EVALUATION OF THE 2015 RHEUMATIC FEVER AWARENESS CAMPAIGN

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ABBREVIATIONS AND ACRONYMS

AoG  All of Government
BPS  Better Public Services
CATI Computer Assisted Telephone Interviews
DHB District Health Board
GAS Group A Streptococcus
HPA Health Promotion Agency
GP General Practitioner
MOH Ministry of Health
OECD Organisation for Economic Co-operation and Development
PHOs Primary Health Organisations
RF Rheumatic fever
RFPP Rheumatic Fever Prevention Programme
UFE Utilization-Focused Evaluation
VFI Value for investment
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EXECUTIVE SUMMARY

Background
The incidence and burden of rheumatic fever in New Zealand is unacceptably high, with reported rates significantly higher than other developed countries. In 2014, the national incidence of rheumatic fever was 3.4 per 100,000 people, however much higher rates were reported for Pasifika and Māori (26.8 and 9.3 per 100,000, respectively). As part of a five-year government initiative to reduce rheumatic fever by two-thirds, the Ministry of Health are leading the Rheumatic Fever Prevention Programme. The 2015 Rheumatic Fever Awareness Campaign was a component of this wider programme of work.

The 2015 Rheumatic Fever Awareness Campaign focused on those families with children and young people at greatest risk of rheumatic fever. These were Māori and Pasifika parents and caregivers, aged 21-40 years, of children and youth aged 4-19 years, particularly those living in the 11 high-risk District Health Board (DHB) areas. The main objectives of the campaign were to raise awareness of the link between sore throats and rheumatic fever, the importance of getting sore throats checked by a health professional, and as a secondary message the importance of completing the full antibiotic course for children who have Group A Streptococcus infection.

The 2015 campaign was expected to be efficient, effective and relevant. Specifically, the resources and associated processes are expected to be aligned to other activities, and campaign materials and modes of delivery are expected to be relevant to the target audience. It is expected that the campaign effectively reaches those at greatest risk, and these outcomes lead to developing communities' understanding of sore throats and rheumatic fever. It is believed that these campaign outcomes will contribute to changes in desired behaviours over time, and ultimately reduced incidence of rheumatic fever.

Purpose, objectives and methods of the evaluation
The purpose of this evaluation was to provide independent advice to inform improvements to the 2016 Rheumatic Fever Awareness Campaign in support of the overarching Rheumatic Fever Prevention Programme.

The objectives of the evaluation were to: assess the relevance of the 2015 campaign resources; the efficiency of the campaign in terms of alignment with other key activities and overall value; and the effectiveness of the campaign resources in improving awareness and understanding of key rheumatic fever messages. These key campaign messages focused on the link between sore throats and rheumatic fever, the importance of getting sore throats in at-risk children checked by a health professional, and the importance of completing the full antibiotic course for children who have Group A Streptococcus infection.

The evaluation was informed by 8 documents, a review of 47 curriculum materials as well as call statistics to Healthline (New Zealand's national telephone triage and health service), 12 interviews with key stakeholders including the Health Promotion Agency (HPA), Ministry of Health (MOH), GSL Promotus and DHBs, 8 focus groups of
Māori or Pasifika families in 5 regions, 257 telephone interviews with the target audience and a workshop with key stakeholders. This evidence was assessed against a set of standards, established as part of the evaluation process and agreed by key stakeholders.

**Findings and conclusions**

**Efficient**

The campaign achieved excellent value for the level of investment, given that the campaign was judged as exceeding all expectations. The distribution of resources were also considered appropriate to achieve the outcomes, with only some minor improvements necessary to improve outcomes.

In terms of value for investment:

- the campaign development costs were efficient, reusing or recycling materials from previous campaigns;
- the campaign delivery mechanisms provided good value for investment, with posters providing the greatest value for Ministry investment;
- the campaign activities and associated resources were adequate to deliver the campaign on-time, but earlier start-up would be ideal and any new resources may benefit from being scripted; and
- the campaign players’ experience and relationship provided added value through the networks and purchasing approach.

In terms of alignment:

- The campaign incorporated engagements with key relevant agencies or networks to ensure that messages, activities and timing are aligned;
- Early and regular engagement with DHBs supported alignment, although broader engagement and a more collaborative process to ensure usability of the resources would further support use of resources within the communities; and
- Although not in scope for the 2015 campaign, there is an opportunity to broaden the uptake and use of these resources within communities (e.g. schools, community centres), particularly if the campaign is to access those that may not typically go to a health service provider.
Relevant

The campaign messages had clear alignment with other rheumatic fever activities, and campaign activities and timing allowed for use of the materials. DHBs were aware of the campaign, accessed and used the materials for local delivery, where appropriate, adding value to the campaign.

In terms of relevance:

- The campaign messages focused on the key message to get sore throats both checked and treated, which were supported by the campaign planning and resource review processes;
- The delivery teams' expertise and knowledge supported appropriate language and messaging across the campaign;
- Experience and knowledge of what works within communities supported an interesting campaign and greater ownership within the community would further support relevance; and
- The ‘right’ package of delivery mechanisms was determined by media research and expertise, coupled with local knowledge and networks. The campaign could be reinforced through supporting regional use of resources.

Effective

The campaign exceeded the expected level of reach amongst the target audiences, with nearly all of the target audience having seen/heard the campaign. Additionally, the campaign supported a good understanding of the association between sore throats and rheumatic fever, but far fewer individuals understood the importance of completing a course of antibiotics.

In terms of reach:

- Media and local knowledge supported the successful reach of the campaign to 95 percent of the target audience; and
- Further support is needed to promote antibiotic adherence.

In terms of understanding:

- The focus of the campaign visuals, messaging and banners as well as community encouragement of the campaign supported good understanding of the association between sore throats and rheumatic fever;
The target audience understood the importance of getting sore throats checked, but a deeper understanding of rheumatic fever could promote individuals seeking out checks/treatment for sore throats; and

Few of the target audience understood the importance of completing the full antibiotic course for children and youth who have Group A streptococcal bacteria, and greater focus of the campaign on this message can support understanding of this key message.

