertised their involvement on the last page of the calendar by the use of either their logos or the mention of their group.

4.5.5 Objective five: *To provide a calendar for people to mark health and other important appointment dates in.*

For most of the focus group respondents this was achieved. For others the calendar was too 'cluttered' for them to write on. This created problems for mostly the older respondents who felt there was no room left for them to write their important appointments in. It became apparent throughout each interview that this was the biggest disadvantage in the format of the calendar. It appears that the dates being 'sold' to help finance the calendar meant many of the dates held an advertisement of some sort.

4.5.6 Objective six: *To inform the public of special dates such as Heart Week, Deaf Awareness Week, SID's Awareness week etc.*

This objective was achieved. Not only were these dates written in the calendar but some of the weeks were highlighted as well. These colours were the acknowledged regional and national colour themes to promote the respective weeks. To illustrate, the Mana Wahine week is highlighted in mauve and Well Child week highlighted in blue.

4.5.7 Objective seven: *To involve local children in the production of the artwork that will be used to deliver the health messages for each month of the calendar.*

Involving local children in the artwork was one of the key features of the healthy messages calendar. Focus group participants identified that the pictures named each child who created the artwork as well as their contributing organization.

The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project achieved all but one of the objectives it set out to achieve and that was partially achieved. If the objectives are the indicator of the project effectiveness then the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project was effective. While determining if the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project achieved the objectives set out in the project plan is a vital step in the evaluation, it was also considered important that the project encapsulated the principles of the Treaty of

Waitangi. To ascertain if this was achieved, the project was evaluated against the whare tapa wha model of Maori health as identified by Durie (1994a). There needs to be an understanding of the application of the Treaty of Waitangi in health promotion practice in New Zealand (Health Promotion Forum, 2002), the Treaty is implicitly associated with perspectives on health and well-being.

4.6 Whare Tapa Wha

In New Zealand there is an ever-increasing recognition of culture as a determinant of health (Health Funding Authority, 2000). The whare tapa wha model (also known as the four cornerstones of Maori health) compares hauora (health) to the four walls of a whare (Maori ancestral house). Each wall of this whare represents a different dimension of health. Maori health is dependent upon the equilibrium of all these dimensions (Health Funding Authority, 2000). This holistic model views health as an interrelated phenomenon rather than an intra-personal one, this being consistent with how the Maori perspective is integrative not analytical. The whare tapa wha model of Maori health (Durie, 1994a) requires health to be understood in the context of the social, economic and cultural position of Maori (MOH, 2003b). Individual health has its boundary blurred between personal and family identity (Durie, 1994a). For any health promotion project to be successful these concepts need to be incorporated throughout.

The calendar promoted wellness at every level by, not only providing health messages, but also encouraging access with the inclusion of contact details. A further relationship of the calendar with the whare tapa wha model of Maori health is in the promotion of te reo and the calendars appeal to the Maori people in the Tairawhiti region. It was evident from the focus group interview; with the kaumatua and kohanga reo groups especially, that the calendar was appealing to Maori. The pictures assisted with this, not only because they were drawn by local children, but perhaps more importantly, as pointed out by one of the kaumatua, that Maori prefer to look at the pictures. The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' was, in part, bilingual with headings and key phrases having been translated. The bilingualism promoted te reo while providing a language educational tool. It also included the Maori names for the months of the year. Maori advice and consultation was obtained to ascertain the correct wording to be used

in the calendar. The community groups perceived these translations very positively with much discussion within the focus groups around the importance of the bilingualism for both Maori and non-Maori. The bilingual messages were important in honouring the Treaty of Waitangi as well as encouraging more meaning for the people using the calendar.

Taha tinana or physical well-being is the physical body and represents growth, development, the ability to move and ways of caring for the body. Taha hinengaro or mental and emotional well-being represents coherent thinking processes. It also encompasses the acknowledgment and expression of thought, feelings of belonging, compassion and caring as well as social support. Taha whanau or social well-being represents family relationships, friendships and other interpersonal relationships. Taha wairua or spiritual well-being represents the values and beliefs that determine the way people live. Taha wairua also encompasses the search for meaning and purpose in life as well as personal identity and self-awareness (Durie, 2004). Taha wairua is considered by some as the relationship with whakapapa (genealogy), tangata whenua (people of the land), taonga tuku iho (inheritance), te reo (the language); all those elements necessary to Maori wellness need to be present (T. Takarangi, Personal Correspondence, 8th June, 2005). The following subsections examine how each of these cornerstones of health were addressed by the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project.

4.6.1 Taha Tinana

The way the calendar relates to the 'whare tapa wha' model of Maori health was evident by the way it encompassed many aspects of everyday life. The physical health issues are clearly promoted throughout the calendar as indicated by all of the respondents who were easily able to identify and relate to these key messages. The stakeholders identified that the calendar was designed as a discussion point for families to talk about health issues.

4.6.2 Taha Whanau

Taha whanau or social well-being was evident from the effort made to involve families throughout the calendar. Most participants identified the whanau concept in the calendar

and positively commented on this. This was illustrated in the comments made from a te kohanga reo parent group interviewee that stated: *"I reckon it's a good thing for our parents to learn within our own whanau, I think this calendar is relevant to us Maoris especially." (Petal, Int.3, p2)*. The calendar appeared to have been enjoyed by old and young people alike. This whanau concept of holistic health and social well-being is further evidenced with the identification from community participants in the school communities and the students producing the artwork depicting Tairawhiti landmarks, seasons, people and their environment. That the project noticeably involved schools and wider community groups meant the project incorporated the wider whanau concept.

4.6.3 Taha Hinengaro

Taha hinengaro or mental and emotional well-being was indicated by the holistic approach the calendar had in promoting positive health messages. From this, the focus group participants identified communication and encouragement for self-control and self-direction. The helping agency page at the rear of the calendar supported services related to emotional well-being such as help lines and support services. Taha hinengaro was also evident from the stakeholders who were able to grow not only as a collective but also as individuals. This extended to the individuals and groups involved in the artwork.

4.6.4 Taha Wairua

Taha wairua or spiritual well-being is generally felt by Maori to be the most essential requirement for health. Without spiritual awareness an individual cannot be healthy (Durie, 1994a). The stakeholders, as indicated by their passion about the calendar project, were just as passionate about the community in which they serve. It was through their knowledge of their community that the importance of the language was recognised and that the people of the land held great importance. While Maori input was not as in-depth as it possibly could have been, it was apparent that this was a new way of working for many of these community groups. It was a stepping stone from which further growth could occur. It encapsulated a view of the need for health service to incorporate taha

Maori that potentially could flow over into other aspects of each organisation's ethos for working with Maori.

4.7 Summary

This chapter began with a presentation of the results from the documentation review. The demographic data obtained from each of the community focus group participant was then outlined, followed by the presentation of findings that were derived from the five focus group interviews. From the information gained from both the documentation review and the focus group interviews, an examination was undertaken to determine if the 'Healthy Messages Calendar (Te Maramataka Hauora)' project met the objectives stated in the project plan. Determining if the objectives were met is considered important in impact evaluation (Hawe et al., 1995). An evaluation of the project against the whare tapa wha model of Maori health was then offered as a commitment to honouring the principles of the Treaty of Waitangi. The next and final chapter presents a discussion of the findings.

Chapter Five: Discussion

5.1 Introduction

The aim of this study was to conduct impact evaluation on the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'. The researcher was interested in what the short-term effects of the programme were, what participants thought of the calendar and what improvements could be made to improve the calendar acceptability. Several sources of data were obtained to answer the research question. A review of the calendar project documentation was carried out and qualitative data obtained from five focus group interviews. Demographic data were collected from four of the five focus groups. Data were then systematically analysed and the results presented in chapter four.

This chapter begins by discussing the improvements to the calendar as offered by the focus group respondents. Following this, the health messages and the use of the calendar as a health promotion tool are then presented. Both of the above points are underpinned by, and discussed in relation to, the social marketing theory of health promotion. Several models of health promotion theories on media communication have been proposed (Nutbeam & Harris, 2004). The social marketing theory was the most appropriate to link with the results. The relationship of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project to the social marketing model is in the social marketing practices that were applied in the development of this project. Next, sponsorship issues and the community relationships that developed from the inter-sectoral collaborative community approach of the calendar project are discussed. The whare tapa wha model of Maori health, the tool used to assess the projects responsiveness to Maori, has then been juxtaposed with the literature relating to communication with Maori. The contribution to nursing knowledge, research and practice are discussed along with the limitations of the study. Finally, the recommendations for future research are offered before ending with a concluding statement.

