Ngā Mihi

_Tuia ki runga_
_Tuia ki raro_
_Tuia ki waho_
_Tuia ki roto_
_Tihei mauri ora!

He mihi whaanui tēnei ki a koutou nā i aata tautokona hei whakamana i tenei pūrongo. Nā reira ka mihi uruhau ki a koutou. Tuia e te miro mā whero, e te miro mā pango e oti ai ngā mahi! Tēnā koutou, tēnā koutou, oti rā, kia ora huihui tātou katoa.

Acknowledgments

Thanks go to all people and groups who contributed to this report through their participation in the evaluation of the Lakes District Health Board Rheumatic Fever Awareness Campaign (Lakes DHB RFAC). In particular a warm thank-you is extended to:

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- Lecturers Ngaira Harker and Denise Riini, and the Year 1 and 2 Nursing Students from Waiairiki institute of Technology, for their energy, innovation and creative talent.
- The RF Campaign Working Group, the RF Campaign Steering Committee and the Combined Group from Lakes DHB and the Bay of Plenty DHB including:
  - Veronica Butterworth; Project/Campaign Coordinator Lakes DHB
  - Mala Grant: CE, Korowai Aroha
  - Dr Neil Poskitt: GP, Rotorua, Rotorua Area Primary Health Services
  - Anneke Slager: Childrens Outreach Nurse, Lakes DHB
  - Tina Winikerei : Manager, Lake Taupo PHO
  - Paora Hurihanganui: CE, Te Papa Takaro o Te Arawa
  - Eru George: Pou Herenga, Lakes DHB
  - Dr Johan Morreau, Paediatrician, Lakes DHB

For your support, involvement, and your kind and learned work and words, thank you all.
Associated Reports


Executive Summary

A community-based education programmes aimed at raising awareness of RF is essential for case detection and may be a critical first step in a comprehensive plan for RF/RHD1.

In September 2009, the Lakes DHB commissioned Dr Tepora Emery of Matāra Ltd Rotorua, to evaluate the Lakes DHB Rheumatic Fever Awareness Campaign (RFAC). Implemented between the months of September to December 2009, the RFAC was undertaken as a critical first step towards the implementation of a wider and more comprehensive Lakes DHB Rheumatic Fever Project (RFP). The fundamental aim of the wider RFP is to reduce the high rates of acute rheumatic fever in Lakes DHB, through a focussed and coordinated approach to primary prevention of rheumatic fever (RF) and secondary management of rheumatic heart disease (RFD).

Utilising a participatory, inter-disciplinary and integrated approach, the RFAC was premised on kaupapa Māori principles and practice. As such, the campaign was designed to build the capacity of individuals, communities and organisations to begin to address, and eradicate, the high incidences of RF among Māori people in the Lakes DHB. The campaign outcomes show that this goal was achieved.

Evaluation Outcomes

The outcomes of the Lakes DHB RFAC reflected the charitable spirit of community engendered through the campaign design, planning and implementation processes. As well, and importantly, the outcomes also reflect the achievement of some of the objectives of the wider Lakes DHB Rheumatic Fever Project.

The work of the Lakes DHB Rheumatic Fever Awareness Campaign Working and Steering Groups was underpinned by kaupapa Maori principles and practice. By raising awareness of RF, the mission of the two groups was to assist whānau Māori to make informed decisions to overcome the disease. Subsequently, at the time this report was written, the outcomes of the group’s work were underpinned by the same principles upon which their work was premised.

Joined in their efforts by other likeminded Māori Health Providers, the outcomes of the process evaluation have shown that, through the assignation of the right people and the right processes, the possibilities for engaging communities for a worthy cause (without high levels of material inducements) is still possible. Through the adoption and application of kaupapa Māori principles and practice, the RFAC engendered, fostered and demonstrated high levels of community spirit and care. At the time this report was written the outcomes of the RFAC included:

- A commitment by the local Māori radio station (Radio Te Arawa) to playing the RFAC ‘jingle’ in perpetuity.
- The uptake of RFAC work by individuals who attended RF education seminars and/or who were involved in the campaign (for example the family involved in developing the campaign pamphlet).
- The identification of a process by which to advance the relationship between the LDHB Population Health Team and the WIT School of Nursing in order to assist student learning and experience through actual involvement in population/public health projects.
- The inclusion of RF education and prevention in the health and science curriculum in 2010 by two Kura Kaupapa Māori.
The development of a collaborative and participatory kaupapa Māori model of health promotion that can be used as a blue print for other such programmes.

The production of a body knowledge regarding Māori health promotion that can inform the theory and practice of Māori health promotion generally.

A kaupapa Māori model for Māori health promotion and education that encourages and fosters Māori self responsibility, self empowerment, self efficacy and self determination (tino rangatiratanga)

The successful execution of RF education seminars which saw a 58% increase in RF knowledge and awareness of participants.

The development, and successful implementation, of an integrated HP evaluation framework.

The development of strong relationships and open communication across all stakeholders to support cooperation, collaboration and understanding of stakeholder roles and responsibilities.

A strength based model [of Māori health promotion] which has the child and their whanau as the programmes focus.

An acknowledgement of, and reference to, cultural factors and their influence on health status.

Increased capacity of Māori Health Providers to understand and to use research (theory) in their practice. That is, the use of rheumatic fever research and report findings, and the Heart Foundation Guidelines, to inform and guide their work in planning, developing and implementing the RFAC.

Without doubt the outcomes of the RFAC planning and implementation process will be ongoing. In the context of the wider Lakes DHB RF project that is proposed, the campaign is but a beginning. As such, a measure of the campaign’s impacts and outcomes will be determined by the degree to which the full RF programme is provided with the support necessary to continue; or otherwise. To this end, the recommendations that follow are offered as a support mechanism that can assist this process.

2 This outcome is has been lifted from the objectives of the wider Lakes DHB RF Project.
Recommendations

The outcomes of the report have shown the participatory, inter-sectoral and integrated nature of the RFAC. Premised at one level on the principle of ‘totika’ (effectiveness) the campaign assisted in building the capacity of individuals, communities and organisations to begin to address, and to eradicate, the high incidences of RF among Māori people in the Lakes DHB. The recommendations made by the report were also premised on the principle of totika (effectiveness). Few in number due to the high number of positive outcomes of the campaign, the recommendations can be viewed as ‘tools’ for assisting to bolster, strengthen and to maximise the positive impacts and effectiveness of any future health promotion work (including RF reduction) undertaken by the Lakes DHB.

The recommendations are as follows:

**Recommendation One: Resourcing**

Under resourcing was identified as a barrier to the effectiveness of the RFAC. For the future, it is recommended that resourcing for like work be more realistically scoped, rationalised, ‘costed’ and effected during the development phase of funding applications and with key personnel. In particular resourcing to enable dedicated staff time for providers and sufficient resourcing for development of campaign resources is necessary.

**Recommendation Two: Evaluation Methods**

As explained in the Limitations Section (Section 2.2) the evaluation of the RFAC was unable to determine any direct impact of the campaign on the target community. For the future, it is recommended that provision for the development and implementation of impact surveys and other tools for measuring community impact, be made. While requiring higher resourcing levels for planning, development, implementation and data collection and analysis, such tools allow for triangulation of data to occur. In turn, triangulation of data increases the reliability of evaluation results. As with the first recommendation, provisions to expand evaluation methods to better reflect the costs of a more in-depth and comprehensive
evaluation process, needs to occur at the time when funding applications for this type of work are developed; and with key personnel.

**Recommendation Three: Campaign Effectiveness**

The RFAC was the first phase of the wider Lakes DHB Rheumatic Fever Project. Other deliverables of the wider project include:

- Adherence to Heart Foundation guidelines for primary and secondary RF treatment and care.
- The development of RF monitoring and evaluation systems.
- A comprehensive RF register for Lakes & BOP DHBs amongst others³.

To a certain degree, the success (or otherwise) of the RFAC can be judged by the degree to which the longer term RF project gains the support necessary to continue post RFAC and beyond. Based on the groundswell of support for the RFAC and an ensuing commitment to RF reduction by Māori communities in the Lakes DHB, the recommendation of this report is that the Lakes DHB RF Project be supported to the levels required to ensure its objectives are met in full. The reduction of the high rates of acute rheumatic fever in Lakes DHB requires a focussed and coordinated approach to primary prevention and secondary management of rheumatic fever⁴. The RFAC is but a first step on this journey. The work needs to continue.

**Recommendation Four: Ongoing RFA work**

The RF puppet show that was developed and staged by the WIT student nurses was a highly effective teaching and learning tool. As an exemplar method for delivering the RFAC messages to a range of audiences, in particular primary school children, the puppet show cannot be faulted. The recommendation of this report is that a plan, including adequate resourcing to continue this form of RF education programme in schools, be developed and implemented.

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³ Lakes DHB Rheumatic Fever Project for Lakes District Health Board
⁴ Lakes DHB Rheumatic Fever Project for Lakes District Health Board
Recommendation Five: Increasing Reliability

To increase the levels of reliability of any further Lakes DHB funded evaluation work, it is recommended that any evaluation tools that may be returning invalid data (during the evaluation implementation process) be identified and modified prior to further use.

Overall the RFAC evaluation showed that the RFAC had a positive impact upon knowledge, attitudes and information seeking about Rheumatic Fever. The campaign was particularly effective in promoting and fostering strategic and constructive collaborations between key stakeholders. As such, the RFAC exemplifies the value of partnerships between these groups and individuals to effectively deliver important health messages. As the words of the New Zealand Heart Foundation\textsuperscript{5} tell us:

\textit{`he korokoro ora he manawa ora, mō tātou katoa’}

A healthy throat, a healthy heart for us all.

\textsuperscript{5}NZ Heart Foundation, 2006, NZ Guidelines for Rheumatic Fever
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Introduction

‘A training protocol incorporating simple messages can effectively create practical awareness of RF/RHD control among teachers, Health Providers and [school] pupils’1.

This report presents the findings of the evaluation of the Lakes District Health Board Rheumatic Fever Awareness Campaign. Developed as part of the Lakes DHB Rheumatic Fever Project, the goal of the RFAC was to reduce the incidence of Rheumatic Fever amongst Māori people in the Lakes DHB. The campaign had two main objectives. Objective one sought to increase knowledge and awareness of Rheumatic fever amongst Māori communities in the Lakes DHB. Objective Two pressed home the message that “sore throats matter” or, that sore throats experienced in particular by Māori children aged 5 – 14 years, should be taken seriously when they occur and be followed up with a visit to a General Practitioner (GP) for a throat swab. The methods used to evaluate the RFAC consisted of a Process and an Outcomes evaluation. Both quantitative and qualitative data was collected by these means.