Recommendations for improvement

The campaign achieved all of the intended outputs and outcomes. It provided contextually relevant resources, effectively reaching the target audience and supporting understanding in a cost-effective way. However, continued support remains relevant to rheumatic fever prevention efforts, and some recommendations to further enhance the 2016 campaign as part of this support are provided below.

The evaluation recommends:

1. the Ministry and HPA modify the timing of the campaign planning to begin earlier, ensuring an efficient and effective campaign that is able to be achieved more easily with current resourcing;

2. HPA and the Provider (selected for the 2016 campaign) further build upon the current resources to advance awareness of antibiotic adherence messages and strengthen this understanding among the target audience;

3. HPA and the Provider (selected for the 2016 campaign) design a 2016 Rheumatic Fever Awareness Campaign that enables community ownership of the resources and rheumatic fever messages while taking advantage of the resource materials that are currently held; and

4. the Ministry and HPA engage more broadly to support local relevance of the campaign, uptake and ultimately efficient use of current resources, and to gain broader support from local communities with communicating key campaign messages.
1. INTRODUCTION

1.1. Background

Rheumatic fever is an inflammatory disease that may develop after a Group A Streptococcal (GAS) infection, such as a sore throat.\(^1\) The incidence and burden of rheumatic fever in New Zealand is unacceptably high. The annual incidence of rheumatic fever in developed countries (as reported in 2001) was below 1.0 per 100,000\(^2\); therefore the New Zealand rate of rheumatic fever is 4 times higher than this average (4.0 per 100,000). In 2014, the national incidence rate of rheumatic fever was 3.4 per 100,000 people, however much higher rates were reported for Pasifika and Māori (26.8 and 9.3 per 100,000, respectively). The highest rates are concentrated in specific New Zealand regions.\(^3\) It is highly likely that a combination of crowded housing conditions and socio-economic deprivation, barriers to primary healthcare access and the subsequent higher burden of untreated strep sore throat infections are important factors leading to higher rates of rheumatic fever among Māori and Pacific people.\(^4\)

Comprehensive awareness raising campaigns about rheumatic fever have been associated with reductions in rheumatic fever.\(^5\)\(^6\)\(^7\) For example, a 10-year education programme undertaken in two French Caribbean islands found that over the course of the 10-year educational intervention, the incidence of rheumatic fever progressively declined on both islands by 74-78 percent.\(^8\)

The New Zealand government is investing in rheumatic fever prevention. In 2012 the New Zealand government started working towards the five-year Better Public Services (BPS) target to reduce rheumatic fever by two-thirds to 1.4 cases per 100,000 people by June 2017.

The Rheumatic Fever Prevention Programme (RFPP) is a broad programme of work aiming to reduce the incidence of rheumatic fever in New Zealand. This includes three core strategies: improving access to treatment of Group A Streptococcus (GAS) throat infections; reducing the transmission of GAS by reducing household crowding; and raising awareness of rheumatic fever. The RFPP aims to meet the Government’s BPS target (noted above). The 2015 Rheumatic Fever Awareness

\(^3\) The 2014/2015 rheumatic fever rates (per 100,000) are: Auckland (3.2), Counties Manukau (8.0), Waitematā (1.6), Capital and Coast (1.7), Hutt Valley (2.8), Northland (9.0), Waikato (3.6), Bay of Plenty (3.2), Tairāwhiti (14.8), Lakes (5.8) and Hawkes Bay (not available: rates have not been calculated where there were fewer than four cases).
Campaign is a component of the RFPP, which focuses on increasing knowledge of the link between sore throats and rheumatic fever and the serious heart damage that it can cause in at-risk families and communities. The campaign provides information on how families can protect their children from rheumatic fever, and how and where to seek help for a sore throat.

The 2015 campaign is an extension of the 2014 Rheumatic Fever Awareness Campaign. The 2014 campaign was novel; it was the first mass media campaign in New Zealand aimed at increasing awareness among parents and caregivers of at-risk children and young people about the causes and effects of rheumatic fever.

Similar rheumatic fever prevention campaigns focus on reaching children and young adults living in impoverished settings, where unhealthy environments and lack of awareness and knowledge of streptococcal infection progression are common. These communities often have high rates of poverty, overcrowding, under-nutrition, experience access barriers to healthcare and a lack of awareness of rheumatic fever.9,10,11,12

The previous year’s (2014) Rheumatic Fever Awareness Campaign in New Zealand was highly effective with high recall, strong message out-take and a call to action to take children with sore throats to be checked by a doctor or nurse.13 The 2014 campaign was also viewed by almost all as being easy to understand, and the main message out-take by those aware of the campaign (74 percent) was to take children with a sore throat to the doctor.14 Among those aware of the 2014 campaign, 69 percent of Māori and 77 percent of Pasifika people agreed that the campaign was talking to people like them.15

However, focus groups suggested that the 2014 campaign messages may not have reached all the priority audience to the extent needed to ensure the audience appreciated that sore throats matter and need to be checked.16 Many parents remain unconvinced of the urgency of having sore throats checked.17

There was an argument for making the messages more hard-hitting by explaining the bigger picture about how having rheumatic fever has affected the lives of those affected and their family, and considering increasing the range of communication channels when promoting the message.18

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14 ibid (p.5).
15 ibid (p.22).
Ensuring reach of complex messages, such as those messages related to the 2015 Rheumatic Fever Awareness Campaign, is key to support understanding amongst target audiences. For this reason, communicating messages has moved into an era of strategic communication often characterised by integrated communication messages; the use of mobile phones to educate people at low cost; the role and use of electronic media and social networks; involving local community with a strong consultative process; increased attention to evaluation and evidence-based programming.\textsuperscript{19}

Complex concepts can also be better understood when appropriate communication strategies employ a systematic approach that utilises a variety of mechanisms (e.g. printed material, displays, videos and discussions) to improve awareness in and stress motivating principles, cultural relevance and feasibility.\textsuperscript{20}

The Ministry and the HPA aimed to deliver a relevant, efficient and effective rheumatic fever campaign in 2015 as part of the wider RFPP, supporting the overall objective to reduce incidence of rheumatic fever by two-thirds to 1.4 cases per 100,000 people by June 2017.