5.2 Improvements

Because of the lack of funding sources, the Maramataka calendar committee members felt pressured to sell dates on the calendar in order to finance the project. This resulted in the focus group respondents identifying the calendar as being too 'cluttered', thus potentially reducing its effectiveness. The respondents suggested a bigger calendar as a possible solution. The reason given for this increase in size in the calendar was to retain the information currently provided. The layout and design, including the spacing of printed materials can be an important determinant as to whether a person will read them (Griffen et al., 2003; Keller & Brown, 2002). In addition, the message must be clear and in a language, image and style that fits the expectations of the proposed users (Bond et al., 1997; MOH, 2000; MOH, 2003a; Robinson, 1992). For a health promotion project to be effective, similar audience assessment tools used in commercial marketing need be applied (Lefebvre, 1997). In social marketing the strategy is based on identifying consumer needs (Neiger et al., 2003; Nutbeam & Harris, 2004; Sidell, 1998).

Important to social marketing is the placement of a product in finding high access points for the priority population (Neiger et al., 2003; Nutbeam & Harris, 2004). Feedback indicated some households either had not received a calendar, or had been unaware what the calendar was. It was thought the timing of the delivery of the calendar might have caused households to throw away the calendar thinking it was 'junk' mail as opposed to the calendars not being delivered. This was one of the supporting factors for the stakeholders wanting to change to a June-to-June calendar to prevent the Christmas mail out confusion, whilst supporting the Maori New Year known as Matariki. It is suggested by the MOH (2000) that a covering letter should be written which summarises the purpose of a resource. This prevents the resource being jeopardised by not having sufficient information as to its intent. The promotion of a product in social marketing is also considered important to facilitate the message delivery (Nutbeam & Harris, 2004). In addition, the packaging, colour and label help the consumer identify the product and determine if the product will stand out (Blythe, 2000; de Chernatony, 2001; Kelly, Slater & Karan, 2002).

Apart from the inclusion of the phases of the moon in the calendar, no further improvements were suggested. This may have been due to the concept having been pre-tested with randomly selected members of the Tairawhiti community prior to production. It was from this pre-testing that the key messages in the calendar were determined. It also enabled the planned format of the calendar to be confirmed including the use of the children's artwork and colour schemes to convey the key messages. Pre-testing firstly tests the characteristics of the audience and their needs (MOH, 2000; Zimmerman, 2003). Secondly, pre-testing tests the content of the programme and its mode of presentation (Sidell, 1998; Zimmerman, 2003). Research and evaluation are used to assist in the marketing decisions (Hague & Jackson, 1999).

5.3 Health Messages/Health Promotion Tool

The multimedia and other new technologies are beginning to offer new tools for the dissemination of health information (Catford, 1997; Naidoo & Wills, 2000). However, clear communication between health promoters and those they are trying to influence is essential (Jones & Cribb, 1998; Nutbeam & Harris, 2004). This communication can be at an individual level or through the development of mass campaigns. The aim of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)', a mass campaign, was to target those considered most 'hard to reach' who are generally those in the low socio-economic groups. How to reach target audiences with these messages, products, and services should be a constant consideration in health promotion (Lefebvre, 1997; Sidell, 1998). In order to locate the 'hard to reach' the calendar was delivered to every household. This was sensible considering the low socio-economic status of Tairawhiti with pockets of poverty throughout. Reaching the 'hard to reach' audience occupies a great deal of attention in health promotion. So much so that health promoters need to spend more time studying what 'hard to reach' people do, to learn from them and then use it to the health promoters advantage (Lefebvre, 1997).

The concept of having the opportunity to look daily at a health-related message was one of the key objectives of the calendar project. The calendar equates to the product in social marketing terms. The consistency of the message getting 'stuck into minds of people' in an attractive format was what appealed to the stakeholder group. This was also

identified by several of the community participants, the constant reminder acting as a prompt to phone in for an appointment with the advertised provider. Overall, the feedback from the community indicated the calendar was a very powerful tool to remind people of health issues and provide contact details to improve access. Without an understanding of the audience or the consumers, the product may end up without meaning or value (Neiger et al., 2003). The notion is that the consumer is central to all aspects of the marketing process (Jones, Katz & Sidell, 1998; Sidell, 1998). Therefore, resources produced in consultation with the priority group can increase the chances that the resource will be supported (MOH, 2000; MOH 2003a; Nutbeam & Harris, 2004). As a social change tool, social marketing can influence attitudes and behaviours.

The influential effects of the children's artwork increased acceptability of the Healthy Messages Calendar (Te Maramataka Korero Hauora)' project. The artwork was identified by most of the focus group respondents as being a key feature of the calendar. Awareness, liking, interest and enjoyment are considered important elements of commercial marketing (Blythe, 2000). The children's artwork was not discussed as much by the rangatahi group as it was with the adult group participants. It may not be because it was of more or less value, but more related to the age and social world of these respondents. This reinforces the importance of understanding and ascertaining the needs of the consumer to communicate with them (Jones et al., 1998; MOH, 2000; Neiger et al., 2003; Sidell, 1998); a key step in commercial marketing (Griffen et al, 2003; Blythe 2000).

The Maramataka calendar committee attempted to brand the product by using the same logo, colourings, type set, headings, and layout for each of the three years it was produced. Purple was one of the two key colours in the Healthy Messages Calendar (Te Maramataka Korero Hauora)', the other colour was blue. The colour purple formally associated with royalty confers an upmarket image (Blythe, 2000). While the distinctive purple and blue created the scene for the calendar, the colours also created a problem for two of the respondents. In addition to the colour, a distinctive logo was developed and used. The label on the calendar was bold and clearly identified the product and contents. Labelling is also used in marketing to denote the information printed on the packaging and is an important part of marketing communication (Blythe, 2000; Kelly et al., 2002; Zimmerman, 2003).

The Healthy Messages Calendar (Te Maramataka Korero Hauora)' provided something physical that the people in the community required and could use. Its usefulness was important. It was also considered an opportunistic teaching tool for children. For example, the use of the children's artwork provided a mechanism for parents and others to talk about health related issues. It was more than educational; it was considered 'beautiful' as well as 'insightful' by one member from the rangatahi group. It was viewed every day by most of the respondents, the messages then a constant reminder of the issues promoted on that page. While respondents were encouraged to offer other means of disseminating health information into the community, most preferred to stay with the calendar. This fits well with the concept of health promotion, a concept that is about empowerment and reinforces the notion of greater control and self-direction (Moewaka Barnes, 2000; MOH, 2000). Further, health promotion will have to be inventive and test a variety of new techniques in order to communicate with a community (Levin & Ziglio, 1997).

The calendar provided at no cost to consumers was definitely seen as advantageous by not only the community participants but the stakeholders as well. This free calendar was something the community appeared to readily accept into their homes. In social marketing the price is seen in terms of the monetary and non-monetary costs associated with adopting the behaviour (Nestor, 2001; Thorogood & Coombes, 2000). The price signifies the relationship between the costs and benefits of the product (Nutbeam, & Harris, 2004). These benefits may be real or perceived and are not restricted to fiscal costs but can include time, social, psychological, physical and/or opportunity costs (Guba & Lincoln, 1989). For the stakeholders, the time and effort spent in preparing the calendar for print, the effort required to access funding, the final result of the calendar far outweighed any disadvantages of their association with the Healthy Messages Calendar (Te Maramataka Korero Hauora)' project. It was considered by this group to be a very economical way to reach so many people at approximately $1.28c per household and carry so many messages for such a length of time.

5.4 Sponsorship

The sponsorship of the Healthy Messages Calendar (Te Maramataka Hauora)' project was of concern as evident in the stakeholder interview. Whilst free to the community, there were enormous costs associated with the production of the calendar. This cost was more than the fiscal amount but also in terms of the time, person power and effort required ensuring the calendar was of a high quality and met the objective set in the project plan. The securing of financial sponsorship was an enormous burden for the committee who spent most of the first half of each year seeking funds for the calendar to go ahead the following year. This burden of seeking funds caused the most frustration for the stakeholder group and some felt uncomfortable from where some of the sponsorship money was obtained. More financial resources need be put into such inter-sectoral projects to enable the formation and continuation of working relationships. This lack of financial commitment from government-funded organisations has a negative influence on non-government organisation participation (Sindall, 1997), and is not new for community development programmes (Boyce, 2002; Farrant, 1997).