Divided into three sections, Section One of this report provides the background to, and the details of, the Lakes DHB Rheumatic Fever Awareness Campaign. Section Two discusses the evaluation methods, methodology and limits; while Section Three presents the findings, outcomes and recommendations of the evaluation.

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1 Iyener; Grover; Kumar; Ganguly; Wahi, (1989). Teachers and pupils in the control of rheumatic fever: Evaluation of a training programme. Department of Community Medicine, Cardiology and Experimental Medicine, Postgraduate Institute of Medical Education and Research, Chandigarh 160 012. Retrieved on 4 December 2009 from http://indianpediatrics.net/july1992/875.pdf
SECTION ONE:  
The Lakes DHB Rheumatic Fever Awareness Campaign  

1. Background  
Reducing inequalities  

‘Success in reducing inequalities in health brings positive results for the individual, the economy and society. It enables New Zealanders to live healthier, longer lives. In turn, a healthier population will increase the country’s prosperity’.  

The Lakes DHB Rheumatic Fever Awareness Campaign was supported by the New Zealand Government’s programme for ‘reducing inequalities’ in health status for the people of Aotearoa New Zealand. Direct funding for the campaign was made available to the Lakes DHB, by Te Kete Hauora and the Public Health Group within the Ministry of Health. With a particular emphasis on Māori health inequalities, the Government posed the following rationale for the establishment of a fund to support health initiatives such as the Lakes DHB RFAC:  

In New Zealand, ethnic identity is an important dimension of health inequalities. Maori health status is demonstrably poorer than other New Zealanders; actions to improve Maori health also recognise Treaty of Waitangi obligations of the Crown. Pacific peoples also have poorer health than Pakeha. In addition, gender and geographical inequalities are important areas for action.  

Addressing these socioeconomic, ethnic, gender and geographic inequalities requires a population health approach that takes account of all the influences on health and how they can be tackled to improve health. This approach requires both inter-sectoral action that addresses the social and economic determinants of health and action within health and disability services themselves.  

Reducing Inequalities in Health proposes principles that should be applied to whatever activities we undertake in the health sector to ensure that those activities help to overcome health inequalities.  

Inside of the Government’s Reducing Inequalities in Health framework, the development and implementation of the Lakes DHB RFAC was underpinned by the findings of two  

---  

reports. The first report, ‘Rheumatic Fever in the BOP and Lakes District Health Boards – A Review of the Evidence and Recommendations for action’, was undertaken in 2008 by Toi Te Ora Public Health\(^4\). The second report was researched and written by Dr George Gray. Entitled ‘Epidemiology of Acute Rheumatic Fever in Lakes DHB 1998-2007, this report was published in 2009\(^5\).

1.1 The Lakes DHB Rheumatic Fever Awareness Campaign: Rationale

‘Health is defined in the WHO constitution of 1948 as ‘a state of complete physical, social and mental well-being’, and not merely the absence of disease or infirmity’\(^6\).

As mentioned, the Lakes DHB RFAC was developed and implemented as part of the wider Lakes DHB Rheumatic Fever Project. The rationale for the RFAC was presented (by the Lakes DHB) in an application to the Government’s Reducing Inequalities fund\(^7\). Support for the campaign was secured due to the alarming facts and figures relating to the incidence and impacts of rheumatic fever among Māori in the Lakes DHB. Based on the 2008 The Toi Te Ora Report, the Lakes DHB reported that:

1.1.1 The risk for Maori in the Lakes DHB [of contracting rheumatic fever] is 12 times that for non-Māori.

1.1.2 Most of the cases of rheumatic fever in the Bay of Plenty and Lakes DHB are Māori.

1.1.3 The annual incidence of acute rheumatic fever in children in Lakes DHB is nearly double the NZ rate (22/100,000) but, as the data collection for the district was incomplete, it is likely that this figure is an underestimate.

1.1.4 Māori people continue to have significantly poorer health outcomes than others due to the following factors:

- Structural/Historical: colonisation – including loss of land, urban migration, 1990 reforms.
- Social: Māori leaving school without formal qualifications, access to poor housing, overcrowding, racism.
- Economic: Māori [are] clustered in lower paid employment [and] more Māori are accessing government benefits\(^8\).

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\(^7\) Lakes DHB Reducing Inequalities, proposal.

\(^8\) Lakes DHB, Reducing Inequalities, 2008.
The findings of Dr George Gray’s report\(^9\) supported the account of the Māori experience of rheumatic fever, as given by the Lakes DHB. Accounting also for Pacific Island people in Aotearoa New Zealand, Gray stated:

That rheumatic fever is a growing problem among Māori and Pacific Islanders in New Zealand. In these ethnic groups, rates equal to or greater than those seen in developing countries are common. In contrast, the condition has been decreasing among the non-Māori/non-Pacific population of the country.

Further supporting the Lakes DHB’s case for the campaign, Gray maintained:

That rheumatic fever increases morbidity and mortality over the lifespan but can be prevented with low cost antibiotics in primary prevention. Similarly, recurrences can be avoided with inexpensive monthly antibiotic prophylaxis. Despite this, rheumatic fever rates for Māori and Pacific peoples are gradually increasing.

Following a successful bid to the ‘Reducing Inequalities’ fund, the Lakes DHB RFAC was carried out during the period from September – December 2009\(^10\).

1.2 RFAC Campaign Goal and Objectives

Health is a resource for every day life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities\(^11\).

The goal and objectives of the RFAC were presented by the Lakes DHB as follows.

1.2.1 Goal: To reduce the incidence of Rheumatic Fever amongst Māori people in the Lakes DHB.

1.2.3 Objectives:

1.2.3.1. To increase the awareness and knowledge of Rheumatic Fever amongst Māori people in the Lakes DHB.

1.2.3.2. To increase the awareness and knowledge of “Sore Throats Matter” amongst Māori communities in the Lakes DHB.

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\(^10\) Please see Appendix II: Lakes DHB Rheumatic Fever Awareness Campaign Plan.

1.3 **Campaign Content and Delivery Methods**

The key campaign messages were:

1.3.1 Rheumatic fever is a serious disease that can cause heart damage.
1.3.2 If your child has a sore throat take them to the doctor for a throat swab
1.3.3 Māori children aged 5 – 14 years are particularly at risk
1.3.4 It is very important that you take all your medicine as prescribed so that all the Group A Strep Bugs are killed.

Key message transference to the target community occurred through a range of methods; they included:

1.3.5 Dissemination of information pamphlets and posters.
1.3.6 Advertorials
1.3.7 Press releases Rotorua/Taupo/Mangakino
1.3.8 Formal presentations (by the DHB representative)
1.3.9 Māori Radio Advertorials
1.3.10 Dissemination of information through Local Iwi networks.
1.3.11 Puppet show
1.3.12 Iwi Bulletins
1.3.13 Community Association newsletter/ Rotorua
1.3.14 GP Practice newsletters Rotorua/Taupo/Turangi/Mangakino
1.3.15 PHN newsletters
1.3.16 School newsletters
1.3.17 Interview Rotorua TV
1.3.18 Interview Radio Te Arawa
1.3.19 Intranet publications Lakes DHB
1.3.20 RF project folder Lakes website for access by staff and the general public
1.4 RFAC Personnel

‘Ko tōu rourou ko tōku rourou ka ora te Iwi’
By your contributions and by mine so shall wellness for the people be realised.

The RFAC was developed and delivered through the collective and collaborative efforts of a number of key individuals and groups being:

1.4.1 The Lakes DHB Project Co-ordinator – who lead the project.
1.4.2 The RF Campaign Working – who developed the community awareness campaign.
1.4.3 The Lakes and BoP DHBs RF Steering Group – who had oversight of the project.
1.4.4 The Combined Group being the Lakes DHB and the Bay of Plenty DHB.

Membership of these groups included representatives from Korowai Aroha Health Services, Te Papa Tākaro o Te Arawa, Lake Taupo PHO, Rotorua Area Primary Health Services, Lakes DHB, Bay of Plenty DHB and the Waiairiki Institute of Technology School of Nursing. The role of the Campaign Working Group was to assist with the development of the campaign resources and to assist and guide the development and delivery of the campaign generally.

Designed to maximise the impact of the limited campaign resources, the education seminars were used to ‘educate the educators’ or, to ‘train the trainers’. Following one such seminar, nursing students from the Waiairiki Institute of Technology School developed a rheumatic fever education package. The students then set about delivering the RF campaign message to school children by way of a puppet show supported by a story book and an RF information DVD. The show, and the resources that were distributed afterwards, was a ‘smash hit’ with children, teachers and parents of Sunset Primary School.
The following chart lists the types of campaign resources that were developed and by whom and also, the ways in which the resources were utilised, distributed and disseminated to the target group.

**Fig 1: Campaign Resource Development, Distribution and Dissemination**

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<th>Resource/s Developed</th>
<th>Developed By</th>
<th>Distribution and Dissemination</th>
</tr>
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<td>Local pamphlet and poster in English and te reo Māori. Theme “Sore Throats Matter.”</td>
<td>Project Co-ordinator and Working Group</td>
<td>See Attachment VI RF Brochure Totals</td>
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<tr>
<td>The pamphlet was piloted by Korowai Aroha Health Services.</td>
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<tr>
<td>Composition of a RF awareness waiata. The waiata will have a regular spot on the weekly Kohanga Reo programme as well as being played with the interview November 2009; and March – July 2010.</td>
<td>Beatrice Yates Roger Cunningham</td>
<td>Te Reo Irirangi o Te Arawa</td>
</tr>
<tr>
<td>Rheumatic fever knowledge and awareness workshop/presentations</td>
<td>Project Co-ordinator</td>
<td>Korowai Aroha Maori Nurses Forum including staff from Ngati Pikiao Services; RAPHS; Mental health, Hospital staff; Tipu Ora including Family Start/Parents as first Teachers; Hunga manaaki Lakes DHB; Public Health Nurses; Plunket Nurses; Whānau hui-Te kura kaupapa Māori o Hurunga Te Rangi; TKKM o te Koutu with principal; Rotovegas with clinical manager and secondary school based nurses;</td>
</tr>
<tr>
<td>Event</td>
<td>Organizer</td>
<td>Staff</td>
</tr>
<tr>
<td>-------</td>
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<tr>
<td>RF training for GPS</td>
<td>John Morreau</td>
<td>General Practitioners: Rotorua (50) Taupo, Turangi (16)</td>
</tr>
<tr>
<td><strong>Community Promotional Events:</strong></td>
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<tr>
<td>Pasifika Cultural Event</td>
<td>Project Co-ordinator (with the support of WIT student nurses)</td>
<td>Rotorua Pasifika Community and General public</td>
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<td>National Manu Korero Speech Contest</td>
<td>Korowai Aroha</td>
<td>National Māori High Schools Community</td>
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<td>Yr1 Student Nurses WIT</td>
<td>Rotorua Public</td>
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<td>Whanau Day Apumoana Marae - CVD focus</td>
<td>Campaign Co-ordinator</td>
<td>Whānau-hapū-Iwi</td>
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<td>Fordlands Community</td>
<td>Korowai Aroha</td>
<td>Fordlands Community</td>
</tr>
<tr>
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<td>Sunset Primary School Students/staff</td>
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SECTION TWO
Campaign Evaluation

‘Evaluations of health promotion activities may be participatory (involving all those with a vested interest in the initiative) interdisciplinary (by involving a variety of disciplinary perspectives), integrated (into all stages of development and implementation of a health promotion initiative) and helping to build the capacity of individuals, communities, organisations and governments to address important health problems’\textsuperscript{12}.