The 2015 Rheumatic Fever Awareness Campaign built upon the 2014 campaign, using many of the same resources while employing a range of resources and delivery mechanisms (television, print, radio and digital advertising) to raise awareness amongst Māori and Pasifika audiences. It specifically sought to raise awareness amongst target audiences of the following key messages:

1. the link between sore throats and rheumatic fever;
2. the importance of getting sore throats in at-risk children checked by a health professional;
3. the importance of completing the full antibiotic course for children who have GAS infection; and
4. what families of high-risk children can do in their own homes to stop their children from getting rheumatic fever.\textsuperscript{21}

The 2015 Rheumatic Fever Awareness Campaign focused on those families with children and young people at greatest risk of rheumatic fever. These were Māori and Pasifika parents and caregivers, aged 21-40 years, of children and youth aged 4-19 years, particularly those living in the following DHB areas: Auckland, Counties Manukau, Waitemata, Capital & Coast, Hutt Valley, Northland, Waikato, Bay of Plenty, Tairāwhiti, Hawke’s Bay and Lakes.

The projected outcomes associated with the 2015 awareness campaign are shown in the figure below.\textsuperscript{22}

\[\textsuperscript{19} \text{Zuhlke, L. J., Engel, M. E. (2013). The importance of Awareness and Education in Prevention and Control of RHD. Global Heart, 8(3), 235-239 (p. 237).}\]
\[\textsuperscript{20} \text{ibid (p. 236).}\]
\[\textsuperscript{21} \text{The fourth key message - “what can families of high-risk children do in their own homes to stop their children from getting rheumatic fever” - is out of scope of this evaluation due to timing restraints.}\]
\[\textsuperscript{22} \text{The expected outcomes were derived from contractual documents, and then these were tested against a literature review on Rheumatic Fever Awareness Campaigns (section 1.1) and further supplemented with discussions with key Ministry, HPA and GSL Promotus.}\]
Figure 1: Chain of theorised outcomes associated with the 2015 Rheumatic Fever Awareness Campaign

The model above suggests a sequence of intended achievements associated with the 2015 campaign. First were efficient campaign resources and associated processes that were aligned to other activities, and campaign materials and modes of delivery that were relevant to the target audience. It was then expected that the campaign
effectively reached those at greatest risk, and these outcomes would then lead to developing communities’ understanding. These campaign outcomes contribute to changes in desired behaviours over time, and ultimately reduced incidence of rheumatic fever.
2. EVALUATION

2.1. Purpose

The evaluation focuses on the efficiency, relevance and effectiveness of the 2015 Rheumatic Fever Awareness Campaign according to the evaluation criteria (c.f. Figure 1). The evidence from the 2015 campaign serves a formative purpose to inform decision-makers about how the development and implementation of the 2016 Rheumatic Fever Awareness Campaign can be enhanced.

To meet these objectives, this report:

- assesses the campaign against the criterion (c.f. Figure 1), summarising the evidence under each section to endorse the evaluative statements in the Evaluation Findings section;
- tracks behaviours of the target audience in the Monitoring Findings section;
- summarises the merit and value of these achievements against the criteria in the Conclusions section; and
- provides recommendations to the 2016 campaign in the dedicated Recommendations section.

More widely, this report provides accountability and lessons to the New Zealand Ministry of Health and the HPA regarding the resources invested in the campaign.

2.2. Approach

The evaluation examined how well the campaign was implemented and delivered, and whether the campaign achieved its intended outcomes. It did this by judging the campaign against “expected” practice, derived from contractual documents. These expectations were supported from the literature review (section 1.1) and further supplemented with discussions with key Ministry, HPA and GSL Promotus personnel.

These expected achievements were used to develop an evaluation framework (c.f. Appendix A), which identified explicitly both the desired outcomes of the evaluation (c.f. “what is good”) along with performance indicators (c.f. “what does good looks like”) and appropriate sources of data (c.f. “where/how can these indicators be found”).

The evaluation framework supported a rubric (Appendix C) which described levels of performance for the criteria considered in this evaluation: value, alignment, relevance, reach and understanding. The rubrics were developed iteratively; initial drafts were provided to the Ministry, HPA and GSL Promotus to gain agreement on what success looks like for each criterion.
2.3. Methods and data sources

To ensure this evaluation provides accurate and useful findings, a range of methods were used to evaluate the 2015 campaign. The methods, provided in full detail in Appendix B, included the:

- **Review of rheumatic fever campaign documents**, including eight relevant documents relating the development and delivery of the 2015 campaign (e.g. contracts, resource requests, media schedule);

- **Analysis of administrative data**, including the 2015 campaign-resource request database (managed by HPA), media expenditures according to delivery mechanisms (summarised by GSL Promotus), and Healthline call statistics relating to sore throats;

- **Review of campaign materials**, including 47 resources of the 55 2015 Rheumatic Fever Awareness Campaign resources\(^\text{23}\) (e.g. posters, digital display screens, online videos, TV ads, English radio advertisements, postcards and a banner);

- **Interviews**, including key personnel involved in the Rheumatic Fever Awareness Campaign, including the Ministry \((n=5)\), HPA \((n=5)\), Healthline staff \((n=2)\), GSL Promotus \((n=1)\) and DHBs (individuals at three DHBs);

- **Focus groups**, including eight separate groups in Auckland, Counties Manukau, Hamilton, Gisborne and Porirua, with either Māori or Pasifika parents and caregivers (aged 21-40 years) of children and young people aged 4-19 years;

- **Computer Assisted Telephone Interviews (CATI) survey of target audience**, with 257 Māori and Pasifika parents and caregivers, aged 21-40 years of children and young people aged 4-19 years across the 11 targeted regions. Results based on the total sample of \(n=257\) respondents are subject to a maximum margin of error of ±6.1 percent (at the 95 percent confidence level); and

- **Sense-making workshop with key stakeholders**, including approximately 20 key stakeholders from Ministry, HPA, GSL Promotus and DHBs to enable joint discussion and interpretation of preliminary findings.