A strong theme that came out of the stakeholder focus group interview was the ethical discord experienced by the stakeholders in the sponsorship of the calendar. Value conflicts arose among the stakeholders over the issue of Pub Charity sponsorship within the Maramataka calendar committee. The issue of financial sponsorship by Pub Charity, an organisation who gathers its funds from gambling machines (Pub Charity, 2003), was discussed at length in every interview. The ethical dilemma faced by the stakeholder group was the biggest cause of discomfort for this group; the stakeholder group remained divided on the sponsorship they received from this source. The division arose because of potential addiction and that gambling contributes to poverty (Griffiths, 1995; Taber, 2002). Problem gambling has recently emerged as a significant public health issue in Australia (Marshall, 1998) with growing concern that young adults represent the highest risk group for gambling problems (Griffiths, 1995; Marshall, 1998; Messerlian, Derevensky & Gupta 2005).

It was this potential for promotion of gambling and the effect this would have in a community such as Tairawhiti that was the cause of concern for the stakeholder group.

Without the Pub Charity sponsorship the calendar project would not have eventuated. The general consensus throughout the community group interviews however, indicted that while it might contradict what the calendar is about, or offer mixed messages; most participants thought the end justified the means. The community group participants did not appear to experience the same level of discomfort as the stakeholder group.

A further cause for unease with the stakeholder group was evident in the interesting discussion over the possibility of having a corporate sponsor. Sponsorship has been widely used in commercial advertising to influence people's perceptions of a product or behaviour (Dobbinson, Borland & Anderson, 1999; Newell, 2001). However, sponsorship is a relatively new tool for health promotion (Corti et al., 1997). Dobbinson et al. (1999) suggest, while less commonly used in health promotion, sponsorship does have the potential to be an effective tool in modifying social environments. There were both benefits and disadvantages associated with sponsorship identified by the stakeholder group. The benefits are obvious in terms of financial support. This potentially would reduce the time spent seeking sponsorship, which, as indicated from the documentation review and stakeholder feedback, was an enormous task. Some of the stakeholders would choose corporate sponsorship if there were a partnership match. A partnership match is a relationship with a company with sound ethical principles whose product 'fits' with the principles of the charity it supports (Pringle & Thompson, 1999). With the calendar's promotion of healthy choices a relationship with a fast food restaurant would not be a good 'fit'. Similarly this poor 'fit' could be seen in the Pub Charity sponsorship that was currently taking place.

The potential disadvantages from corporate sponsorship were identified as the calendar losing control or losing its localness if the corporation was a national or international organisation. This could be avoided by negotiating a contract that clearly set out the terms and conditions of the relationship. This contract could include who will lead the project, what financial and other support could be expected, the duration of relationship and what advertising or other return for involvement the sponsor is expecting (Pringle & Thompson, 1999).

Ethical discussion also occurred in the stakeholder interview around how the health dollar was spent. Some stakeholders felt the health dollar was mostly spent on personal

health in the secondary services rather than population health programmes such as the calendar. Purchases face a dilemma when, at the same time as current clients are waiting for treatment, they are being urged to commit resources to prevention (Godfrey, 1997). The price of the calendar to go to every home in Tairawhiti to promote messages and improve access was probably less than the price of some surgical procedures on offer in modern health care systems. Treatment only involves those who have the disease or condition, the cost more per individual. Prevention on the other hand, can involve large numbers who may or may not develop the disease therefore; the cost per individual is less (Godfrey, 1997).

In health promotion the Ottawa Charter is read as a statement of ethical commitment with the acknowledgement of social justice and equity as prerequisites for health (Norton, 1998; Sindall, 2002). Health promotion is about building a healthier society, empowering people and enabling their ability to make healthier choices and yet is faced with ethical dilemmas (Jones & Cribb, 1998). With society's increasing demand for attention to ethics there is a wide range of ethical dilemmas that health promotion needs to address (Norton, 1998; Sindall, 2002). Ethics are principles that serve as operational guidelines for individuals as well as organisations that help establish boundaries regarding acceptable and unacceptable behaviour (Clow & Baack, 2001). With no health promotion code of ethics to be guided by, ethical considerations will continue to be a source of anxiety for some health promoters. If health promotion is to take a leading role in responding to health inequalities there needs to be clarity of the ethical issues relating to it (Norton, 1989; Sindall, 2002).

Davidson and Novelli (2001) consider it ironic that ethics is an issue in social marketing when social marketing is intended to improve society. Social marketers, as with commercial marketers, often face the same ethical issues such as deception in advertising in a social marketing campaign. Likewise there are ethical issues in social commercial marketing that are unlikely to occur in commercial marketing (Smith, 2001a). It is generally agreed that social marketers need to have a stronger obligation to ethical practice than do commercial marketers (Kirby & Andreason, 2001; Smith, 2001b). By ensuring the programme is ethical reduces the risk that the programme goal will be undermined, or worse, doing harm to the target audience and secondary others (Smith,

2001b). This risk of harm has the potential to further disadvantage an already disadvantaged community such as Tairawhiti.

5.5 Keeping It Local

Keeping it local was a theme that came through as being very important, not only to the health promoters but also to the community focus group respondents. The pride the stakeholder group felt in producing a local resource, and their belief in the importance of local resources as more appropriate to local communities, were evident throughout. Community respondents also expressed pride in knowing some of the children who produced the artwork. There was an association not only with the people, but a place or an event advertised in the calendar. This is consistent with Simmons and Voyle (2003) who suggest that the messages need to be relevant and useful to the particular community. There is strong evidence pointing to multiple advantages of a locally produced resource (Conway, 2002; Huckle et al., 2005; MOH, 2003a; Simpson et al; 2003). As well, what works in larger communities might not work in smaller ones (Simpson et al., 2003).

The calendar had its own special place on the wall for some of the respondents; it was because of this that the calendar was thought by the focus group respondents to be most powerful in its acceptability. This association appeared very important to the Maori respondents in particular. This is supported by MOH (2003a) who suggest the collective ownership of a resource is important for Maori. However, assessing local needs and listening to local voices is not a simple matter according to Jones et al. (1998). Indeed, the central concern of social marketing in particular is the consumer, therefore the health promoter must be responsive to consumer needs, issues and unique situations (Lefebve, 1997). The needs of the market have to be identified and messages developed that will appeal to the market audience, as well as an examination of media channels to determine their effectiveness in reaching the targeted population (Naidoo & Wills, 2000). This knowledge comes from being part of, and knowing your local community.

5.6 Community Involvement/Relationships

An active process of empowering communities to deal with their own health issues is highly supported (Moewaka Barnes, 2000; MOH, 2000. The involvement of a community in the planning, development and implementation of a resource ensures the community's acceptability and lends to more effective health promotion strategies (Moewaka Barnes, 2000; WHO, 1986). This study illustrated that, in this instance, the practice of health promotion is shaped by a community context. From local health organisations, including non-government organisations, through to the input of the education sector, involvement in the calendar occurred at many levels across many organisations. While individuals and organisations bring their own interests and agendas to any collaborative ventures (Farrant, 1997; Sindall, 1997), this did not result in any issues for this project.

The willingness of health organisations to collaborate with groups and communities to promote health is supported by Germann and Wilson (2004). The efficacy of this campaign was evident in the positive effects of the collaboration, community involvement and the formation of community relationships from those working on the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project. The benefits of this approach were identified in the stakeholder interview where the relationships that were established from their involvement in the calendar project were numerous. Some of these benefits were seen in the increased awareness of each of the organisations involved, as well as in the sharing of ideas, resources and workload. The benefits extended to the calendar capturing multiple perspectives from a wide age range to numerous health issues. These spin-offs are considered valid endpoints for community development projects (Watson & Platt, 2000). For most, the only commonality was their input into the calendar. What this indicates are the benefits of more community ownership of health issues (Conway, 2002; Huckle et al., 2005; Moewaka Barnes, 2000; Simpson et al; 2003).

The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project can be regarded as highly effective in terms of the inter-sectoral relationships that developed as a direct result of the inter-sectoral involvement in the project. This approach was evident

by the community involvement that served to increase community ownership of the project. One of the principles of the New Zealand Health Strategy is to have active involvement of consumers and communities at all health service levels (King, 2000). Sindall (1997) suggests health promotion faces a paradox in the understanding of inter-sectoral collaboration for health. This is reiterated with the broad levels of knowledge about the meaning of community development (Robinson & Elliott, 1999).

Citizen action, voluntary participation, co-operation, collaborative problem solving, empowerment and the focus on holistic community-wide outcomes are components of community development identified by Lindsey et al. (2000). The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project enabled the stakeholders to experience all of the above components through their involvement. Participation on the committee was voluntary and there was strong evidence of collaborative problem solving and co-operation. The empowerment of the individual, as well as the group, was noticeable from the stakeholder interview. The community wide outcomes are portrayed in the relationships that developed because of each person's involvement. The close working relationship, the sharing of a common goal and the respect for each other and each other's organisation was also evident.