2.1 Method
Consisting of a Process and an Outcomes evaluation\textsuperscript{13} the methods used to evaluate the RFAC were mixed. The process evaluation undertook to investigate the implementation of the campaign into practice while the outcome evaluation examined the achieved results documented by the evaluation of the campaign. The outcome evaluation results included the data from the pre and post evaluations of the RF awareness seminars. Qualitative data was gathered by way of the process evaluation while the outcomes evaluation gathered quantitative and some qualitative data. Both evaluation tools were developed in conjunction with the Lakes DHB Project Co-ordinator. To this end, the Project Co-ordinator played an important role in the overall evaluation process. Acting as both an intermediary and a conduit between the evaluator and the evaluation participants, the Campaign Co-ordinator’s role greatly assisted the ease with which the evaluator gained access to evaluation ‘sites’ and engaged with participants.

2.2 Limitations
Two factors limited the evaluation of the RFAC. The first was that of limited funding and resources which saw the Campaign Working Group members engaged in a voluntary capacity. Providing their services and organisational resources to the campaign free of charge, the requirement for this group to evaluate their areas of involvement (or to have their work evaluated) was not appropriate. Consequently, a proposed random impact

\textsuperscript{13} Please see Appendix III Evaluation Plan
survey of the target community was not used in the evaluation process\textsuperscript{14}. The decision not to include this type of survey in the overall evaluation process was also influenced by the level of available resources.

The second limiting factor to the evaluation process was also underpinned by insufficient resources which, in turn, lead to limited human capacity. In explanation, an endeavour to access statistics detailing the numbers of children presenting with sore throats (to GPs during the period of the campaign) was unsuccessful. As a potential indicator of the success (or otherwise) of the campaign, this data would have been useful and, could have improved the reliability of the evaluation results. However, although possible, the method for gathering this type of data required a more organised, structured, controlled and labour intensive approach on the part of the GPs. Campaign resources, the campaign timeframe and limited human capacity could not accommodate this approach. Consequently, the idea did not find traction.

These limitations aside, the evaluation of the RF campaign, and the approaches taken inside of the campaign itself, remained effective. The chosen approaches occurred inside of a kaupapa Māori framework, the details of which are provided in section 2.3 below.

2.3 Method and Methodology – Kaupapa Māori

‘As a philosophy, kaupapa Māori is derived from a Māori metaphysical base which influences the ways in which Māori people think, understand, interact with and interpret the world’\textsuperscript{15}.

Two fundamental principles underpin the conduct of a ‘culturally safe’ (kaupapa Māori) evaluation of a Māori focused health promotion campaign. The first requires the establishment of the programme context through the identification of the historical setting and cause. The second entails the identification of appropriate methods by which to work

\textsuperscript{14} Further discussion on this matter can be found in the recommendations section of this report.

with people while, at the same time, promoting their self-determination (tino rangatiratanga)\textsuperscript{16}.

The context in which the Lakes DHB RFAC was set is one which sees Māori people continuing to have significantly poorer health outcomes than other New Zealanders. The historical setting and cause of this phenomenon is that of ongoing colonisation, urbanisation, assimilation and hegemony\textsuperscript{17}. As identified previously in Section 1.1.4, the inception of the Lakes DHB RFAC is premised on the knowledge that poorer health outcomes for Māori can be attributed to:

- **Structural/Historical:** colonisation – including loss of land, urban migration, 1990 reforms.
- **Social:** Māori leaving school without formal qualifications, access to poor housing, overcrowding, racism.
- **Economic:** Māori [are] clustered in lower paid employment [and] more Māori are accessing government benefits\textsuperscript{18}.

The RFAC and this evaluation report, therefore, are viewed as critical first steps to the Lakes DHB’s comprehensive plan, current and future, for eliminating the growing problem of rheumatic fever among Māori people in the Lakes DHB.

In keeping with the fundamental principles of kaupapa Māori, the evaluation methods for the Rheumatic Fever Campaign included:

- **2.3.1.1** The use of te reo Māori in the development of evaluation communication (letters and emails) and inside of the data collection (research) instruments.
- **2.3.1.2** Where appropriate, necessary or desired, bilingual face to face interviews.
- **2.3.1.3** The use of tikanga Māori protocols and practices where appropriate, necessary or desired (e.g. at kanohi ki te kanohi – face to face – interviews).
- **2.3.1.4** The development of questions that enabled participants to contribute their knowledge toward the development of (present and future) kaupapa Māori focused health promotion.
- **2.3.1.5** The development of questions that enabled participants to identify and articulate enablers and barriers to Māori health and health promotion.

\textsuperscript{16} Emery, T. 2008.

\textsuperscript{17} See: Walker, 1990; Mahuika, 1992; Ballara, 1998; Durie, M. 1997; Mead, H. 1997; Durie, M. 2001

\textsuperscript{18} Lakes DHB, Reducing Inequalities, 2008.
2.3.1.6 The return of interview transcripts to participants for the purposes of authentication and legitimation (of interview data). This process allowed participants to maintain control of their own voices and the legitimation of their voices (inside of the evaluation process and product). Participants were also given an option to remain anonymous.

2.3.1.7 The respectful reporting of data so as to uphold the mana (dignity and integrity) of all participants in the project.

2.3.1.8 In the reporting, a commitment to privilege Māori ‘voice’; in ways that assists to promote and advance Māori self-determination (tino rangatiratanga).

2.4 Participant Selection

2.4.1 Process Evaluation - Semi-structured interviews

The participants in the process evaluation were people who were involved in the development of the RFAC. Semi-structured face to face interviews were conducted with the Campaign Working and Steering Group members. The group had the option to participate in an interview and/or to complete the questionnaire as an alternative (to an interview). Two people chose this option while five (5) people opted for face to face (kanohi ki te kanohi) interviews. One person chose non participation in the evaluation.

2.4.2 Pre and post RF education seminar evaluations

In total, sixty seven (67) people participated in RF education seminars conducted by the Project Co-ordinator. Evaluation forms were completed by all participants. Of the completed evaluation forms, 42 were valid while 25 were incomplete and therefore invalid. Although the Pre and Post Evaluation tool was piloted and adjusted accordingly and, although participants were shown how to complete the form prior to filling it in, the numbers of invalid forms returned is possibly related to a general lack of enthusiasm towards ‘form filling’ among people generally.

Rheumatic Fever education seminars were conducted with:

2.4.2.1 Tipu Ora

2.4.2.2 Korowai Aroha Health Centre

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19 Please see Appendix IV Process Evaluation Questionnaire
20 Please see Appendix V Pre and Post Evaluation for Presentations
2.4.2.3 Health Rotorua PHO
2.4.2.4 Plunket
2.4.2.5 Public Health Nurses
2.4.2.6 Waiairiki Institute of Technology School of Nursing
2.4.2.7 Sunset Intermediate
2.4.2.8 Te Kura Kaupapa Māori o Hurunga te Rangi

The following table shows the figures for the pre and post evaluation of the RF education seminars. The numbers are also categorised according to the groups of people represented.

**Fig 2: Pre and Post Evaluation Numbers of Responses and Respondents**

<table>
<thead>
<tr>
<th></th>
<th>Pre and Post Evaluation Numbers of Responses and Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Responses</strong></td>
<td><strong>Total Valid &amp; complete</strong></td>
</tr>
<tr>
<td>67</td>
<td>42</td>
</tr>
</tbody>
</table>

**2.5 Data Collection Process**

2.5.1 **Process Evaluation: Semi-structured interviews**

Semi structured interviews were conducted with five (5) members of the campaign Working Group. Two (2) members of this group chose to respond to the questionnaire without submitting to an interview. One group member did not participate in the evaluation. The interview schedule and the questions used in the evaluation process were developed in conjunction with the Lakes DHB RF Awareness Project Coordinator. At the time of inception, the steering group members had all been informed that the campaign evaluation was in progress. Verbal invitations to participate had been issued by the Campaign Coordinator. Members were formally introduced to the evaluation by way of a written invitation to participate; sent by way of email. Including a combined consent form and questionnaire, this invitation was followed up by a phone call at which point interview times were established. Interviews were held at times and places that

21 Please see Attachment IV Process Evaluation Questionnaire
were convenient for the interviewees. Informed consent was sought and granted prior to
the commencement of the interviews; discussions were recorded by way of note taking
and, in some instances, digital recorder.

2.5.2 Transcript accuracy checks - authentication and legitimation
Interview participants were invited to check their interview transcripts for accuracy. At
the end of each interview, participants were informed that they would receive a copy of
the interview transcripts within one week. Subsequently, transcripts were sent out
electronically with a cover letter explaining the process of authentication and legitimation
of data. Once returned, transcripts were analysed for meaning using a process of constant
comparison or, grounded theory.

2.5.3 Pre and Post Evaluation of the RF Education Seminars
Pre and post evaluations of the RF education seminars were conducted after each
seminar, by the Lakes DHB Project Co-ordinator. Gathering predominantly quantitative
data, completed forms were analysed numerically in order to show the pre and post levels
of RF knowledge and awareness among presentation participants. Analysis of the
quantitative data was assisted by the Lakes DHB Population Health Analyst.

2.5.4 Informal Data Collection

‘If we relied solely on the data from the questionnaires and the interviews, we
would not have the ability to articulate what happened.’

As well as collecting data from the two prescribed evaluation methods (i.e. the process
and the outcomes evaluations) data for the evaluation was also collected by informal
means. Initiated by the Campaign Coordinator at the beginning of the campaign,
information was recorded and sent to the evaluator at regular intervals. The data
included:

2.5.4.1 Monthly progress and campaign activity reports by the Campaign
Coordinator to the RF Project Steering Group.

2.5.4.2 Rheumatic Fever pamphlet distribution totals.

2.5.4.3 Campaign Coordinator field notes.

\[22\) Participant transcript, 2009.\]
In effect, this process created an integrated RFAC evaluation process and framework. Conducted in tandem with the campaign, critical data was captured throughout the project rather than at the end; as per usual evaluation process.