The evaluation triangulated the evidence, using multiple sources of information and indicators to assess the campaign against the established criteria. This approach allowed the evaluation team to verify findings and support valid evaluative judgements.

2.4. Strengths and limitations

A particular strength of the evaluation was that it considered the campaign by using evidence and feedback from a variety of sources. The evaluation included collecting context-rich, qualitative information from key stakeholders involved in the

campaign development and implementation process (e.g. Ministry, HPA, GSL Promo触us), as well as those stakeholders delivering relevant information within regions (e.g. DHBs). By engaging with different stakeholder groups, the evaluation considered the campaign’s implementation from multiple perspectives. The methods permitted in-depth discussion of strengths, weaknesses and areas for improvement, which informed the evaluation recommendations.

While the interviews provided rich information about individuals’ views and experiences, not all pertinent stakeholders could take part. The evaluation did not engage with Primary Health Organisations (PHOs) and community medical staff, which limited the ability to make justified conclusions about uptake amongst these key groups and limited our understanding of why some community groups do not access campaign resources.

The evaluation included data collected from the target audience, supporting an assessment of the campaign’s intended outcomes. First, a quantitative approach was used to estimate overall reach and understanding across this population. The target audience was people living in one of 11 DHB areas of interest, being of Māori or Pasifika ethnicity, aged 21 to 40 years, responsible for a child or youth aged 4 to 19 years, and have at least some involvement in decisions about when to take that child to the doctor or nurse.24

The approach provided results that could be extrapolated to the target audience with a 95% confidence interval of ±6.1 percent. This means, for example, that if 50 percent of respondents reported they had seen the Rheumatic Fever Campaign advertisements, we could be 95 percent sure of getting the same result, ±6.1 percent, had we interviewed everyone in this population.

Focus groups built upon this information, and explored the barriers and enablers to accessing, engaging and understanding the campaign resources across a selection of regions.

The evaluation triangulated the evidence, using multiple sources of information and indicators to evaluate the campaign against each criterion (c.f. Appendix C). The evaluation team triangulated data to verify findings and support valid evaluative judgements.

The qualitative and quantitative approaches used to engage the target audience provided a good overall assessment of the campaign’s reach, and of the current understanding and health-related behaviours of this specific target audience. The evidence identified areas of strength and development across these 11 targeted regions, which informed the evaluation recommendations.

However, data collected from the target audience were not large enough to enable comparisons of success (and, in turn, needs) across individual regions. Significantly more numbers of interviews would be necessary to determine, for example, if more Māori and Pasifika parents from the Hutt Valley understood the key messages than those target audiences in Counties Manukau.

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24 The survey gathered additional demographic detail that may be of interest for this campaign (e.g. household income level, number of people living in a household) but these were not included as part of the sample considerations.
3. EVALUATION FINDINGS

Throughout the Evaluation Findings section, the overall judgements are provided as:

- subheading statements, identifying the achievement of each key outcome according to the agreed standards of performance (e.g. “The campaign achieved good value for investment”); and
- side-text statements (in green text), identifying the processes that supported and inhibited the specific outcome as well as associated areas of improvement (e.g. “Recycling materials and building upon established relationships saves time and money, but any new materials would best be scripted”).

The data to support these statements are summarised under each subsection.

3.1. The campaign provided excellent value for investment

The campaign achieved excellent value for the level of investment, given that the campaign was judged as regularly exceeding expectations. The distribution of resources were considered appropriate to achieve the outcomes, with few minor improvements suggested.

3.1.1. The campaign development costs were efficient

The 2015 campaign was very efficient in development. The material review showed that the campaign reused many of its materials from the previous campaign delivered in 2014, including TV commercials, posters, online banner ads and online videos. When other materials were new to the current campaign, these were often recycled from previous campaigns. For instance, GSL Promotus “cut” materials from the previous campaigns to create something new, or developed digital screens from other campaign materials.

Radio “featurettes” required full production for development. Featurettes were developed as pre-recorded interviews with individuals, rather than live interviews, which proved problematic to organise in the previous campaign due to the availability of clinicians during specific radio talk-back air times. Prerecorded interviews allowed for greater flexibility in line with radio shows. The development process took longer than anticipated. The fact that this was the first time senior cultural advisors have led the production was suggested as one factor contributing to this longer process. The intent of the featurettes was that they would be unscripted and natural stories, as told by the clinicians, health providers and whānau. The resulting recordings, however, were not deemed technically accurate enough for delivery, and therefore it was necessary to recut and script the materials to ensure such accuracy.

25 The achievement level “excellent” refers to overall level of success for the “value for investment” criterion. Rubrics (appendix C) were used to establish standards against which the campaign was evaluated. These identified what would be considered “excellent”, “good”, “adequate” and “poor” within two months after the 2015 campaign ended. These four levels of success were negotiated and agreed with all primary stakeholders prior to presenting results.
The document review along with the material review revealed that the reuse of the 2014 campaign content and recycling of previous materials produced a significant cost-saving to the Ministry from 2014 to 2015. In total, 55 materials were used for the 2015 campaign for significantly less than one-half of GSL Promotus’ development and management costs associated with the 2014 campaign.

Figure 2: Number of resources, and development and management costs (as evidenced in administrative data and contractual documents) associated with both the 2014 and 2015 campaign materials (as evidenced on the HPA-hosted internet sites).

Given this evidence, future rheumatic fever campaigns would best continue to take advantage of already available resources, while ensuring any reused materials are up-to-date and relevant, and give consideration to scripting of new materials before they are recorded.