Another positive spin-off from stakeholder involvement in the programme was evident from the great importance stakeholders placed on the relationships that grew as a result of their involvement in the project. There was also a strong drive to gain more community involvement for future projects. There was also an opportunity to get more involvement locally as identified by the community interviewees. For example, it was offered that local kohanga reo and marae could support a page. This fits well with the principles of Treaty of Waitangi whereby Maori involvement in the calendar project brings with it a feeling of ownership (MOH, 2003a).

A point of interest that came out of the interviews was the fact that the stakeholders interviewed appeared to be 'in tune' with their community. Their responses to all the questions asked mirrored that of what the community group participants had to say. From the lack of space on the calendar dates and the 'cluttered look' through to the issue of sponsorship, their responses throughout each interview were very similar. Several assumptions can be made from this apparent stakeholder/community connection. The

first assumption could be that the stakeholders or members of the Maramataka committee were aware of the needs of their community from the feedback from their client groups. Secondly, the stakeholders were also members of that same community and therefore the everyday-lived experience in the Tairawhiti community were similar. This is indicative of the implementation of local community action strategies (Conway, 2002), highlighting the advantages of employing local people in local health promotion activities.

The stakeholder group was also very passionate about their community. Despite the effort required producing the calendar; the fiscal restraints, the frustrations and the sometimes lack of support from their employing bodies, these people truly believed in the calendar and the community in which they served. From this experience they were each able to grow as individuals and develop personal skills. Through their involvement in the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project their contributing organisations were reoriented towards a health promotion model of practice. The evaluation findings indicated the strengthening of community action. These are all health promotion actions as identified in the Ottawa Charter for health promotion (WHO, 1986), and consistent with Maori approaches to maintaining and improving well-being (MOH, 2000).

5.7 Whare Tapa Wha

The Maori Health Commission (1998) suggests that improving hauora Maori can be achieved through a community development approach that focuses on collaboration, education, creativity and co-operation between whanau, hapu, iwi and key mainstream providers within the health sector. The calendar project can be regarded as moderately effective in terms of responsiveness to Maori. This is evidenced by the assessment of the 'Healthy Messages Calendar (Te Maramataka Hauora)' project against the whare tapa wha model of Maori health. The integral philosophy to improve health and well-being ensured the calendar had the right 'fit' with its target community. This right 'fit' with the community ensured that the principles of the Treaty of Waitangi were an integral part of the project planning and development. This is consistent with the integration of the

Treaty of Waitangi into health promotion practice (Health Promotion Forum, 2000). Its importance intensified with the Maori health strategic direction (MOH, 2001a).

The principles of taha tinana, taha whanau, taha hinengaro and taha wairua were evident in the promotion of wellness at every level, from the physical aspects of health to the way the 'Healthy Messages Calendar (Te Maramataka Hauora)' project encompassed many aspects of everyday life. The relationship with the calendar to the whare tapa wha model of Maori health was also evident in the promotion of the Maori language and its appeal to the Maori people. Bilingualism, with the use of both the English and Maori language throughout the calendar, was expressed by many respondents as being very important for the Tairawhiti community in terms of recognising this regions cultural mix. As well as providing more meaning for this particular community, the use of bilingual terms suggested an honouring of the Treaty of Waitangi. This is supported by (Durie, 1994b; MOH, 2003b) who suggest te reo and culture have a central part in the communication process with Maori.

It is equally important that the language and images fit the expectations of the recipients and that accurate and clear messages are presented and promoted (Blue & Ihaka, 1999; MOH, 1997; MOH, 2003a). The calendar was appealing to the Maori focus group respondents, especially those in the kaumatua and kohanga reo parent group. An important consideration for Tairawhiti is that different cultural groups may benefit from different channels of communication (MOH, 1997). Maori prefer visual presentations (Blue & Ihaka, 1999). The calendar was indeed a visual health promotion tool and as pointed out by one of the kaumatua 'Maori prefer to look at pictures'.

It is recognised the most appropriate people to produce resources for Maori are Maori themselves (Health Promotion Forum, 2002; MOH, 2003a). It is also acknowledged that this is not always possible (King, 2000). At the very least the resource should be designed with input from Maori right from the start. The processes employed should encourage meaningful participation (Health Promotion Forum, 2002). It was identified that a local Maori health provider was actively involved in the original committee for the first year of the calendar production. While this did not continue, it did allow for more Maori input in the initial designing of the project. Maori involvement also occurred in the pre-calendar survey of which 47% were Maori (as identified in the documentation

review), whereby the issues to be promoted in the calendar were identified by the participants of this survey.

Unfortunately Maori participation in the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project was probably not as extensive as it should have been. Maori consultation had occurred but despite attempts to gain greater participation, the committee failed to engage significant Maori throughout every step of the process. Two key groups have been identified by (MOH, 2003b) in order to consult effectively with Maori: the groups using the resource namely the priority group and the providers. It is identified through the stakeholder and community feedback that this was probably where the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project needed improvement. There was however active participation from the East Coast schools; these schools had a predominantly high Maori population. This participation had occurred with all three calendars produced. However, it is acknowledged that whilst processes should be employed to encourage meaningful Maori participation, Maori might choose not to participate (Health Promotion Forum, 2002). If Maori do choose not to partcipate then the reasons for this need to be examined. Next is a discussion on how the information gained from this study could contribute to the knowledge base of health promotion and nursing.

5.8 Contribution to Nursing Knowledge, Research and Practice

The significance of this study to nursing is in the increased understanding of health promotion and health promotion evaluation. The need for high quality research to provide evidence of effective health promotion programmes is paramount. However, it is equally important that nurses are actively involved in any health promotion research activities. In addition, nurse involvement not only adds to the body of knowledge on health promotion but it also enables nurses to distinguish between health promotion and health education. Whitehead (2003a) asserts that nurses often use the terms health education and health promotion interchangeably and incorrectly. This study provides the evidence that nurses are able to work beyond the narrower bio-medically defined behavioural frameworks that health education offers, to working more within the broader socio-political empowerment health promotion based approach, as identified by

Whitehead (2003a). While health education is an intrinsic part of nursing (Piper & Brown, 1998), this study provides justification that health promotion is integral to nursing, especially those working within the primary care setting. As such, health promotion should be recognised as one of the registered nurse competencies. This is supported in the Ottawa Charter for health promotion (WHO, 1986), who asserts that the health sector must move beyond curative and clinical services towards a health promotion approach.

The importance of this research is in the impact evaluation of a health promotion intervention the 'Healthy Messages Calendar (Te Maramataka Hauora)', a project that promoted health. A commitment to good health promotion practice means a commitment to robust evaluation (Hawe et al., 1995). Evaluation breaks the division between research and practice by applying research methods to improve the organisation of health care (MOH, 2000). Not all health promotion programmes are successful in achieving their aims and objectives (Nutbeam & Harris, 2004). Whitehead (2003b) suggests that nurses fail to provide successful health promotion programmes because of a distinct lack of evaluation research by nurses. However, nurses are unaware or poorly equipped to carry out evaluation effectively (Beanland et al., 1999). This study offers an example of health promotion research that can be used as a template for nurses to evaluate other health promotion interventions.

The justification for the continuation of the 'Healthy Messages Calendar (Te Maramataka Hauora)' health promotion project can be strengthened from this research. The evidence to support this claim has been presented in this study (the calendar provided a novel way to advertise health services thereby improving access). Offering access to improve, maintain, and restore peoples' health is one of the six key directions for primary health as identified in the New Zealand Primary Health Care Strategy (MOH, 2001b). The stakeholders believed the calendar improved access to services while providing a vehicle for health promotion messages. In addition, for the stakeholders, the benefits of being part of the project team were invaluable in building community relationships and networks. The personal skills each individual acquired from being part of the project team were an additional bonus not identified in the project plan. The project enabled the emergence of a strong collaborative, inter-sectoral initiative based on partnership, a common vision and community ownership. As well, the use of

the whare tapa wha model of Maori health was effective, as a tool in which to assess the appropriateness of the project in terms of the responsiveness to Maori health needs. The present study has provided evidence that significant Maori input in any health promotion project is crucial, particularly at the conceptual stage of development. In addition, this study adds to the limited body of knowledge available on impact evaluation and health promotion evaluation in New Zealand.