The reporting of informal data by the Campaign Co-ordinator to the Campaign Evaluator allowed for two things. Firstly, information regarding the early design, planning and implementation phases of the RFAC was able to be reliably represented in the evaluation report. Secondly, through examining the informal data at various stages of the evaluation process, the evaluator was able to reflect on the campaign evaluation process itself. That is, *to evaluate the evaluation as it was occurring*. Acting as a reflective tool, the informal data that was gathered assisted to improve the quality of both the RF campaign and the evaluation which were occurring in concert with each other.
SECTION THREE

Findings

3.1 Introduction

‘Health promotion needs to be part of the brief of all Health Providers. From that perspective the therapeutic tasks can be conceptualised not so much as solving problems but as unleashing potential. An approach that isolates culture and community from the equation tends to obscure the potential for change; an ecological approach on the other hand encourages a greater utilisation of community resources and community wisdom’23.

Divided into three Parts, Section Three reports the findings the RFAC evaluation. Part one covers the results of the Process Evaluation; including a description of the principles underlying the inception, development and implementation of the campaign. The principles are drawn from, and supported by, the data. Following this description, the general evaluation themes as elicited from the qualitative data are presented. The themes are interwoven, discussed and synthesised with the responses to the interview questions.

Predominantly statistical in nature, Part Two of section three reports the findings of the Outcomes Evaluation (i.e. the pre and post evaluation of the RF knowledge and awareness education seminars). To conclude, Part Three presents the evaluation outcomes and recommendations. In order to provide a measure of the success (or otherwise) of the campaign, these outcomes are benchmarked against the objectives of the Lakes DHB Rheumatic Fever Campaign24.

3.2 Part One: Process evaluation: - underlying kaupapa Māori principles

‘It’s about the people and the process. If you get that right – the relationships – then the outcome will flow ... ’25

The Rheumatic Fever Evaluation Campaign was an inter-sectoral initiative conducted inside of a kaupapa Māori framework. As such, the planning, development and implementation of the campaign was lead by a local Māori health professional who was assisted by key members of the Lakes DHB health sector; the majority of whom were

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23 Durie, M. 2003, Ngā Kahui Pou: Launching Māori Futures, p. 156.
25 Participant transcript, 2009
Māori. All members of the group had direct, health based, working relationships with various sectors of the RFAC target community. Māori members of the Working Group (some of whom were also members of the combined Lakes/BOP Group) also had culturally based -whānau-hapū and Iwi- relationships within this community. Recruitment of the Māori working party members was based on their capability [in the field of Māori health] and their passion towards improving Māori health outcomes through kaupapa Māori health related philosophy and practice; including the capacity for manaaki (to care) and tohatoha (to share).

The recruitment of community based Māori Health Providers to the combined Lakes and BoP DHBs RF Steering Group met with some resistance. The increase to the size of this Group (to include Māori Health Providers) was queried\(^{26}\). However, the inclusion of this cohort was a non-negotiable requirement; their presence and input was foremost to the Lakes Project which was premised upon kaupapa Māori theory and practice. The presence and expertise (including cultural expertise) of these people grounded the campaign inside a ‘Whanau Ora’ model of Māori health\(^{27}\). Described as ‘a way forward to achieving a future where whānau determine what is in their best interests\(^{28}\), the selection of the Whanau Ora model as a basis for the campaign, was in keeping kaupapa Māori philosophy which promotes Māori self determination. In the context of the RFAC, the Māori Health Providers place, role and presence was critical to building the relationships needed to engage with the target (Māori) community.

As a framework for the RFAC, the philosophy and practice of kaupapa Māori was repeatedly articulated and reinforced by members of the Working Group. For example, when asked as to their experience of working within the Lakes DHB RFAC, one member stated: “Māori are no longer happy to wait for health to happen to us. What we see now is that, politically, Māori are saying “we own this” and we will deal with this in a way that suits us and, to do that, I need the best information and resources that I can get and

\(^{26}\)Participant transcript, 2009.
\(^{27}\)Participant transcript, 2009.
I’m going to find them. Promotion of Māori self-determination is central to this statement. Likewise another member when describing her role said:

The planning development and implementation [of the RFAC] was located in a kaupapa Māori context [but it ] was also guided by ‘He Korowai Oranga’. That is, by supportive processes enabling mainstream responsiveness in the campaign. By way of observation I have noticed key people being more responsive to working collaboratively and co-operatively as a team.

Within the context of this report, and based on the findings of the process evaluation, a ‘Māori process’ is defined as a process premised on the principles of tohatoha (to share), manaaki (to care) whakapiki (enablement), whai wahi (participation), whakaruruhau (safety), totika (effectiveness), putanga (accessibility) and whakawhanaungatanga (integration). Central to the RFAC planning, development and implementation, these principles emerged as recurrent themes throughout the interview data. The themes are extrapolated in the section 3.3 below which lists, discusses and synthesises responses to the qualitative questions while, at the same time, juxtaposing them with the (process) elements described above. The questions are listed and individual (synthesised responses) are given.

3.3 Semi-structured interviews - a synthesis of responses

Everybody who is Māori knows somebody who has rheumatic fever. We are aware of the problem. It hasn’t been addressed it’s hidden and it affects Māori disproportionately and Māori should be part of the solution.

The following questions were used to guide the semi-structured interviews conducted for the Process Evaluation. Interviews were held with members of the campaign Working Group.

3.3.1 The interview questions

3.3.1.1 What motivated you and/your organisation to become involved in the community campaign?

3.3.1.2 In your view, what factors have contributed to the successful planning and implementation of the community campaign?

3.3.1.3 What barriers, if any, have been experienced?

3.3.1.4 How has the overall process of contributing/working within a Lakes DHB project worked for you/your organisation?

3.3.1.5 What does successful Health Promotion for Māori look like?

3.3.1.6 What would assist in promoting health among Māori people in the Lakes DHB?

3.3.1.7 What, if any, are the barriers to health promotion and health awareness raising among Māori people in the Lakes DHB?

3.3.1.8 Where you involved in developing the campaign pamphlet? If so, how would you describe the process? That is, what were the positive aspects of the development; what, if any, were the barriers (encountered when developing the resource)

Please note that the responses to questions 3.3.1.5 and 3.3.1.6 have been integrated in the following dialogue. The amalgamation is due to the similarity of information given by respondents when answering these two questions.

### 3.3.2 Question One- motivations for voluntary involvement in the RF campaign

‘[It is] important that future nurses are aware of the importance of primary health and health promotion. The opportunity to observe and be involved in this campaign [and] to identify whether the principles discussed within the paper relating to effective primary health care are actually utilised as the foundation with the RF campaign ....’

Motivations for participant engagement in the RF campaign are located are underpinned by the principles of manaaki (to care), whakapiki (enablement), whai wahi (participation), totika (effectiveness), putanga (accessibility) and whakawhanaungatanga (integration). Giving personal, professional and political rationales for assisting in the work of the Campaign Co-ordinator, the Steering and Working Group members provided the following insights into their motivations for involvement. Derived solely from interview transcripts, the motivating factors are juxtaposed with the principles listed above.

3.3.2.1 Whakapiki: The opportunity for new learning for example, understanding research and learning how to translate and ‘use’ research as a basis for their work.

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3.3.2.2 **Whakapiki:** The desire to understand more about RF, its impacts and the treatment of RF generally.

3.3.2.3 **Manaaki, putanga:** The desire to work in ways that pro-actively support Māori health and wellness; including access to healthcare.

3.3.2.4 **Totika:** The prospects of enhancing and extending particular roles for example, maintaining the RF register; and conveying Māori health issues to the PHO [Taupo] and to General Practice.

3.3.2.5 **Whakapiki, whai wāhi, whanaungatanga:** The engagement in learning experiences that effect health outcomes for the community and the opportunity also, for trainees (student nurses) to work alongside local DHB initiatives that are driven by research and public need.

3.3.2.6 **Totika, whakawhanaungatanga:** The opportunity, again, for student nurses to extend learning and to examine the degree to which the principles that underpin public health policy are implemented in practice (for example the principles encompassed within the Ottawa Charter/Treaty of Waitangi).

3.3.2.7 **Whakapiki, whai wahi:** The recognition that Māori are disproportionately affected by RF and the recognition also, that Māori need to be, should be, and can be, pro-active in solution seeking to eradicate the problem.

Passion, commitment and opportunism were the driving forces of the RFAC Working Group. Although involvement in the campaign was on top of their core work, members seized the opportunity to participate in the campaign not only to assist to meet a critical and urgent community need, but also, to extend personal knowledge, learning and practice in the field of health and, in particular, Māori health.

### 3.3.3 Question Two - Campaign success factors

‘….I think having a wider view – rheumatic fever is a disease that affects people who are socio-economically deprived in different ways – a realisation that we need a different model of care. One of the successes has been looking a bit wider at what we can do [differently] to deliver good care to these people’.33

Whakapiki (enablement), whai wāhi (participation) and whanaungatanga (integration) were foremost to the successful planning and implementation of the RFAC. In addition, the fundamental principle ‘kia mohio kia mārama’ is also acknowledged. This term

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33 Participant transcript, 2009.
denotes that ‘to know is to understand’. In the context of the campaign planning and implementation, the principle was identified as an important success factor by one participant who said:

From my perspective, positive to [the planning] was the initial needs assessment to identify issues relating to rheumatic fever. Evidence collected relating to the incidences of this condition, its impact for Māori including long-term social, emotional, physical, whānau and economic effects. [I] could see there was a need to better inform the community within the Bay of Plenty area.

Other identified success factors included:

3.3.3.1 Whanaungatanga: The collaborative endeavours of the Steering and Working Group as a whole; and the opportunity for the group to participate in the presentation from the Northland District Health Board (showing how RF has been eradicated in their area).

3.3.3.2 Whanaungatanga, whai wāhi, whakapiki:: The promotion of a kaupapa Māori process that advocated for, and promoted, the involvement of key Māori Health Providers in the process; as a priority. That is, the promotion of a ‘by Māori, for Māori, with Māori’ approach – with the support by key non Māori health professionals.

3.3.3.3 Whakawhanaungatanga, whakapiki: The promotion of kaupapa Māori principles and practice as enablers for building and strengthening the relationships necessary to undertake the work involved.

3.3.3.4 Whakapiki: The enabling mechanisms employed by the leaders in the RFAC. Campaign leaders were identified as ‘Public Health’ – as the initial drivers of the campaign; and the Campaign Co-ordinator who was deemed successful because ‘[she] understands Māori dynamics and the messages and processes that work for Māori’.

3.3.3.5. Totika: Campaign effectiveness was enhanced by effective planning inside of constrained time frames and limited budget.