3.1.2. The campaign delivery mechanisms generally provided good value for investment, with posters providing the greatest relative value for investment for the Ministry

In addition to the development costs, there were also costs associated with delivering the campaign. The document review and interviews suggested that the campaign was delivered through a variety of mechanisms. The review of data showed that the largest investment in delivery mechanisms was made in television ads (63 percent of the 2015 delivery costs), followed by radio advertisements / featurettes (23 percent of the 2015 delivery costs) and digital screens placed in petrol stations or offices - “digiscreens” (12 percent of the 2015 delivery costs). The remaining delivery investment was made on postcards dropped in letterboxes (0.22 percent of the 2015 delivery costs), and in digital video, search and social media (2 percent). Costs associated with posters (e.g. printing) were paid by local providers or organisations wanting to use the resources.

26 The overall costs largely include warm and dry homes component of the awareness campaign, which are outside of scope of the current evaluation.

27 2015 campaign development and management costs largely include “warm and dry homes” which is out of scope of the evaluation. This figure would therefore be significantly smaller than the $292,000 estimated here, and showing even greater value for money.


Recycling materials saves time and money.
Media research was available to GSL Promotus (as a professional marketing agency) and HPA. This information determined the quantity of each mechanism as those modes most likely to reach the audience within the overall budget. This investment was then discussed with the Ministry and HPA, using research to rationalise the proposed investments in the kick-start meeting with key internal stakeholders, and following discussions with key stakeholders in the regions. At least some DHBs provided advice on the best ad placements for their regions, and helped to distribute materials to the sector; for example, one DHB was putting resources on a memory stick, whereas another supplied posters to providers.

When comparing costs of delivering these different components, some were “seen” or “heard” by the target audience more than other modes. As shown below, the campaign resources were allocated efficiently and effectively according to outputs (how much was spent on delivering the campaign through specific mechanisms, as evidenced in the document review) and outcomes (what was achieved in terms of reach, as evidenced in the CATI survey).

The investments achieved what would be expected for the most part – those with lower investments reached a smaller proportion of the population (i.e. letterbox, digiscreens, internet and radio) whereas greater investments reached a larger proportion of the population (e.g. TV).

![Figure 3: Investment in different delivery mechanisms (delivery costs, as estimated from the material review) and the reach of these mechanisms amongst target audiences (as estimated from the survey of target audience)](image)

What is particularly notable, however, is that the internet and to a much greater extent, posters appeared to provide very good reach relative to the small investment put into these modes. As noted above, the costs associated with posters are paid for
by DHBs and providers, as they print and place these posters within their communities.

Digiscreens provided less value for investment, as their costs did not achieve what may be expected in terms of reach relative to other modes (c.f. Figure 3, dotted diagonal line). It should be noted, however, that some digiscreen ads began after the CATI survey; (free) digiscreen placements within Work and Income New Zealand (WINZ) offices, for example, were placed between 21 September to end of October 2015.

It would be valuable if the 2016 campaign considered how to further build upon community efforts to increase awareness and understanding of key rheumatic fever messages, while continuing to take into account the breadth of modes necessary to reach those harder to reach audiences.

3.1.3. Campaign activities and associated resourcing was adequate for the 2015 campaign

The interviews showed that the distribution of resources was also considered adequate for HPA and the Ministry, although it required some flexibility with the timing. HPA resourced the project at approximately 2.0 Full-Time Equivalents (FTE) among six different staff, dividing up the tasks according to the specific capability requirements of the campaign. Various HPA staff managed the procurement process, including developing materials and associated protocols, and managing relationships as part of this process.

The interviews confirmed HPA staff also managed the programme of work with GSL Promotus to support alignment and manage sector communications. Although the time requirements fluctuated depending upon the stage of the campaign, 2.0 FTEs was believed to be appropriate to achieve similar outcomes.

Interviews with Ministry officials approximated their project resourcing at 0.8 FTEs with seven different staff dividing up tasks from September 2014 to January 2015, and 1.3 FTEs among five staff from February to April 2015. Key individuals contributed to the cultural aspects of the campaign, ensuring the messages, delivery mechanisms and content were appropriate, that the campaign used effective communication procedures, and that these communication procedures aligned with the overall RFPP activities. Similar to HPA’s experience, this approach required greater planning among 5 to 7 individuals but also provides broader skill sets than might be provided by 1 to 2 individuals (1.3 FTE).

The planning processes across HPA, the Ministry and GSL Promotus supported an efficient approach by incorporating skill sets from many individuals and inviting those individuals to meetings and peer review at times only when specific skills were necessary. Efficiencies were also gained by:

- reusing the same materials from the previous year’s campaign, requiring less peer review than a typical development process;
- using staff and providers involved from the 2014 campaign, and learning from the experience; and
• requiring the provider to have cultural competencies and health literacy capabilities, which meant less reliance on Ministry staff for these types of reviews.

Although the campaign was adequately resourced and deadlines were met, some interviewees noted the processes to implement the campaign felt "rushed" to meet the desired timeframe. Also, sometimes staff were required to work outside of designated work hours to deliver to the timelines. It would be important to revise the starting dates to enable easier delivery.

It was also widely recognised that the procurement process, although useful for securing the right skills, is time consuming. It would be useful to consider efficiencies for the future campaign while following the All of Government (AOG) process, such as direct procurement (as appropriate).

3.1.4. The campaign players’ experience and relationships provided added value, as did the trust built between the players

In addition to the costs, GSL Promotus and HPA provided additional value through their large ad-placement purchasing approach and established relationships. For example, the supplier negotiated an efficient placement of radio featurettes on Pacific Media Network in early September 2015, with the network adding 18 additional placements for free. GSL Promotus and HPA relationships also supported free digiscreen placements on screens in 107 WINZ offices in Northland (9 offices); wider Auckland (43 offices); Waikato (16 offices); wider Bay of Plenty (16 offices); East Coast (11 offices) and wider Wellington/Hutt/Porirua regions (12 offices).

Selecting the right “players” with the right skills, competence and capabilities built trust, as did the specific experience of GSL Promotus having delivered the previous campaign and having a “kick-start” meeting with all those involved. This trust enabled faster sign-offs during the development process.