5.9 Limitations of the Study

As with any research project there are limitations that can be identified. This is inherent in the very nature of research and the undertaking of any research process. Consequently, the limitations associated with this thesis need to be identified. Firstly, this study was undertaken on a small number of groups in the Tairawhiti community. Due to the limitation of a Masters thesis, only five focus group interviews were conducted. The sample could be considered small when recognising the number and variety of groups that make up this population. Secondly, participation from other cultures and socio-economic backgrounds were limited. Ideally the sample would have included more groups to enable comparisons to take place and to further identify if the calendar was of benefit to one group more than another. The study could also have included interviewing those not using the calendar to identify who these people might be, if they belong to a particular cohort, and what their reasons are for not using the calendar. The study also did not involve the views of the stakeholder contributing organisations that may have offered a different perspective toward the project.

Because of the qualitative nature of the research the results are not generalisable. However, the information gained on the impact of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project provided an in-depth understanding that was "... employed to answer evaluative questions about effectiveness, utility, and most of all, value for money" (May, 2003, p.19). This study could be criticised because no evidence of behavioural change was identified. However, impact evaluation measures the immediate short-term effects that have taken place as a result of a health promotion intervention (the calendar). Long-term behavioural changes were beyond the scope and intent of the present study.

5.10 Recommendations

This research focussed on impact evaluation using a qualitative approach of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project. The evidence from this evaluation suggests the calendar project was a useful tool for the promotion of key health messages and therefore should continue as a local joint venture. It is suggested that a co-ordinated community development approach to health promotion works well in isolated, disadvantaged communities such as Tairawhiti. It is also recommended that the calendar should be redesigned to reduce the cluttered look by removing some of the health advertising that sits within each date square. It is also recommended that greater Maori input is sought and obtained in the design, co-ordination, and development of the calendar project to ensure the projects responsiveness to Maori is enhanced and sustained. In addition, it is strongly recommended that the issue of sponsorship be addressed at a local health funding level. This will reduce the need for the use of Pub Charity money, reduce the time involved in seeking funding, as well as ensure the continuation of the project. Without the funding pressures, greater community representation is likely to occur, including Maori representation.

Further research is recommended to encompass outcome evaluative methods, evaluation that could be undertaken by nurses. Outcome evaluation would identify any long-term changes in people's knowledge, attitude and behaviour as a direct result of the intervention. Both impact and outcome evaluation data have a place in determining the legitimacy and credibility of a health promotion programme. Further recommendations for future study would be to investigate the impact the calendar has in meeting the needs of the 'hard to reach'. As well, research could be undertaken to investigate the impact and outcome of print media on 'at risk' populations to determine the most suitable and effective medium to inform and educate this particular population. Investigation into the relevance or advantages of locally or nationally produced resources would also provide information for future models of health promotion. Finally, a recommendation is made to determine what health promotion and health education means to nursing in New Zealand. This would determine the potential for health promotion to be included as a competency for the registered nurse scope of practice. Currently the competency is limited to health education (Nursing Council of New Zealand, 2005).

5.11 Concluding Statement

The purpose of this study was to conduct impact evaluation on the 'Healthy Messages Calendar (Te Maramataka Hauora)' project to determine if the calendar was an effective health promotion tool for the dissemination of healthy information. Consistent with impact evaluation, a documentation review was undertaken to identify the processes behind the project. Qualitative information was also sought to determine what selected people in the community thought of the calendar and how it was of benefit to them. Also sought was information as to how the calendar could be further improved to increase product appeal and usefulness. One focus group was made up from the stakeholders, who were members of the Maramataka calendar committee. The purpose of this was to establish any perceived benefits by them as individuals, or to their contributing organisation from being part of this committee. The other four focus group respondents were made up from selected cohorts in the Tairawhiti community.

Five one-hour focus group interviews were held in 2004. The qualitative data from the focus group interviews were analysed using a general inductive approach that elicited eight categories. Demographic data was also collected from the community participant focus groups in order to identify the demographic and socio-economic make up of these groups. This information proved invaluable in providing evaluation feedback from the 'Healthy Messages Calendar (Te Maramataka Hauora)' project target audience. The information from both the documentation review and the focus group interviews were then assessed against the 'Healthy Messages Calendar (Te Maramataka Hauora)' project objectives and the whare tapa wha model of Maori health. It was established the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project achieved most of the objectives it set out to achieve with a possible flaw in its reduced ability to provide a calendar for people to write important dates on. The positive relationship with the whare tapa wha model of Maori health was also apparent.

Overall, both the stakeholder and community participants were supportive of the calendar. It appeared that community participants were easily able to identify what messages the calendar was promoting. Other health promotion ideas were offered with the majority preferring the calendar. The children's artwork was a highlight for both the

community participants as well as the stakeholders, with the use of colour being identified as positively influencing the message promoted. Keeping it local was also a strong theme that came through. For the stakeholders the calendar had a deeper meaning that related to the knowledge gained from being involved in the project. In addition, the feedback they had received from their community, as well as being part of something the community had created, were also important. All the stakeholders interviewed acknowledged that they would be happy to be part of the project in the future should it continue.

Despite the identified areas for improvement that mainly centred on the calendar design, the calendar was very popular with the community. The pictures drawn by the local children, the bilingual messages and the fact that the calendar was free were identified as valuable for community acceptability. The health promotion social marketing theory of communication helped identify the product, placement, price and promotion. What this indicated were the positive influences of commercial marketing strategies utilized within the calendar approach to meet the needs of the consumer. Also established was the need for greater Maori involvement at all levels in the project. This need was recognised by the stakeholders in their commitment to fulfilling their obligations to the Treaty of Waitangi.

This study highlighted the advantages of community ownership and collaboration. Community development is therefore recommended as away of working in health promotion in the Tairawhiti community. The 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project served as a useful community development tool for the calendar stakeholders by providing the opportunity for a wide variety of community organisations to work together on a common project. These organisations included both government and non-government funded health related groups. By strengthening networks between organisations it allowed the potential for long-term benefits for the community, including partnership with Maori. For the stakeholders as individuals, being part of this committee enabled them to grow as practitioners in their field of expertise and to develop a new set of skills in health promotion. For their contributing organisations the calendar provided the opportunity to advertise their organisation at a minimal cost.

Ethical discord arose within the stakeholder group over the sponsorship of the calendar. The community participants did not experience this ethical unease; most of who believed the use of Pub Charity money to financially support the calendar was justified. The possibility of a corporate sponsor to ease the burden of seeking funding for the stakeholders was also discussed as an option. There were pros and cons to this form of sponsorship as identified from the stakeholder interview. Despite this financial burden faced by the Maramataka committee, all interviewed were in full support of the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project and were keen for the project to continue in the future. The ethical issues over sponsorship identified the need for the project to be funded through the local health-funding agency to ensure project continuity.

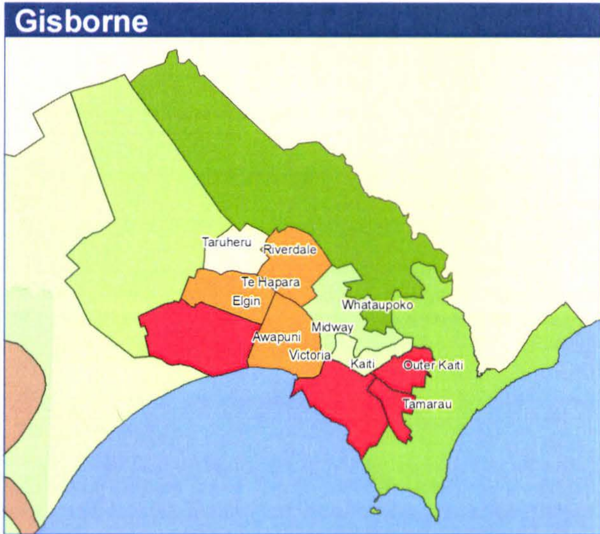
In summary, the findings suggest that the 'Healthy Messages Calendar (Te Maramataka Korero Hauora)' project is an effective means of entering the home to enable the distribution of health information. It is an acceptable means of supplying those most in need in the community with health promotion messages, as well as informing them of health related contacts. It is an affordable means to encourage people to participate in wellness checks such as breast screening, cervical screening and children's dental and hearing as well as children's health checks. The results of this research will provide the stakeholders of the Maramataka calendar committee with the evidence to support funding applications for the financing of future calendar projects. The justification for the continuation of this health promotion project can be strengthened from this. The encouragement for nurses to be involved in health promotion and health promotion evaluation can also be gained from this study. The evaluation also served as a tool for future health promotion evaluations. A challenge is offered for all nurses in their individual area of practice to become involved in health promotion and health promotion evaluation.