The successful planning and implementation phases of the RFAC are attributable to the kaupapa Māori framework in which the campaign was set. The establishment of an

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34 Participant transcript, 2009.
36 Participant transcript, 2009.
historical context and the identification of appropriate methods by which to work with people while, at the same time, promoting their self-determination were foremost to the work of the Campaign Co-ordinator and the Working Group.

3.3.4 Question Three - Campaign barriers

Low levels of commitment to ongoing planning and the provision of adequate funding (resources) for RF prevention (at a national/government level) were identified as main barriers to achieving the overall campaign objectives (in the longer term). Participant responses were unanimous in this regard. In keeping with this theme, business model based health care for people with RF generally, was deemed highly inappropriate. This view was expressed by one respondent who said:

[That] having [in] sufficient funds is an ongoing issue. RF has been around for years. The silo attitude to funding streams – how do you get funding to be ongoing? The hospital, public health, general practitioners, primary care… Our patients move between all of these areas of care – you need something that works for the patient rather than ‘we have a service here’ and patients have to come to us – [we need to] develop a model of care that works for the patient. You can’t deliver health care to these people based on a business model – people who have RF are generally people who find it difficult to access health care – if you have developed RF it says something.

Further concerns regarding the absence of ongoing and committed funding for RF were articulated by another respondent who saw a need for the inclusion of RF in the Lakes DHB District Area Plan. Conversely, however, under resourcing for the RFAC was identified as an advantage by one respondent. A seeming contradiction, the phenomenon was explained in the following way:

We are all talking. We have all the players at the table planning and talking rather than it being dictated down – usually it’s down according to specifications and lead by General Practitioners [but] everybody is talking and sharing ideas and seeing how we can work together.

Because there is not a lot of money in it it’s about relationships – and we have a good working relationship within the group. We can communicate to decide where the funding is best used. We’re not competitive around the table – it’s about the kaupapa. We have a serious problem around Māori health …. How can we reduce the inequalities? We can take the tools from this Working Group into the GP’s and say “this has been identified” and run a training session and raise awareness [so] everyone can do things better.

37 Participant transcript, 2009.
The kaupapa rather than the funding – if it had gone to RFP it would have become competitive. We all went to one big workshop and realised this in not good for Māori whānau and thought “how can we work together?” A different perspective altogether.

This statement highlights the charitable community spirit of engagement exercised by campaign personnel. As a measure of campaign ‘success’, however, there is reason for caution. Inadvertently, the statement can be seen to uphold a false notion that a reliance on charitable community spirit for Māori health promotion initiatives, less adequate resourcing, is acceptable. This thinking cannot prevail.

Although expressing some dissatisfaction in regard to these barriers, campaign personnel adopted strengths based, solution focused, ‘can do’ attitudes towards their work in the RFAC.

3.3.5 Question 4 - Contributing and working within a Lakes DHB project

‘It’s the dynamic of the group and what we come with; we can speak freely to each other. There is trust and respect and we work together. We don’t always agree but we can bring it to the table …… We know our Māori DHB Portfolio people.’

The RFAC was co-ordinated and managed by the Lakes DHB. Resourcing for the campaign was sourced through Te Kete Hauora, the Ministry of Health’s Inequalities Fund, and the Public Health Group. Recruited by the Lakes DHB Campaign Coordinator, the campaign Working and Steering Group were drawn from health related organisations, institutions and providers in the Lakes DHB. The services of this group were provided on a voluntary basis with the Waiairiki Student Nurses each receiving a certificate of appreciation and a $20.00 petrol voucher. Providing their services at the Pacifica cultural event in Rotorua, some of this cohort travelled from places outside of Rotorua, and in their own time, to assist.

When asked as to their experiences of contributing and working within this framework, the Working and Steering Group members, and the WIT nursing students, responded in

38 Participant transcript, 2009.
ways that, again, upheld kaupapa Māori principles and practice. Juxtaposed with these principles, the following aspects were highlighted by respondents:

3.3.5.1 Totika, whai wāhi, whakapiki: The participatory and collaborative campaign framework that made best use of minimal resources to achieve maximum effect.

3.3.5.2 Manaaki: The flexibility around timetabling to accommodate the ‘day jobs’ of the Working Group members (for example the re-scheduling of meeting times to suit certain members).

3.3.5.3 Whakaruru: The way in which the campaign was planned and presented including frequent communication and information updates and, clear expectations (as provided to the Working Group in regard to their rights, roles and responsibilities). In regard to planning, one respondent suggested that (more) advance notice of planned activities would have been helpful (i.e. notice of the visit by the Northland health group).

3.3.5.4 Whai wāhi, putanga, whakawhanaungatanga: The opportunity to meet and link with key people, to develop key resources, to access good quality information and to deliver it to Māori people in ways that are best suited to them.

3.3.5.5 Whakapiki, whai wāhi, whakawhanaungatanga: The opportunity for learning (about the processes involved in a health promotion campaign) and the opportunity also, to receive constructive feedback from the Campaign Co-ordinator when developing campaign resources (WIT nursing students).

3.3.5.6 Whakapiki: As part of their training, the opportunity for the WIT nursing students to engage in experiential learning. That is, to be included in the campaign, to experience both the ‘good and the bad aspects’ of the campaign processes and dynamics and to work in the community with ‘real people with real problems’.

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40 Participant transcript, 2009.
41 Participant transcript, 2009.
3.3.5.7 *Tohatoha, whakapiki*: The opportunity for student nurses to engage with whānau and tamariki Māori and to deliver the campaign message in a fun, meaningful and effective way (i.e. through the puppet show) – and to develop a resource that ‘has the potential to make a difference as part of a wider campaign’\(^{42}\).

Endeavours that rely on voluntary labour can be tenuous. Motivating, engaging, inspiring, and maintaining a volunteer work force requires a special form of leadership. In the absence of a formal contract, the levels of voluntary support put toward any endeavour, is at the discretion of the volunteer. In this regard, the findings of this evaluation indicate that the project was very well lead, managed and co-ordinated. The voluntary contributions of the Working and Steering group were valued and the group felt supported by the Campaign Co-ordinator. The positive experience of working alongside the Lakes DHB in the RFAC is summed up by one respondent who said “I put it down to the wairua of the group – the people and their focus on the kaupapa and their passion for Māori health. Being able to work collaboratively because there is no competitiveness between the organisations\(^{43}\)”.

3.3.6 **Question Five and Six - Successful health promotion for Māori people**

‘People, places and things that are significant and recognisable to the Māori community. You need the right person, the right way and right resources. It’s all about something that’s been developed, planned and implemented within the reality of that community’\(^{44}\).

Six characteristics of successful health promotion for Māori people were identified in the evaluation. Underpinned by the guiding principles of the RFAC, the characteristics included:

3.3.6.1 *Putanga, totika*: The provision of information that is developed and delivered in ways that are accessible to and understood and ‘owned’ by the intended audience. For example, depicting community health issues using images that belong to that community and which are taken to the community.

\(^{42}\) Participant transcript, 2009.

\(^{43}\) Participant transcript, 2009.

\(^{44}\) Participant transcript, 2009.
3.3.6.2 **Totika:** In the first instance, the establishment of a valid rationale for a Māori health promotion programme (through a needs assessment undertaken from within a Māori health framework).

3.3.6.3 **Totika:** The inclusion of Māori from the outset and throughout the health promotion activity, but with experts who are both Māori and non-Māori to provide guidance in an advisory capacity. Māori health promotion should be Māori lead.

3.3.6.4 **Totika:** The development of ‘tools’ that take account of Māori learning styles. For example in the knowledge that Māori are a visual and oral people, the use of pictures, colours and stories to tell/sell a message.

3.3.6.5 **Whakapiki:** The provision of sufficient funds to enable the production of a wide and more diverse range of resources; i.e. for age, gender and cultural specificities.

3.3.6.6 **Totika, whakawhanaungatanga:** Changing the negative perceptions of Māori health through the development and use of positive, motivational, innovative and interactive strategies that focus on positive outcomes; and which support and promote holistic wellbeing. The engagement of, for example, youth, teachers/schools and artists to deliver messages.

3.3.6.7 **Whakaruruhau:** In Māori health promotion, the use of culturally aware, culturally sensitive and culturally safe health promoters. That is, people who are aware of their own biases and who don’t impose their own beliefs into their engagement with those in need of health awareness. Educators who are sensitive to the diverse realities of Māori people.

In the view of one respondent, Māori health promotion was seen as an integral and integrated aspect of the work of health professionals and Health Providers generally. Health promotion was not seen as something that stood apart. Articulating this view the respondent said:

> [Successful Māori health promotion] is right from reception. When you go in it has a good wairua and when the GP speaks with our people – any questions, any problem is not a hassle to ask … they need to be open to our people and it starts in their training even our mainstream nurses in hospital. The health service is running from a business model. There are no family GPs anymore; they stick to their 5 – 10 minutes and its over. In the
old days it was about family practice ….. It’s no longer cradle to the grave. Attitudes are changing\(^{45}\).

The ability for Māori to exercise tino rangatiratanga and self determination in promoting Māori health was foremost to the views of the respondents.

3.3.7 Question Seven - Barriers to Māori health promotion

'Research is awesome but it has to be workable – it has to be able to be used to move forward''^{46}.

Four fundamental barriers to Māori health promotion were evidenced in the process evaluation findings. The barriers were: access to information, access to resources (funding), attitudes, and communication barriers; including cross-cultural communication. Proactive in their accounts; respondents, in identifying barriers, also identified what they saw as necessary to overcome them. The following points extrapolate and present the barriers and needs (to and for Māori health promotion) as articulated by the Working and Steering Group.

3.3.7.1 Barrier: People who have a knowledge-experience gap in community work and networking.

Need: Access to current research/information that can be/has been analysed so as to be applicable and useable (by Māori health providers and promoters).

3.3.7.2 Barrier: An absence of culturally congruent health education, health awareness, innovative educational resources and funding.

Need: Sufficient funding to enable the development of innovative and culturally appropriate health promotion resources

3.3.7.3 Barrier: The belief of some Māori, and whānau Māori that “unless it happens to me I don’t need to know ….”

Need: A pro-active campaign directed at changing beliefs/attitudes.

3.3.7.4 Barrier: The belief of some Māori that certain messages can only be delivered at certain times and in certain places. Note: this barrier relates to matters of tapu and noa.

\(^{45}\) Participant transcript, 2009

\(^{46}\) Participant transcript, 2009.
Need: To help people to understand that (Māori health promotion) messages can be tactfully presented (in those places) without causing cultural/spiritual harm.

3.3.7.5 Barrier: Trying to drive the RFAC from the ‘ground’ up.

Need: A more integrated, holistic approach to health promotion driven from Government/policy level.

3.3.7.6 Barrier: Insufficient acknowledgment and support for health promotion that is delivered within the whānau ora model and the disconnect between mainstream and Māori reality.