3.2. The campaign had good alignment\textsuperscript{29} with other activities

The campaign messages have clear alignment with other rheumatic fever activities. DHBs are aware of the campaign, can access and use the materials for local delivery, where appropriate, adding value to the campaign. A few minor recommendations are provided to improve distribution of resources.

3.2.1. The campaign incorporated engagements with key relevant agencies or networks to ensure that messages, activities and timing are aligned

Interviews consistently reflected that alignment with other rheumatic fever activities was supported by engaging with key personnel in charge of the RFPP as well as other officials within HPA, the Ministry and DHBs. The materials reviewed showed that contract documents with HPA, the advertising Agency Brief document,

\textsuperscript{29}The achievement level “good” refers to overall level of success for the criterion “alignment” (see Appendix C).
and planning documents supported alignment with the RFPP objectives, with each reflecting the objectives and language of the wider RFPP goals.

Interviews and a workshop with key stakeholders confirmed that communications between HPA and DHBs were planned and managed, and included telephone and email communications, and presentations. For example, DHBs held teleconferences every month with HPA in attendance; the Rheumatic Fever Awareness Campaign was a standing agenda item to ensure they were made aware of the campaign and campaign updates. HPA would collate these updates and send these ahead of time to discuss at the teleconference. The communications informed the DHBs about what materials would be available to them, when they would be available, and that they could adapt them.

The timing of the campaign was designed to align with the winter season, a time when more sore throats were present, rather than other individual campaigns. A couple of participants within DHBs, however, report that the timing of some of the campaign messages and activities did not align with the season. In particular, one DHB and its networks were not aware of when campaign activities were happening although schedules and updates were sent to all DHBs Communications Managers, and made available to all DHBs throughout the campaign development and implementation periods.

Secondary support for the campaign came through DHBs engaging with local communities who in turn actively promoted the campaign. These community organisations were noted in some interviews, and included an Auckland-based youth campaign, Pacific churches, a Pacific engagement service, a community innovation service, PHOs and clinicians, and representatives from school based programmes. Many focus group participants verified that school nurses and general practitioner (GP) clinics in particular played a large role in increasing their understanding and awareness of the campaign.

The material review showed clear links to the 2015 campaign website;30 individuals can download information directly from the site, or groups can contact HPA (enquiries@hpa.org.nz) if they are interested in using advertisement materials for regional activities.

The interviews and workshops confirmed that DHBs are aware of the campaign, and have accessed and used the materials for local delivery. DHBs leverage off of the campaign materials, for example, the Auckland DHB incorporated their local ‘Say Ah’ and “Fight the Fever” rheumatic fever communications into national campaign communications. The Auckland DHB also ran rapid response clinics that promote the messages about getting sore throats checked. DHB workshop participants noted that this engagement could be wider, including groups and individuals beyond the DHBs, and this engagement would best identify the right individuals within agencies to support successful uptake across the sector.

As the campaign (mostly) used materials from last year’s campaign, it was not possible to align the key messages for the current 2015 campaign with other relevant sector-led rheumatic fever prevention messages. However, the interviews

evidenced that this did not appear to be an issue for most. Stakeholders at two organisations felt that campaign messaging was not always clear. In particular, there was some variation in the messaging where posters conveyed messages about free services, but the services were not free for everyone.

The materials were adaptable. For example, posters were modified to include information about local clinics. However, adaptability proved a little difficult for some, whereby it was reported that schools and community organisations experienced difficulty printing the materials, and there was not enough space to include all the required information. Although the print resources were available as a file and therefore were adaptable to suit the user, one respondent also reported that the available dimensions of some resources restricted use.

These reports of uptake of resources from across the sector were supported by HPA's database of resource requests. The database showed 47 formal requests to use campaign resources from 5 March to 11 August 2015. The requests for information varied, including mostly print materials (postcards, posters and images), videos, online banner and radio ads. A variety of organisations requested these resources, including churches, DHBs, medical centres, primary health organisations and schools. In one case, there was also a request for an HPA representative to talk at a DHB stakeholder meeting.

The telephone survey also showed that the target audience were seeing these resources in various locations. Of the five places explicitly asked, 71 percent of participants saw the posters at a doctor's office or health centre, almost a third of the audience saw the resources at schools, and between 15 and 17 percent of the audience saw the resources in a magazine or a community centre. Approximately 7 percent saw the resources at a festival.

Ten percent of survey respondents saw these resources in other areas including at a Polytechnic, placed on sports equipment, on Facebook, teacher workshops, newspapers, marae, pharmacies, on buses and at bus stops, libraries, at events (Waitangi) and Plunket offices.

Figure 4: Locations that the target audience remembers seeing the campaign (as evidenced in the survey of target audience)

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Survey Question: “Can I just check, have you seen or heard any ads about how a sore throat can lead to rheumatic fever and heart damage, in any of these other places?”

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The evidence suggests that health providers are successfully using the resources. This result illustrates the good alignment of the campaign to these services. There is, however, an opportunity for all providers to broaden the uptake and use of these resources within communities (e.g. schools, community centres, festivals), particularly if the campaign is to reach those that may not typically go to a health service provider.

3.3. The campaign had excellent\textsuperscript{32} relevance for the target audience

The campaign was very relevant to the target audience, which showed that they can relate with the campaign imagery and messaging. The ads were also appropriately placed within the community.

3.3.1. The campaign messages focused on getting sore throats both checked and treated

The campaign focus and subsequent key messages were determined by the Ministry to ensure alignment to the other RFPP activities. These messages were also echoed in the Ministry-HPA project plan, where it states the four main objectives around raising awareness about the campaign. As noted in section 1.2, these messages include:

- the link between sore throats and rheumatic fever;
- the importance of getting sore throats in at-risk children checked by a health professional;
- the importance of completing the full antibiotic course for children who have Group A streptococcal bacteria; and
- what families of high-risk children can do in their own homes to stop their kids from getting rheumatic fever.

The plan also confirmed that the Ministry would advise on the priorities of the campaign messages (in the case of developing new materials). Also, the contract between HPA and GSL Promotus ensured that these messages were agreed prior to delivery, and aligned the key messages of the RFPP through an internal review process including (minimally) the Programme Lead of the RFPP.