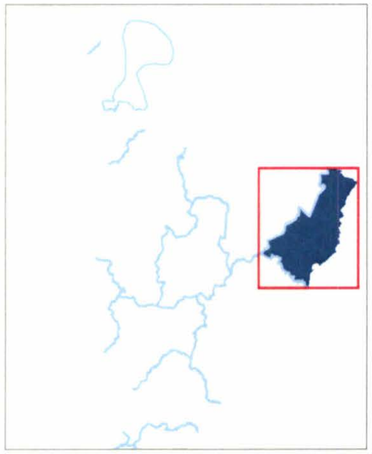
Appendix 1

Demographic Map of Tairawhiti

Tairawhiti DHB

NZ Deprivation 2001 by CAUs





Public Health Intelligence
Charting our Health
www.moh.govt.nz/phi
Public Health Directorate
Ministry of Health

Data Sources:
Statistics NZ
Ministry of Health

July 2005

Appendix 2

Sample Page from the 2004 Calendar

Mau Tonu to Tatua

Always Wear Your Safety Belt

I don't wear a seat belt and I stand up. Don't Do this

I wear a seat belt in a car seat. DO This

Jessica Howard
St John Youth

Ahakoa te rori, ahakoa te roa, Whakamau to tatua I nga wa Katoa

Turu tika tamariki ora. Always use child restraints in vehicles

As well as being dangerous, it is illegal to have a child under five unrestrained in a vehicle

You can rent child restraints from Plunket Ph 06-867 7711 or the Tairawhiti Car Seat Scheme Ph 06-867 8974

Wearing a safety belt increases your chance of surviving a crash by 40 percent

This page Supported by St John Youth

February - Hui-tanguru 2004

SUNDAY RĀTAPU	MONDAY RĀHINA	TUESDAY RĀTŪ	WEDNESDAY RĀAPA	THURSDAY RĀPARE	FRIDAY RĀMERE	SATURDAY RĀHOROI
1 www.sunsmart.co.nz	2 **Nelson Anniversary**	3 AUAHI KORE **Pregnant?** Need help to stop smoking Call Julia 0800-MUM WELL 0800-686 9355	4 TAIRAWHITI District Health Mau Tonu to Tatua: Always Wear Your Safety Belt	5 cervical SCREENING Women aged 20-69 have a regular smear 0800 729 729	6 **Waitangi Day** Call Quitline 0800 778 778 Quit Me Mutu	7 ALZHEIMERS Forget Me Not Secretary Ph 06-868 9311
8 Be SunSmart Remember to Slip, Slop, Slap and Wrap	9	10	11 WellChild Is your child due for a Well Child check? Ph 06-867 9119	12	13	14 DRCT Ph 06-867 9352 www.weka.net.nz
15 **Bikewise Week**	16 Enrol your child at 18 months to see the Dental Therapist Ph 06-867 9119	17	18	19 www.healthywomen.org.nz	20	21 Phone for a free Health Resource Catalogue Ph 06-867 9119
22 4 FREE UV INDEX UPD8 TXT UVI & SEND TO 8806	23 MA TE WERO MATE AI TE HUKETO	24 BreastScreen AOTEAROA Early Detection, Best Protection for Breast Cancer Phone 0800-270 200	25	26 Cancer Society Cuppa Last Thursday Each Month Ph 06-867 1795	27	28 **Relay For Life** 24 Hours Life Celebration and Remembrance at Showgrounds Ph 06-867 1795
29 **Relay For Life** 24 Hours Life Celebration and Remembrance at Showgrounds Ph 06-867 1795		KEEP FOOD SAFE clean·cook·cover·chill	I Love My Ears Me tiaki au i aku taringa Children's ears and eyes are the window to the world		Breastfeeding is the best	Kiwa Education Partnership Celebrate and Expect Success

Appendix 3

Massey University Albany Human Ethics Committee Approval

Massey University
AUCKLAND

OFFICE OF THE
DEPUTY VICE-CHANCELLOR - AUCKLAN
Private Bag 102 904
North Shore MSC
Auckland
New Zealand
T Deputy Vice-Chancellor - Auckland
64 9 414 0800 extn 9517
Regional Registrar - Auckland
64 9 414 0800 extn 9516
F 64 9 414 0814
www.massey.ac.nz

12 July 2004

Heather Robertson
C/- Stephen Neville
College of Humanities & Social Science
Massey University
Albany

Dear Heather

HUMAN ETHICS APPROVAL APPLICATION – MUAHEC 04/053
"Health promotion impact evaluation research: healthy messages calendar"

Thank you for your application. It has been fully considered and approved by the Massey University, Albany Campus, Human Ethics Committee.

If you make any significant departure from the Application as approved then you should return this project to the Human Ethics Committee, Albany Campus, for further consideration and approval.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a new application must be submitted at that time.

Yours sincerely

Associate-Professor Kerry Chamberlain
Chairperson,
Human Ethics Committee
Albany Campus

cc. Stephen Neville
College of Humanities & Social Science

Appendix 4

Tairawhiti Regional Ethics Committee Approval

Tairawhiti Regional Ethics Committee

295 Gladstone Road
P.O. Box 1245
Gisborne
Phone (06) 867 7874
Fax (0[redacted]

5 November 2004

Ms. Heather Robertson

Dear Heather

Twh 04/08/22 (as amended) - HEALTH PROMOTION IMPACT EVALUATION RESEARCH – HEALTHY MESSAGES CALENDAR

As all outstanding issues in regard to your study have now been satisfactorily addressed, ethical approval has now been given by the Tairawhiti Regional Ethics Committee.

Accreditation
This committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

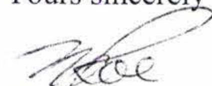
Progress Reports
The study is approved until November 2005. The approval will be reviewed annually, and a progress report is required for this study in November 2005. You will be sent a form requesting this information prior to the review date. Please note failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study. Please note that, in terms of the enclosed letter, these reports should be forwarded to Northern Y Regional Ethics Committee, Ministry of Health, P O Box 1031, Hamilton.

Amendments
All amendments to the study must be advised prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases please notify Northern Y Regional Ethics Committee, P O Box 1031, Hamilton.

General
It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

We wish you well with your research.

Yours sincerely



Trudi Roe
ADMINSTRATOR

Appendix 5

Participant Consent Form

(Health Messages Calendar Te Maramataka Korero Hauora)

Request for Interpreter

English	I wish to have an interpreter	Yes	No
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero	Ae	Kao
Samoan	Ou te mana'o ia I ai se fa'amatala upu.	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai
Cook Island	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokoko kupu	E	Nakai

This consent from will be held for a period of ten (5) years

I have read the Information Sheet dated 16.09.2004 for volunteers taking part in the study designed to evaluate the 'Healthy Messages Calendar (Te Maramataka Hauora'). I have had the opportunity to discuss this study. I am satisfied with the answers I have been given. I understand that I may ask further questions at any time. I have had the opportunity to use whanau support or a friend to help me ask questions about the study.

I understand that taking part in this study is voluntary and that I may withdraw from the study at any time. If I do so it will in no way will affect my future health care needs nor disadvantage me in any way.

I consent to the interview being audio-taped.

I understand that I have the right to decline or answer any particular questions and to ask for the audiotape to be turned off at any time during the interview.

I understand I do not have to complete the written questionnaire should I choose not to, and can remain part of the focus group.

I understand that my participation in this study is confidential and that no material that could identify me will be used in the report on this study.

I have had time to consider whether to take part in this study.

I would like the researcher to discuss the outcomes of the study with me Yes/No

I know whom to contact if I have any questions about the study.

I .... (Full name) agree to take part in this study under the conditions set out in the Information Sheet.

Signature: .... **Date:** ....

Full Name - printed ....

Contact details:

Researcher: Heather Robertson
Contact [redacted]

Supervisor: Stephen Neville
Contact Details: Phone (09) 414 0800 ext 9065
Email: S.J.Neville@massey.ac.nz

Chairperson Human Ethics Committee: Associate Professor Kerry Chamberlain
Massey University Albany Campus Phone: (09) 414 0800 ext 9078
Email humanethicsalb@massey.ac.nz

Project explained by: Heather Robertson

Project role: Researcher

Signature:

Date:

Appendix 6

Health promotion impact evaluation: 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'

Discussion Questions for Stakeholders

1. Please describe your involvement in the Healthy Messages Calendar committee?

2. What was there about the project that prompted your involvement?

3. Tell me what you, as an individual, think of the calendar.

4. Tell me what benefits there are to being involved in this community project.

5. Tell me what disadvantages there are to being involved in this community project.

6. Please describe the feedback you have received about the calendar from your client base.

7. Tell me how you think the calendar could be improved?

8. Do you have any other ideas of how you might get similar information into the home of your target audience?

Appendix 7

Health promotion impact evaluation: 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'

Discussion Questions for Community Respondents

1. Tell me about the key messages in the calendar.

2. Please describe if and how the calendar has been useful or not useful to you and your family.

3. Please describe what you think of the calendar.

4. Please describe what you like and don't like about the calendar.

5. Tell me how you think the calendar could be improved?

6. What are your thoughts on the illustrations, colour etc.

7. Have you any thoughts as to what might be a better way of getting all that information out to the people who need it the most?