Need: To create better understanding and to mediate the risk around the negativity that surrounds Māori ‘reality’.

3.3.7.7 Barrier: The misconceptions held by some non-Māori people who feel ‘out of place’ when working with Māori people.

Need: Leadership from Māori people who are skilled and knowledgeable in regard to Māori cultural requirements and who are inclusive and supportive of non-Māori people (who are skilled, knowledgeable and willing to support kaupapa Māori initiatives and development).

In essence, this naming of barriers to Māori health promotion provides a place where dialogue around the identified issues/needs can begin. Further, the operational framework of the RF campaign, and its underpinning values, offers an effective model for any endeavour that seeks to address these issues.

3.3.8 Question Eight - Developing the Campaign Pamphlet

The final question in the process evaluation related to the development of the Rheumatic Fever information pamphlet. The overall responses to this question were positive. In particular, the responses highlighted the inclusive, participatory development process and the strength of the relationships established within the membership of the Working and Steering groups. Inside of these relationships, although completing much of the work by email, the ability to give and receive critical feedback, and to reach group consensus regarding the final product, was given effect. Aside from the publishing and printing,
respondents’ spoke of being actively engaged in the work of developing the pamphlet; from selecting suitable pamphlet ‘models’ to critiquing the pamphlet wording. The overall outcomes of the process evaluation can be viewed in section 3.6 on page 33 of this report; they follow the findings of the outcomes evaluation which are presented next.

3.4 Part Two: Outcomes evaluation

3.4.1 Pre and Post Evaluation of the RF Education Seminars

This section presents the results of the pre and post evaluations of the RF education seminars. Administered by the Campaign Co-ordinator, 12 education seminars were held with 67 completed pre and post evaluations received. Of the 67 forms returned, 42 were complete and valid. The invalidity of the remaining 25 forms, while not formally determined, has been attributed to a general lack of enthusiasm to form filling by people generally; the evaluation form having been piloted and amended for ease of use; and respondents having been shown how to complete the form at the time of administration. Should the same evaluation tool be used for any future evaluation work, however, it will require further review and revision.

Evaluation participants responded to seven RF related statements/questions. They were then asked to rank their ‘pre’ and ‘post’ knowledge of rheumatic fever against each of the statements on a scale of one to ten (1 – 10). The results were collated and analysed; they are presented in table form on the next page followed by a narrative description, a breakdown and a summary of the individual results for each question.

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47 To view questions please see Appendix V Pre and Post Evaluation for presentations.
Fig 4: Descriptive Statistics

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
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<td>.954</td>
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<td>10</td>
<td>9.40</td>
<td>.989</td>
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</table>

This table shows the average response values across all of the questions asked. The standard deviation column shows that the spread of response values was much wider for the pre questions that the post; which were much closer together indicating greater agreement. The ratings for the ‘post’ questions were much higher than the ‘pre’ on every question indicating a significant increase in RF knowledge and awareness after the education seminars. A breakdown and summary of results for each question follows.
3.4.2 Breakdown of pre and post evaluation results by individual question

NB: All scores are out of 10.

3.4.2.1 Question One: Awareness and Knowledge that Rheumatic Fever is a serious disease which can cause permanent heart damage
The average score across all participants prior to the seminar was 6.7 out of a possible score of 10. Post seminar this score rose by 2.8 to 9.5 out of 10, showing an average increase in knowledge and awareness of 42 %

3.4.2.2 Question Two: Awareness and knowledge of what may cause Rheumatic Fever
Average score across all respondents prior to the seminar: 6.21 /10
Average score post seminar: 9.33 /10. Rise in average score: 3.12
Average increase in knowledge and awareness: 50 %

3.4.2.3 Question Three: Awareness and knowledge of what can be done to help prevent a child getting Rheumatic Fever
Average score across all participants prior to the seminar: 5.93 /10
Average score post seminar 9.40 /10. Rise in average score: 3.47
Average increase in RF knowledge and awareness 58 %

3.4.2.4 Question Four: Awareness, knowledge and understanding of the “Sore Throats Matter” message
Average score across all participants prior to the seminar: 5.10 /10
Average score post seminar 9.52 /10. Rise in average score: 4.42
Average increase in RF knowledge and awareness 86 %

3.4.2.5 Question Five: Awareness and knowledge of treatment for Strep sore throat
Average score across all participants prior to the seminar: 6.07 /10
Average score post seminar: 9.52 /10. Rise in average score: 3.45
Average increase in knowledge and awareness 57 %
3.4.2.6 Question Six: *Awareness and knowledge of what can happen if a child does not have treatment for a strep sore throat*

Average score across all participants prior to the seminar: 6.19 /10
Average score post seminar: 9.33 /10. Rise in average score: 3.14
Average increase in knowledge and awareness 51 %

3.4.2.7 Question Seven: *Awareness and knowledge of who is most at risk*

Average score across all participants prior to the seminar: 5.86 /10
Average score post seminar: 9.60 /10. Rise in average score: 3.74
Average increase in knowledge and awareness 64 %

**Fig 3: Summary of Average Increases in RF Knowledge and Awareness**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Increase</td>
<td>42%</td>
<td>50%</td>
<td>58%</td>
<td>86%</td>
<td>57%</td>
<td>51%</td>
<td>64%</td>
</tr>
</tbody>
</table>

3.5 Summary

These percentages indicate that there was an average increase in Rheumatic Fever knowledge and awareness of 58% (across all questions and all respondents) after the RF education seminars. In combination with the qualitative data that was gathered by the pre and post presentation questionnaire, this increase shows the seminars as having a positive impact. Participants reported that the seminars were very well organised and delivered. Presenting potentially complex information by way of simple messages, the RF knowledge and awareness conveyed, was deemed (by participants) to be important, relevant, and easily understood.
3.6 Part Three RFAC Evaluation Outcomes and Recommendations

‘Various stakeholder groups have different interests, priorities and last, but not least, understandings of what constitutes success. For instance users, carers, patients, funding institutions, researchers or managers have their own needs and perspectives on an intervention’.

3.6.1 Introduction

‘Community awareness of [rheumatic fever] has been found to be essential for case detection’.

The outcomes of the RFAC reflect the charitable spirit of community engendered through the campaign design, planning and implementation processes. As well, and importantly, the outcomes also reflect the achievement of some of the objectives of the wider Lakes DHB Rheumatic Fever Project. Verification that these objectives have been achieved through the RFAC (and can therefore be reported as successful campaign outcomes) can be found in the evaluation findings. The objectives are incorporated into outcomes 3.6.2.9 – 3.6.2.12 below.

The work of the Lakes DHB Rheumatic Fever Awareness Campaign Working and Steering Groups was underpinned by kaupapa Maori principles and practice. By raising awareness of RF, the mission of the two groups was to assist whānau Māori to make informed decisions to overcome the disease. Subsequently, at the time this report was written, the outcomes of the group’s work were underpinned by the same principles upon which their work was premised.

Joined in their efforts by other likeminded Māori Health Providers, the outcomes of the process evaluation have shown that, through the assignation of the right people and the right processes, the possibilities for engaging communities for a worthy cause (without high levels of material inducements) is still possible. Through the adoption and


49Borgani M Mayosi, A proposal for the eradication of rheumatic fever in our lifetime. March 2006, Vol. 96, No.3 SAMJ.
application of kaupapa Māori principles and practice, the RFAC engendered, fostered and demonstrated high levels of community spirit and care. However, as mentioned earlier in this report, there is reason for caution. A double edged sword, the reliance on people’s capacity to care (manaaki), to share (tohatoha), to extend generosity (tuku aroha) and to contribute to projects such as the RFAC, but without adequate resources, is unfavourable.

This concern aside, and as the outcomes and the recommendations that follow demonstrate, the positive aspects of the campaign are many. At the time this report was written the outcomes of the RFAC included:

**3.6.2 Outcomes**

3.6.2.1 A commitment by the local Māori radio station (Radio Te Arawa) to playing the RFAC ‘jingle’ in perpetuity.

3.6.2.2 The uptake of RFAC work by individuals who attended RF education seminars and/or who were involved in the campaign (for example the family involved in developing the campaign pamphlet).

3.6.2.3 The identification of a process by which to advance the relationship between the LDHB Population Health Team and the WIT School of Nursing in order to assist student learning and experience through actual involvement in population/public health projects.

3.6.2.4 The inclusion of RF education and prevention in the health and science curriculum in 2010 by two Kura Kaupapa Māori.

3.6.2.5 The development of a collaborative and participatory kaupapa Māori model of health promotion that can be used as a blue print for other such programmes.

3.6.2.6 The production of a body knowledge regarding Māori health promotion that can inform the theory and practice of Māori health promotion generally.

3.6.2.7 A kaupapa Māori model for Māori health promotion and education that encourages and fosters Māori self responsibility, self empowerment, self efficacy and self determination (tino rangatiratanga)
3.6.2.8 The successful execution of RF education seminars which saw a 58% increase in RF knowledge and awareness of participants.

3.6.2.9 The development, and successful implementation, of an integrated HP evaluation framework.

3.6.2.10 The development of strong relationships and open communication across all stakeholders to support cooperation, collaboration and understanding of stakeholder roles and responsibilities\(^{50}\).

3.6.2.11 A strength based model [of Māori health promotion] which has the child and their whanau as the programmes focus.

3.6.2.12 An acknowledgement of, and reference to, cultural factors and their influence on health status.

3.6.2.13 Increased capacity of Māori Health Providers to understand and to use research (theory) in their practice. That is, the use of rheumatic fever research and report findings, and the Heart Foundation Guidelines, to inform and guide their work in planning, developing and implementing the RFAC.

3.7 Summary

Without doubt the outcomes of the RFAC planning and implementation process will be ongoing. In the context of the wider Lakes DHB RF project that is proposed, the campaign is but a beginning. As such, a measure of the campaign’s impacts and outcomes will be determined by the degree to which the full RF programme is provided with the support necessary to continue; or otherwise.

3.8 Recommendations

As evidenced by the previous outcomes, the Lakes DHB Rheumatic Fever Campaign was participatory, inter-sectoral and integrated. Premised at one level on the principle of ‘totika’ (effectiveness) the campaign assisted in building the capacity of individuals, communities and organisations to begin to address, and to eradicate, the high incidences of RF amongst Māori people in the Lakes DHB. The recommendations that follow are also premised on the principle of totika (effectiveness). Few in number due to the high

\(^{50}\) This outcome is has been lifted from the objectives of the wider Lakes DHB RF Project.
number of positive outcomes of the campaign, the recommendations can be viewed as ‘tools’ for assisting to bolster, strengthen and to maximise the positive impacts and effectiveness of any future health promotion work (including RF reduction) undertaken by the Lakes DHB. The recommendations are as follows:

3.8.1 Recommendation One: Resourcing
Under resourcing was identified as a barrier to the effectiveness of the RFAC. For the future, it is recommended that resourcing for like work be more realistically scoped, rationalised, ‘costed’ and effected during the development phase of funding applications and with key personnel. In particular resourcing to enable dedicated staff time for providers and sufficient resourcing for development of campaign resources were identified.