The material review showed the messages conveyed in the 2015 campaign materials aligned with these objectives, and were clear and consistent in nearly every resource. Many reviewed resources conveyed stories and/or images of what it is like to have rheumatic fever as well as stories of the long-term effects of having had rheumatic fever. For example, some materials included the message of what to do if

\textsuperscript{32} The achievement level "excellent" refers to overall level of success for the "relevance" criterion (see Appendix C).
you get a sore throat, whereas others focused on the link between sore throats and rheumatic fever, or where to find more information about sore throats and rheumatic fever. Messages about completing a course of antibiotics were present in fewer visual ads but more in radio ads.

The radio ads also conveyed messages about the likelihood of contracting rheumatic fever according to its intended audiences - Māori and Pasifika families: “Māori children are 20 times more likely to get rheumatic fever” and “Pacific children are 40 times more likely to get rheumatic fever”.

This consistency varied in only one online video. The first message suggested that sore throat clinics were free to all children aged 4 to 19 years, and the final message was that free sore throat clinics are available in Porirua or Auckland. Sore throat clinics are free to eligible individuals (aged 4 to 19 years) across all 11 targeted regions. For the 2015 campaign, a message was included within this online advertisement to update it; the message read ‘There are now clinics across most of the North Island, click here to find the one nearest you’, and by clicking the message, users can be redirected to the Ministry webpage listing regional sore throat clinics.

It is understood that this inconsistency was the result of reusing materials from the 2014 campaign.

3.3.2. The campaign used appropriate language and messaging

The campaign resources consistently showed appropriate language and messaging. The material review revealed that nearly every campaign resource was completely free of medical jargon, except by noting “rheumatic fever” and to a much lesser extent “antibiotics”, particularly among the television advertisements, posters, banners, digiscreens, postcards and radio stations. Group A Streptococcus, or “Strep” or “Strep throat” was mentioned in three of the online videos. One video used more technical language than the other videos; clinicians used phrases such as “endemic to communities”, “inflammation” and “strep throat” in the video “clinicians talk about rheumatic fever”.

The telephone survey showed that 89 percent of the target audience found the ads “easy to understand”. This result was supported in the focus groups; the majority of Māori and Pasifika families reported they could understand the message easily, in consideration of language and medical jargon (health literacy), regardless of first language. The target audience felt that the language used in the campaign, including any medical jargon, was not a barrier to them understanding the message.
The radio ads were presented in four languages: English, Te Reo Māori, Samoan and Tongan. In New Zealand, the most common language spoken is English (91 percent of the population). Te Reo Māori (3.5 percent), Samoan (2.0 percent) and Tongan (0.8 percent) were the next most commonly spoken languages (of the campaign target audiences) in New Zealand. The survey showed that English radio ads were heard more widely than ads in other languages; among all 257 participants, 29 percent heard the campaign ads in English, 3 percent heard campaigns in Samoan and 4 percent in Te Reo Māori (±6.1 percent). This finding was also evident from the focus groups, with all participants having heard and seen the campaign messages in English and very few having heard the campaign messages in another language. In future campaigns, it would be important to consider the reach of radio ads in languages other than English.

![Figure 6: Reach of radio ads according to language (as evidenced in the survey of target audience)](image)

Of the people who had not heard the radio ads in English, approximately 2.3 percent of the target audience heard only Samoan radio ads on radio, and less than 1 percent of this same target audience heard ads only in Te Reo Māori or Tongan. The result suggests that English is an appropriate language, as would be expected, but that Samoan and Te Reo Māori are reaching some who are not tuning-in to English radio ads.

The procurement process supported the development of these relevant resources, as the process ensured the successful provider (GSL Promotus) had adequate cultural competency within their team. As stated in the Agency Procurement Brief for Proposal document, the selection of providers was determined by a range of criteria, with 40 percent of the selection weighting on: “Demonstrated ability to understand, engage with, relate to and communicate to the Māori and Pacific priority audiences including evidence of existing or planned cultural competency and capacity”.

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34 Survey question: “You said before that you heard the ads on the radio, can you remember if those ads were in...?”
35 Including only those who heard ads on the radio (86 participants); 88 percent of this group heard the ads in English; 13% of this group heard the ads in Te Reo Māori; 9 percent of this group heard the ads in Samoan; and 2 percent of this group heard the ads in Tongan.
The resource content was also developed with participation from HPA and the Ministry incorporating a review process from health and media experts, and Māori and Pasifika advisors. In addition to the breadth of expertise, the language and messaging of the current campaign was informed by uptake/download statistics of the specific resources from the 2014 campaign, marketing data about what works with the target audiences, concept and consumer testing of the resources.

3.3.3. The campaign was interesting and relevant for target communities

Evidence consistently showed that campaign resources were interesting and engaging for target audiences. To develop resources which effectively engage groups requires an understanding of what works well to grab the attention of the specific target audience and promote understanding. The cultural and media expertise within the development teams supported this requirement. The HPA and Ministry embedded social marketing skills in teams across both agencies, and the Agency Procurement Brief for Proposal document supported securing the right skills with the requirement for the provider with:

“Demonstrated ability to deliver effective, engaging social marketing campaigns, including demonstrated dexterity in similar work across a range of channels on a national, regional and local scale”.

Interviews with various individuals also suggested that the development teams used previous data and relationships with key sector individuals to determine what would be interesting for the target audiences. Specifically, data on what captures this audience’s attention (e.g. Bay of Plenty evaluation reports, GSL Promotus marketing data) further supported relevance, as well as engagement with health and community related networks (e.g. Auckland PHOs, Alliance Health Plus, Alliance leadership team) for new material development.

The survey found that most Māori and Pasifika families found the ads interesting (or in this case, only 9 percent found it “a bit boring”), felt the ads talk to people like them (72 percent) and were right for their culture (79 percent).

![Figure 7: Interest and relevance of campaign materials (as evidenced in the survey36 of target audience)](image)

36 Survey question: “I am now going to read some statements about the rheumatic fever ads. As I read each one, please tell me if you agree or disagree with the statement, or if you really can’t decide either way”.