8. Are there any other comments you might like to make about the calendar?

Appendix 8

Justification for use of questions

Discussion questions for the Stakeholders

Question 1.

Please describe your involvement in the Healthy Messages Calendar committee?

Justification

This question was asked in order to ascertain how involved the stakeholder perceived their involvement in the project. It would also justify their stakeholder status.

Question 2

What was there about the project that prompted your involvement?

Justification

The purpose of this question was to establish if whether the stakeholder involvement was actively encouraged by the organisation they align to or, their involvement was voluntary. If voluntary, was it because of their personal belief in the project, or were there other reasons such as personal satisfaction or gain? Different stakeholders have different interests and issues, this question would assist in discovering some of those interests and issues.

Question 3

Tell me what you, as an individual, think of the calendar.

Justification

This was included to encourage discussion as to the individual's thoughts on the calendar and to broaden the range of inquiry. The responses sought were relating to whether they thought it was an effective or ineffective health promotion tool, and what they thought of the effort and cost that was required to produce the calendar. 'Group think' and group dynamics could greatly influence this response however the notes taken by the researcher during the group interview would give an indication if this was so. The reason to gain this information from the stakeholders was to then be able to compare their responses with the community's perceptions of the calendar.

Question 4

Tell me what benefits there are to being involved in this community project.

Justification

This was included to ascertain if there were any benefits being part of this committee may have given the participants. It was to encourage discussion on these benefits (if any) at a personal level, an organisation level and/or a community level. The reason this information was sought relates to the values placed on the stakeholder involvement.

Question 5

Tell me what disadvantages there are to being involved in this community project.

Justification

This question was included to discover any disadvantages there might be to being a working stakeholder in this committee. Information sought included time commitments, financial commitments or any other commitments required as part of the stakeholder role at a personal level, an organisation level and at a community level. The question also allowed an opportunity for the stakeholders to express their concerns, claims, and issues that might or might not influence future health promotion project involvement.

Question 6

Please describe the feedback you have received about the calendar from your client base.

Justification

The purpose of this question was to establish stakeholder client feedback on the calendar. Each stakeholder represented an organisation that 'influenced' a client group. These client groups ranged from rangatahi, young parents, though to the elderly. While this information will be the stakeholder's perception, it was considered important to gather stakeholder thoughts on client feedback. This feedback would assist in discovering if the information was getting to the stakeholder client group as was planned in the objectives of the calendar project. It would also enable comparisons to be made with the community responses.

Question 7

Tell me how you think the calendar could be improved?

Justification

Information sought from this question included identifying any problems with the calendar with possible solutions to these problems. It allows the opportunity for stakeholders to express their concerns and share them with their stakeholder colleagues. This question would also determine if the stakeholder thoughts on issues/improvements were similar or dissimilar to the community groups interviewed or within the group. It could also possibly produce ideas for future calendar production or other ideas for mass media or social marketing campaigns. This question would also determine if the stakeholder thoughts on issues/improvements were similar or dissimilar to the community groups interviewed.

Question 8

Do you have any other ideas of how you might get similar information into the home of your target audience?

Justification

This purpose of this question was to encourage thoughts and discussions on other health promotion opportunities that might exist in this community. It would assist in discovering what else might be effective or could be tried in putting health information into the homes of the Tairawhiti community. This information would then be compared to feedback from the community groups. An additional advantage of this question was also to establish if the stakeholder group believed the calendar was effective in achieving its objectives.

Discussion Questions for Respondents

Question 1

Tell me about the key messages in the calendar.

Justification

The purpose of this question was to encourage participant response and involvement in the interview. It was thought many of the community participants might be timid about participating initially and therefore this question was asked first, as it did not require opinion. The responses would also assist with the discovery or confirmation of what the key messages the calendar was trying to promote. If the messages were unclear this would indicate the calendar was not meeting some of its objectives.

Question 2

Please describe if and how the calendar has been useful or not useful to you and your family.

Justification

Not only would this question serve to verify if the participants had the calendar in use in their homes, it would also establish if the calendar was more than a free 'gift' to the community that carried no value other than it being a free calendar. If this were so then this would indicate the calendar was not meeting its objectives. Information sought included if it was used for keeping appointments, phoning the 0800 numbers, influencing health behaviour, accessing services and easy access to health related phone numbers. It would also assist in determining the meaning this calendar has for the community participants and their families.

Question 3

Please describe what you think of the calendar.

Justification

Answers sought from this question included if they thought the calendar was a good or not so good idea. If they thought it was a waste of taxpayer's money, if they thought it could be improved, and what they thought of the pictures. Their responses could then allow comparisons between the groups to take place as well as with the stakeholder group. It would assist in determining if the calendar was advantageous to some groups more than others. This question would also serve to establish the meaning of this calendar to the participants.

Question 4

Please describe what you like and don't like about the calendar

Justification

By finding out what the participants like about the calendar would also assist in discovering the meaning the calendar has for the individual. By learning of the dislikes are they areas where improvements could be made? In addition it would also determine, by comparing the responses between the community groups if the issues raised were similar for each group or were they unique too that particular group and were they similar to the perceptions held by the stakeholder group?

Question 5

Tell me how you think the calendar could be improved?

Justification

The purpose of this question was to discover what areas of improvements could be made to the calendar to make it more 'user friendly'. The responses could be compared between groups and the stakeholder group to establish common themes. The users of the calendar are the people best able to suggest improvements and from their responses recommendations for change could be established.

Question 6

What are your thoughts on the illustrations, colour etc?

Justification

This question is more specific than previous questions that are more general in seeking participant thoughts on the calendar. From this question specific information in relation to the pictures in the calendar, the colour schemes used the use of colour and the illustrations to attract the readers attention was sought. The children's artwork used in the calendar might or might not be appropriate across the wide range of people it was targeting. The colour schemes might make the calendar difficult to read for some. From their responses recommendations for future calendars could be made, especially by comparing the response between the groups including the stakeholder group.

Question 7

Have you any thoughts as to what might be a better way of getting all that information out to the people who need it the most?

Justification

Information hoped for from this question were ideas that could be utilised for future health promotion projects as a means of getting messages into the community. The responses could also potentially confirm the use of the calendar as a health promotion tool.

Question 8

Are there any other comments you might like to make about the calendar?

Justification

This question allowed for final comments people might like to make whether it was new information or a confirmation of what was already said.

Appendix 9

Health promotion impact evaluation: 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'

Demographic Data Questionnaire

Completing this information is voluntary. The information will be kept confidential.

Please complete the following:

a) Gender

❍ Male ❍ Female

b) What is your age group (*tick one only)*

❍ 16 to 24

❍ 25 to 29 ❍ 30 to 34

❍ 35 to 39 ❍ 40 to 44

❍ 45 to 49 ❍ 50 to 54

❍ 55 to 60 ❍ Over 60

c) What is your occupation?

❍ Retired ❍ Homemaker

❍ Student ❍ Beneficiary

❍ Trades ❍ Professional

❍ Other (*specify*)________________________

d) Which ethnic group or groups do you mainly identify with?

❍ New Zealand Pakeha/European

❍ New Zealand Maori

❍ Pacific Island

❍ Other (*specify*)__________________

e) Is the house you live in

❍ Rented ❍ Owned ❍ Other (please specify

❍ Town/City ❍ Country

Appendix 10

Project plan: 'Healthy Messages Calendar (Te Maramataka Korero Hauora)'

Healthy Messages Calendar
Te Maramataka Korero Hauora

1. AIM/GOAL

To develop a healthy messages calendar/ te maramataka korero hauora for 2005

2.1 OBJECTIVES

- To provide a vehicle for the delivery of healthy messages to the whole community especially those that are deemed to be 'hard to reach' – an all year round "in the face" promotion.
- To provide easy access to Well Child services.
- To involve community groups in the planning, production and design of the calendar.
- To provide an opportunity for members of the community to have a vehicle to deliver 'their' health message to the whole community.
- To develop the calendar to coincide with the Maori calendar year.
- To provide a forum for people to have ready access to important community health and social service contact details.
- To provide a calendar for people to mark health and other important appointment dates in.
- To inform the public of special dates such as Heart Week, Deaf Awareness Week, SID's Awareness week etc
- To involve local children in the production of the artwork that will be used to deliver the health messages for each month of the calendar.