3.8.2 Recommendation Two: Evaluation Methods
As explained in the Limitations Section (Section 2.2) the evaluation of the RFAC was unable to determine any direct impact of the campaign on the target community. For the future, it is recommended that provision for the development and implementation of impact surveys and other tools for measuring community impact, be made. While requiring higher resourcing levels for planning, development, implementation and data collection and analysis, such tools allow for triangulation of data to occur. In turn, triangulation of data increases the reliability of evaluation results. As with the first recommendation, provisions to expand evaluation methods to better reflect the costs of a more in-depth and comprehensive evaluation process, needs to occur at the time when funding applications for this type of work are developed; and with key personnel.

3.8.3 Recommendation Three: Campaign Effectiveness
The RFAC was the first phase of the wider Lakes DHB Rheumatic Fever Project. Other deliverables of the wider project include:

- Adherence to Heart Foundation guidelines for primary and secondary RF treatment and care.
- The development of RF monitoring and evaluation systems.
A comprehensive RF register for Lakes & BOP DHBs amongst others. To a certain degree, the success (or otherwise) of the RFAC can be judged by the degree to which the longer term RF project gains the support necessary to continue post RFAC and beyond. Based on the groundswell of support for the RFAC and an ensuing commitment to RF reduction by Māori communities in the Lakes DHB, the recommendation of this report is that the Lakes DHB RF Project be supported to the levels required to ensure its objectives are met in full. The reduction of the high rates of acute rheumatic fever in Lakes DHB requires a focussed and coordinated approach to primary prevention and secondary management of rheumatic fever. The RFAC is but a first step on this journey. The work needs to continue.

3.8.4 Recommendation Four: Ongoing RFA work

The RF puppet show that was developed and staged by the WIT student nurses was a highly effective teaching and learning tool. As an exemplar method for delivering the RFAC messages to a range of audiences, in particular primary school children, the puppet show cannot be faulted. The recommendation of this report is that a plan, including adequate resourcing to continue this form of RF education programme in schools, be developed and implemented.

3.8.5 Recommendation Five:

To increase the levels of reliability of any further evaluations, it is recommended that evaluation tools that may be returning invalid data are identified and modified prior to further use (inside of the evaluation process).

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51 Lakes DHB Rheumatic Fever Project for Lakes District Health Board
52 Lakes DHB Rheumatic Fever Project for Lakes District Health Board
3.9 In Conclusion
The evaluation has shown that the RFAC had a positive impact upon knowledge, attitudes and information seeking about Rheumatic Fever. The campaign was particularly effective in promoting and fostering strategic and constructive collaborations between key stakeholders. As such, the RFAC exemplifies the value of partnerships between these groups and individuals to effectively deliver important health messages.

Finally, the indirect costs of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) to whānau Māori are devastating. Often difficult to measure, these costs include not only the loss of quantity of life (it has been estimated that five to ten young people die each year as a direct result of ARF and RHD) but also, the loss of quality of life. This loss occurs due to time away from education and occupation, impacts on physical development and family relationships, psychological effects and the loss of ability for children and young adults to realise their full potential in their lifetime.53

With these harsh facts in mind, the importance of the Lakes DHB’s work to reduce the incidence of Rheumatic Fever amongst Māori people in the Lakes DHB, and the necessity for the work to continue cannot be over emphasised. As the words of the New Zealand Heart Foundation54 tell us:

‘he korokoro ora he manawa ora, mō tātou katoa’
A healthy throat, a healthy heart for us all.

Sore throats matter!

53 NZ Heart Foundation, 2006, NZ Guidelines for Rheumatic Fever.
54 NZ Heart Foundation, 2006, NZ Guidelines for Rheumatic Fever
REFERENCE


<table>
<thead>
<tr>
<th>APPENDICES</th>
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<tbody>
<tr>
<td>Appendix I</td>
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<td>Posters</td>
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<td>Flipcharts</td>
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<p>| Media Campaign          |                                                                                   | Sept / Oct /  |                                                                                               | Increased awareness and knowledge of rheumatic fever amongst Lakes Māori communities       |        |
|                        | press releases                                                                    | Nov           | Rotorua/Taupo/Turangi/Mangakino&lt;br&gt;Rotorua Daily Post&lt;br&gt;Rotorua Review&lt;br&gt;Rotorua Weekender&lt;br&gt;Taupo Chronicle&lt;br&gt;Mangakino Dambusters&lt;br&gt;South Waikato Times&lt;br&gt;Turangi Chronicle |                                                                                               |        |
|                        | advertorials                                                                      |               |                                                                       |                                                                                               |        |
|                        | Maori radio                                                                        |               |                                                                       |                                                                                               |        |
|                        | Iwi media                                                                          |               |                                                                       |                                                                                               |        |
|                        | Maori television                                                                   |               |                                                                       |                                                                                               |        |
| School newsletters      | Sunset primary                                                                      |               |                                                                       |                                                                                               |        |
|                        | Aorangi                                                                            |               |                                                                       |                                                                                               |        |
|                        | WHP                                                                                |               |                                                                       |                                                                                               |        |
|                        | Kaitao Int                                                                         |               |                                                                       |                                                                                               |        |
|                        | WHHS                                                                               |               |                                                                       |                                                                                               |        |
| Community Newsletters   | ROSSCO                                                                             |               |                                                                       |                                                                                               |        |
|                        | Ngakuru newsletters                                                                |               |                                                                       |                                                                                               |        |
|                        | Mokoia Association                                                                 |               |                                                                       |                                                                                               |        |</p>
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<td>Throat swabbing</td>
<td>Korowai Aroha</td>
<td>Sept-Oct-Nov</td>
<td>Outreach clinic Fordlands City Clinic</td>
<td>Increased awareness of throat swabbing and follow up treatment as a preventer of RF</td>
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<td>Maori / Pacific Community</td>
<td>Marae, PI community events, Kaumatua, MHP</td>
<td>Sept-Oct-Nov</td>
<td>Marae, Kaumatua Groups, Maori Health Providers, Maori Health Team, MWWL/Apumoana marae, Pacific Island gatherings</td>
<td>Awareness/knowledge of RF raised amongst Maori communities</td>
</tr>
<tr>
<td>Wider Community Presentations</td>
<td>VB</td>
<td>Sept-Oct-Nov</td>
<td>PAFT, Family Start, Tipu Ora, Sunset/Aorangi/ Western Heights Primary/Kaitao Intermediate, Western Heights High Health Clinic staff</td>
<td>Awareness / Knowledge raised amongst school staff and provider of services to children and whanau/family</td>
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<tr>
<td>Brochure/ Poster Drop</td>
<td>VB, Korowai Aroha staff, Tina Winikerei</td>
<td>Sept-Oct-Nov</td>
<td>GP clinics, School clinics, MHP, Health Rotorua PHO, Lake Taupo PHO, Tuwharetoa Health Services, Mangakino Hauora Kokiri</td>
<td>Resources available to support/reinforce the campaign messages</td>
</tr>
</tbody>
</table>
Rheumatic Fever Community Awareness Campaign

EVALUATION

Plan to Lakes District Health Board from: Dr Tepora Emery PhD
Attention: Lakes DHB RFAC Co-ordinator
Date: 6 September 2009

Goal of Project to be Evaluated
To reduce the incidence of Rheumatic Fever amongst Māori and Pacific peoples in the Lakes DHB.

Objectives
1: To increase knowledge and awareness of Rheumatic fever amongst Māori and Pacific communities in the Lakes DHB.
2: To increase the knowledge and awareness that “sore throats matter” amongst Māori and Pacific communities. That is, that sore throats experienced, in particular by Māori and Pacific children aged 5 – 14 years, should be taken seriously when they occur (and be followed up with a visit to a GP for a throat swab).

Knowledge and Awareness raising methods
Pamphlets, posters, flipcharts
Press releases
Presentations (by DHB representative)
Māori Television and Māori Radio Advertorials
Dissemination of information through Local Iwi networks.

Key Support
The campaign will be conducted and delivered in conjunction with the following organisations
Korowai Aroha Health Services
Te Papa Takaro o Te Arawa
Lake Taupo PHO
RAPHS

Focus
The key messages that this campaign will deliver are:
1: Rheumatic fever is a serious disease that can cause heart damage.
2: If your child has a sore throat take them to the doctor for a throat swab
3: Māori children aged 5 – 14 years are particularly at risk
4: It is very important that you take all your medicine as prescribed so that all the Group A Strep Bugs are killed.
Types of Evaluation proposed.
The programme will be evaluated using the following methods::

1: Process Evaluation

A survey of MHPs Rotorua-Taupo, Te Papa Takaro o Te Arawa Māori Communities (and those other groups as identified within the Project Plan) to determine, for example:

- Motivations (for engagement)
- Health provider perspectives of ‘successful’ health promotion awareness (campaigns).
- Feedback on campaign process.

2: Impact Evaluation

A questionnaire/survey to determine whether or not key rheumatic fever campaign ‘messages’ are remembered and acted upon; across the target community generally.

3: Outcomes Evaluation

A report on the overall outcomes of the campaign as determined by way of data collected through the impact and process evaluations.

4: Methods – Kaupapa Māori

Two fundamental principles underpin the conduct of a ‘culturally safe’ (kaupapa Māori) evaluation, of a Māori focused health promotion campaign. The first requires the establishment of the programme context through the identification of the historical setting and cause. The second entails the identification of appropriate methods by which to research with people while, at the same time, promoting their self-determination.

In keeping with these principles, the research methods used to evaluate the Rheumatic Fever Campaign will:

- Use research ‘tools’ that are fashioned in both te reo Māori and in English (for example in questionnaires and in written and verbal communications with stakeholders).
- Provide a te reo Māori option for face to face interviews.
- Ensure that verbal and written communications are developed and conducted in accordance with tikanga Māori (for example, mihimihi and karakia at the outset of interviews and meetings).
- Ensure that evaluation participants have access to the evaluation report.
- Ensure that all data reported, is reported respectfully and in ways that uphold the mana (dignity and integrity) of evaluation participants.
- Provide an option for evaluation participants to remain anonymous.
## EVALUATION METHODS AND EVALUATION PLAN

### Purpose
To ascertain the successfulness of the campaign with specific regard to: the process, the impact and the outcomes (of the campaign).