2.2 EXPERT CONSULTATION

- Local health and social service agencies e.g. Cancer Society
- Local printers / photographers
- Sponsors
- Children of Tairawhiti
- Public Health Unit
- Turanga Health

2.3 TARGET GROUP CONSULTATION

- Local health and social service agencies
- Pre-surveys conducted on community

3.2 NEEDS ASSESSMENT

3.1 BACKGROUND

An "in the face" bombardment of healthy messages is a constant reminder to people to take responsibility for their own health. By delivery to every household in Tairawhiti it is hoped messages will deliver to the "hard to reach". Because of the poor socio economic background and high Maori population, Tairawhiti in comparison to other areas has poor health statistics (Blue and Ihaka, 1999).

3.2 EVIDENCE

- Paul Addison (2000) private correspondent Upper Hutt City Council calendar -
  No formal documentation however verbal responses from ratepayers indicate lower water consumption and higher recycling - showing to be more effective than brochures / leaflets delivered to letterboxes.
- Many leaflets / brochures fail to communicate - the reason being they are not interesting or relevant to their audience (Robinson, 1992). A locally produced calendar with artwork from local children would overcome much of this problem.
- Different cultural groups may benefit from different channels of communication – Maori may prefer visual presentations (Blue and Ihaka, 1999).
- Because of its poor socio-economic background with a higher than average percentage of Maori, Tairawhiti has poor health statistics (Blue and Ihaka, 1999). The calendar is a vehicle to reach the hard to reach people.

- Anecdotal evidence from the 2004 calendar thus far indicates an increase in pre-school dental enrolments from children not enrolled with a well child provider. There has also been an increase in 3 & 4-year-old appointments made with well child providers. Quitline have noted people have called in their number from the calendar. Feedback from the community is positive. There has also been an increase in the number of organisations wishing to be part of the 2004 calendar.
- Results from an evaluation of the 2001 Healthy Messages calendar indicates 119 households were contacted before 100 households recalled, and had on display, the calendar. In addition, 72.6% of responders indicated the calendar was in use, with 4.4% using it to call a phone number on the calendar. Most respondents (62.4%) could name messages on the calendar with 80.3% believing the calendar was an effective way of getting healthy messages into the home. (APR Consultants, 2002).
- Many homes visited by the Public health Nurses have these calendars up in their homes and are referred to frequently by clients.

3.4 TARGET GROUP

- Each household in the Tairawhiti Region

4. FORMATIVE EVALUATION

- Random survey asking:
- Did you use the calendar?
- What were some of the key messages?
- Did the messages on the calendar encourage you to make any healthy lifestyle changes?
- The survey on last page of calendar (tear off) - all returned responses go in to draw to win something.

5. STRATEGIES / ACTIONS

Ottawa Charter Table

Build Healthy Public Policy
By enhancing the knowledge base of the community as a whole the people of Tairawhiti will be empowered to co-ordinate action that leads to health, income and social policies.
Create Supportive Environments
The inextricable links between people and their environment constitutes the socio-ecological approach to health. The calendar, by being part of the public's everyday lives, links health with the environment and its various communities. By encouraging changing patterns of work, life and leisure, positive health outcomes will occur.
Strengthen Community Action
Community action in the planning and development of a calendar strengthens community action. By distributing the calendar within the community it will improve the communities' knowledge and empower them to accept responsibility for their own health.
Develop Personal Skills
The calendar will be a vehicle for providing information and education for health and life enhancing skills. It will increase the options available to people to exercise more control over their own health choices. The personnel involved in the creation of the calendar will learn new personnel skills.
Reorient The Health Sector
It is an opportunity for the health sector to be involved in an alternative vehicle for health promotion to occur.

Treaty of Waitangi

Partnership	Participation	Protection
Actively support the advancement of Maori health outcomes by involving Maori in the discussion and development. Have Maori translations / language / culture incorporated within the calendar.	Achieve meaningful involvement in all aspects of health promotion by involving Maori in the planning and creation of calendar, and consultation with key personnel.	Prioritise health promotion action that improves health outcomes. Provide a safe and supportive environment for discussion and sharing of ideas.

5.3 TIMELINE 2004

Re write project plan	End March -completed
Invite agencies 1st meeting	End July
Get costing's etc	End July
Feedback from working party and sponsors	End May -awaiting confirmation
Artwork / design completed	September
Ready for print	November

5.4 BUDGET

The aim is to invite community groups to sponsor a healthy message in the calendar to cover the cost of printing and distribution.

Date	Activity/Item	Predicted Cost	Actual Cost
October	Cost of printing calendar	$24,000	
November	Delivery	$1,900	

5.5 COVERAGE

- All households in Tairawhiti = 17,500 copies
- Estimated viewing audience of 46,000 (The population of the Tairawhiti)

6.1 PROCESS EVALUATION

- Informal feedback from community
- Formal feedback of the process from working party
- Random formal evaluation of recipients

6.2 IMPACT/OUTCOME EVALUATION

- Calendar delivered to every household in Tairawhiti
- Retain community groups involvement in project
- Provide the community with easy access to health agencies in Tairawhiti
- Public is informed of special health day / week dates
- Enough pictures to utilise for the 12 months of the calendar

7. SUSTAINABILITY

- Project will be evaluated and if successful and effective will be redone for 2003.

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Glossary

Term	Definition
Apopo	Tomorrow.
Ataahua	Beautiful, pleasant.
At Risk	Children and/or their families who are in need of extra services and support because of the risk of poor health, education or welfare outcomes due to social and economic factors (MOH, 1998).
Coding	Used to classify groups or words into categories to enable easier analysis.
Community	A collection of people identified by their common values and mutual concern for the development and well being of the group they are associated with.
Consultation	The process of seeking the views of individuals or groups. Consultation includes health service users as well as the providers.
Determinants of health	Personal, social, economic, cultural and environmental factors that determine the health status of individuals and populations.
Disparities	Inequalities or differences relative to a local community or wider society to which an individual or group belongs.
Equity	Equity means fairness.
Evidence Based practice	Clinical decision making based on a review of the scientific literature the produces evidence of the risks, benefits and costs of alternative forms of diagnosis or treatments.
Focus Group	A group of usually 4 –12 people that are assembled for group discussion.
Hapu	Sub-tribe.
Hard to Reach	Individuals or families that are generally difficult to work with. Usually because of their socio-economic circumstances and the different value they place on health.
Hauora	Health.
Health Education	The provision of information and teaching people how to behave safely and in a manner that maintains their health.

Health Promotion	The process of enabling people to increase control over, and to improve their health.
Health Status	A description and/or measurement of the health of either an individual or population.
Health Target	A change in the health status of a population that can be expected within a given timeframe.
Intervention	A programme or series of programmes.
Iwi	Tribe.
Kai	Food.
Karakia	Prayer.
Kaumatua	Elders, either male or female.
Kaupapa	Literally means group of canoe or waka. When someone is on the same kaupapa it means have the same purpose.
Kawatanga	The provision that allows the Government to govern.
Koha	Gift or donation. Usually food or money.
Marae	A meeting area of whanau or iwi. A central area of the village, buildings and courtyard.
Needs Assessment	A process designed to establish the health requirements of a population.
Objective	An objective states what is to be achieved. The range of desired outcomes to achieve a goal.
Oritetanga	Protection for all Maori to have the same rights as those of the people of England. Addresses issues of equity and equality.
Partnership	The relationship of good faith, mutual respect and understanding between the Crown and Maori.
Primary Health Care	Essential health care based on practical, scientifically sound, culturally appropriate and socially accepted and is the first level of contact with the health system.
Pukapuka	Book.
Rangatahi	Used to define Maori youth in the 15-24 age range.
Tamariki	Children – usually includes those that have not reached adulthood.
Taonga	A treasure – something valuable

Tangata Whenua	People.
Kohanga Reo	Early childhood education in te reo (Language) with a focus on Maori culture and beliefs. Sometimes known as Maori language nests.
Te Reo	The Maori language.
Tikanga	Customary practice.
Tino Rangatiratanga	Maori control and authority and responsibility for their affairs.
Treaty of Waitangi	The founding document of New Zealand that establishes the relationship between the Crown and Maori.
Whakapapa	Genealogy.
Whanau	Family includes not only the immediate family but the wider family as well.
Whare	House.

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