<table>
<thead>
<tr>
<th>Conveying of Knowledge and Awareness Methods</th>
<th>Interface and ‘Transmission’ Organisations</th>
<th>Evaluation Method/s</th>
</tr>
</thead>
</table>
| Presentations/education workshops (delivered by Project Manager) | Kai-mahi (staff) at Korowai Aroha Health Services Te Papa Takaro o Te Arawa Lakes Taupo PHO (including Turangi and Mangakino) School Principal’s Association School Staff | **Impact Evaluation**  
Pre and Post Evaluation/questionnaire |
| Advertorials – targeting general Māori and Pacific Island communities | Iwi Radio and Māori Television Schools (through newsletters) | **Impact Evaluation**  
Questionnaires/kanohi ki te kanohi interviews  
(With targeted (random) population samples for example, (Māori) mothers/fathers with children in Rotorua city and other places where the target groups congregate.) |
| Posters, brochures / information ‘drops’ (by Project Manager) | MHPs Rotorua/Taupo Te Papa Takaro o Te Arawa Māori Communities (and those other groups as identified within the Project Plan) | **Process Evaluation**  
Survey/Questionnaire  
Campaign Effectiveness (to ascertain the effectiveness, benefits and any problems associated with the project)  
Kanohi ki te kanohi interviews/meetings  
(with a random sample of these organisations/people) |
| Throat Swabbing | Korowai Aroha | **Quantitative Survey** |
**EVALUATION ACTION PLAN**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline</th>
<th>Completed/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop evaluation plan and submit to Veronica</td>
<td>11 September 2000</td>
<td></td>
</tr>
<tr>
<td>Develop Questionnaires x 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Pre and Post Knowledge and awareness assessment (Impact Evaluation)</td>
<td>8 September 2009 (Pre and Post)</td>
<td></td>
</tr>
<tr>
<td>b) Campaign Effectiveness (Process Evaluation)</td>
<td>11 September 2009</td>
<td></td>
</tr>
<tr>
<td>c) General target group surveys</td>
<td>11 September 2009</td>
<td></td>
</tr>
<tr>
<td>Where necessary, meet with interface organisations (preferably in conjunction with Project Manager Veronica Butterworth)</td>
<td>September/Oct/Nov 09</td>
<td></td>
</tr>
<tr>
<td>Distribute Questionnaires including Campaign Effectiveness interviews</td>
<td>September/Oct/Nov 09</td>
<td></td>
</tr>
<tr>
<td>Collect Data/completed Questionnaires</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualitative data through interviews (with selected interface organisations)</td>
<td>Nov 09</td>
<td>20 Nov 09</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>23 November 09</td>
<td></td>
</tr>
<tr>
<td>Report writing and submission</td>
<td>Dec 09</td>
<td>31 December</td>
</tr>
</tbody>
</table>
Rheumatic Fever Community Awareness Campaign
Presentation

PROCESS EVALUATION

Name of Group: Date:

Tēnā koe oti rā, tēnā koutou.

Ngā mihi nui ki a koe i runga i ngā āhuatanga o te wā. Hari koa ana te ngākau kua whai wā koe ki te whakaoti i tēnei pepa patapatai.

Thank you for taking the time to be involved in the DHB Rheumatic Fever Awareness campaign and for taking time to complete this evaluation; your views are important to us. Please note that information gathered by way of this questionnaire will provide feedback to the Lakes District Health Board on the process and the outcomes of the Rheumatic Fever Awareness Campaign.

To ensure your intellectual ‘safety’ in this evaluation/interview process, we would be pleased if you could take a minute to read the information below regarding informed consent. Nō reira ka nui ngā mihi ki a koe.

Informed Consent

I understand, acknowledge and agree that:

1. I will be involved in an interview which will take approximately 40 minutes.

2. The aims, methods and anticipated benefits of my involvement in the RFAC campaign evaluation have been explained to me.

3. Data gathered from this interview will be used for evaluating the Lakes DHB RFA Campaign and I will have access to the final campaign evaluation report.

4. I am free to withdraw from the evaluation/interview at any time. If I should decide to withdraw, my participation in the evaluation will stop immediately and any information I have given will not be used.

5. I voluntarily and freely give my approval to participate in this evaluation/interview.

6. I have the right to remain anonymous and issues of confidentiality will be fully respected.

7. This evaluation seeks to identify factors that have contributed to the success (or otherwise) of the campaign.

SIGNED: ______________________ NAME: ________________________________

ROLE: ☑ Awareness Campaign Working Group ☑ Steering Group Member

☑ Other – please state _______________________________ (Please tick ☑ ✔)
NGĀ PĀTĀI – QUESTIONS

1a: Can you describe your role in the RF project/awareness campaign?

1b: What motivated you and/or your organisation to become involved in the community campaign?

2. In your view, what factors have contributed to the successful planning and implementation of the community campaign?

3. What barriers, if any, have been experienced?

4: How has the overall process of contributing/working within a Lakes DHB project worked for you/your organisation?

5: What does successful Health Promotion for Māori look like (in your view)?

6. What would assist in promoting health among Māori people in the Lakes DHB?

7. What (if any) are the barriers to health promotion and health awareness raising among Māori people in the Lakes DHB?

8. Were you involved in developing the campaign pamphlet? If so, how would you describe the process? That is, what were the positive aspects of the development; what, if any, were the barriers (encountered when developing the resource).

9. Is there anything else you would like to add to this conversation?

10. Campaign Awareness

How has your awareness/knowledge of Rheum and Strep Sore Throat improved by being involved in the campaign?

<table>
<thead>
<tr>
<th>00%</th>
<th>20%</th>
<th>40%</th>
<th>60%</th>
<th>80%</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

100% = maximum improvement
0% = no improvement
Rheumatic Fever Community Awareness Campaign
Presentation
EVALUATION

Name of Group: ________________________________      Date:  __________________

Your Role in Organisation/Group:_____________________________________________

Tēnā koe oti rā, tēnā koutou.

Ngā mihi nui ki a koe i runga i ngā āhuatanga o te wā. Hari koa ana te ngākau kua whai wā koe ki te whakaoti i tēnei pepa patapatai.

Thank you for taking the time to complete this evaluation, your views are important to us. Nō reira ka nui ngā mihi ki a koe.

---

**Awareness & Knowledge**

Mark the level of your awareness and knowledge before the presentation with an ✗
Mark the  level of you awareness/knowledge after the presentation with a ✓

| Awareness and Knowledge that Rheumatic Fever is a serious disease which can cause permanent heart damage | 1 2 3 4 5 6 7 8 9 10 |
| Awareness and knowledge of what may cause Rheumatic Fever | 1 2 3 4 5 6 7 8 9 10 |
| Awareness and knowledge of what can be done to help prevent a child getting Rheumatic Fever | 1 2 3 4 5 6 7 8 9 10 |
| Awareness, knowledge and understanding of the “Sore Throats Matter” message | 1 2 3 4 5 6 7 8 9 10 |
| Awareness and knowledge of the treatment for Strep sore throat | 1 2 3 4 5 6 7 8 9 10 |
| Awareness and knowledge of what can happen if a child does not have treatment for a strep sore throat | 1 2 3 4 5 6 7 8 9 10 |
| Awareness and knowledge of who is most at risk | 1 2 3 4 5 6 7 8 9 10 |

Scale: 1 = Lowest   10 = Highest

No awareness - no knowledge
Very knowledgeable and very aware
1) Previous to this presentation I heard about this campaign through:

Word of mouth ------------------------------------- □
Press releases ------------------------------------- □
Radio -------------------------------------------- □
Television --------------------------------------- □
My workplace ------------------------------------- □
Whānau- hapū-Iwi-marae ------------------------ □
Information/pamphlets --------------------------- □
None of the above/Didn’t know about it -------- □

Other (please state) ______________________________

I will help promote/spread the key rheumatic fever campaign messages by/through:

Key: Y = Yes   N = No   U = Unsure

Word of mouth – friends/family/colleagues       Y   N   U

Distributing information pamphlets

Other________________________________________________________

Do you have any other comments you would like to make?

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Ngā mihi uruhau ki a koe. Thank you for taking the time to complete this questionnaire
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Total Brochures</th>
<th>Total Brochures Returned</th>
<th>Number Distributed</th>
</tr>
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<tr>
<td>15/9</td>
<td>Owhata Surgery</td>
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<tr>
<td>16/9</td>
<td>Korowai Aroha promotion (Manu Kōrero)</td>
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<td>18/9</td>
<td>Korowai Aroha</td>
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<td>1000</td>
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<td>19/9</td>
<td>Pasifika event</td>
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<td>22/9</td>
<td>Health Expo Yr 1 nursing students</td>
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<td>29/9</td>
<td>Practices: TPO/Turangii/Mangakino</td>
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<td>Te Papa Tākarohia o Te Arawa</td>
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<td>8/10</td>
<td>RAPHS/extra</td>
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<td>8/10</td>
<td>Korowai Aroha Staff</td>
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<td>13/10</td>
<td>Health Rotorua PHO</td>
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<td>14/10</td>
<td>H. Pearson for CHPAC</td>
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<td>14/10</td>
<td>Māori Nurses Forum:</td>
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<td>15/10</td>
<td>Toi Te Ora Public Health</td>
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<td>15/10</td>
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<td>19/10</td>
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<td>Sunset Primary ( for staff)</td>
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<td>28/10/09</td>
<td>TTO Public Health; for distribution to schools in Murupara (PHNs)</td>
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<td></td>
<td>600</td>
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<td>29/10/09</td>
<td>Sunset Primary</td>
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<td></td>
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<td>29/10/09</td>
<td>Te Kura Kaupapa Māori o Hurunga Te Rangi</td>
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<td>10/11/09</td>
<td>Te Whare Hauora o Ngongotaha</td>
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<td>15/11/09</td>
<td>Promotion Apumoana Marae</td>
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<td>17/11/09</td>
<td>Plunket</td>
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<tr>
<td>Date</td>
<td>Event</td>
<td>Language</td>
<td>Quantity</td>
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<tr>
<td>26/11</td>
<td>Health Clinics: JPC/WHHS/KBHS/RHS</td>
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<td>200</td>
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<td>27/11/09</td>
<td>Kura Kaupapa Māori Hurunga/Te Koutu</td>
<td>Te Reo English</td>
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<td></td>
<td></td>
<td>English</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td>30/11</td>
<td>Healthy Homes</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>30/11</td>
<td>Tuwharetoa Whānau Trust/Taupo</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>3/12</td>
<td>Tipu Ora Well Child</td>
<td></td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>3/12</td>
<td>Te Whare o Kenehi</td>
<td></td>
<td>50</td>
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<tr>
<td>10/12</td>
<td>Ngati Pikiao Health Clinic</td>
<td></td>
<td>200</td>
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</tr>
</tbody>
</table>

Total Brochures Distributed (English) 8500

Total Brochures Distributed (Te Reo Māori) 950*

* Te Reo Māori brochures were not delivered until mid January hence the low number of distributions