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This result was confirmed in focus group discussions, with most Māori and Pasifika families reporting the campaign is interesting.

The simplicity of the campaign was due to the use of bold, hard-hitting messages, such as “My brother nearly died”, “I almost died”, and appropriate visuals (e.g. the Katoa twins, the scar, family members, relatable community images, and contrasting and bold colours such as the words “Heart damage” appearing in bold red). The above messages and visuals were attention grabbing for most of the target audience, with focus group participants saying they saw themselves in the images and were able to relate to the emotionality the ads in particular produced. Hearing the voices of both children and their parents was engaging for parents as it brought home the reality of personal relationships and the responsibility that parents have for the wellbeing of their children. The combination of the “scar” visual, the key messages, family environment, and youth speaking, captured their attention.

Adding to the campaign interest was the community reinforcement of the campaign messages. For example, individuals became more interested in the campaign when nurses at schools contacted parents about having their children swabbed for Strep A, and GP clinics displayed rheumatic fever information at their premises.

The future campaign may build upon the success of the 2015 campaign by enabling greater community ownership of these messages, supporting awareness and the discussion of rheumatic fever among locals.

3.3.4. The campaign materials were delivered through media suitable to reach most of the target audience

The campaign media schedule showed a range of delivery mechanisms were used. TV channels, including TVNZ, Media Works, Prime, Sky, Choice and Māori TV, showed 15 and 45 second commercials. Additionally, TV ads were placed during International, Warriors and State of Origin Rugby League competitions, and on Prime during All Blacks’ games.

Digiscreens, as shown below (left) were placed in community settings in all targeted regions throughout the campaign. A letter box drop included 18374 homes in high deprivation index (8-10) neighbourhoods in Tairāwhiti, Lakes and Wellington. The website and videos were promoted online via search engines, Facebook and YouTube. Radio stations played advertising and featurettes across the targeted regions, and talkback radio was included in Auckland, Northland, Tairāwhiti and Wellington.
The survey\textsuperscript{37} showed that 70 percent of respondents (who had seen the campaign) believed the ads were on at the right times and in the right places for them to be noticed by people with small children. The other 30 percent either didn’t know (16 percent) or said they were not placed effectively for this target audience (14 percent).

All Māori and Pasifika focus groups reported the delivery mechanisms (e.g. TV, radio) were appropriate to reach them, but, some mechanisms were more appropriate than others. As mentioned in section 3.1.2, campaign awareness for the target audience was mostly attributed to television, and to a lesser extent, through observing posters and digital screens displayed at doctors’/GPs’ premises. Similarly, the CATI survey revealed that TV and posters were the mechanisms reaching more of the target audience than other delivery mechanisms.

\textsuperscript{37} Survey question: “Do you feel the ads are on at the right times and in the right places for them to be noticed by people with small children?”
Further analysis showed that 90 percent of the target audience were reached by these two mechanisms alone. In other words, if the campaign had excluded all other mechanisms, 9 in 10 people within this audience group would have experienced the campaign.

What is also clear is that the other modes of delivery, such as digiscreens, postcards, internet and radio are important. Although, a smaller proportion of the audience were reached through these other mechanisms (5 percent), without the help of TV or posters, these individuals would not have been otherwise reached with TVs and posters alone. Therefore, the collection of mechanisms is relevant, particularly as saturation of these messages, often times through multiple channels, is important to improve understanding and change behaviour.

For most focus groups, the campaign materials in partnership with community efforts provided sufficient awareness of the campaign messages and desired behaviours for preventing rheumatic fever. Conversely, for two of the eight groups this was not the case; it was the qualitative group discussion with the evaluators and other focus group participants that provided sufficient awareness of the campaign messages and desired behaviours for these group participants. However, all groups appreciated the qualitative group discussion process, which enabled them to: 1) discuss the campaign messages in depth; 2) fully realise the seriousness of rheumatic fever; and 3) realise/reinforce the importance of being proactive about their children's wellbeing in relation to rheumatic fever symptoms. The additional awareness raised through focus group and the sense-making workshop discussions suggests that future rheumatic fever campaigns could consider additional engagement with community members to further support the adoption of desirable attitudes and understanding of rheumatic fever.

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38 Survey question: “Can I just check, have you seen or heard any ads about how a sore throat can lead to rheumatic fever and heart damage, in any of these other places?”

39 This figure identifies the proportion of respondents who remember seeing the campaign in specific settings, and does not account for the effects of recall bias.
The campaign employed a range of processes to determine what media would be suitable to the target audience. Interviews with several stakeholders confirmed that the development team utilised GSL Promotus’ experience in marketing and subscriptions to the research data which shows the reading, listening and watching habits of the target audiences. The development team also used HPA data regarding the appropriate mechanisms through other evaluations, feedback from internal media experts and networks. The HPA also contacted three DHBs to determine which mode would work most effectively in Tairāwhiti, Hutt Valley and Northland.

The secondary delivery mechanisms also included engaging with the DHBs to ensure they distributed and used the resources. The sense-making workshop with key stakeholders provided examples of how some DHBs are supporting the sector in delivering relevant campaign messages. This included giving providers a memory stick with all campaign resources as well as a “goody bag”. Although HPA’s role was solely to ensure awareness of the resources; the stakeholders believed receiving resources was important as a delivery mechanism directly to the community.

3.4. The campaign had excellent\(^{40}\) reach among target audiences

The selected modes of delivery are successfully reaching the target audiences, with nearly all of the target audience having seen/heard the campaign. Additionally, the majority of the target audience are able to recall the messages or explain the images, unprompted.

3.4.1. The campaign reached and was remembered by those at high risk of rheumatic fever, their families and communities and people who care for them

The CATI survey showed that the campaign had exceeded expectations in terms of reach, with approximately 95 percent of the target audience (±6.1 percent) having seen or heard the rheumatic fever campaign in the preceding four months through any mode (e.g. radio, TV, posters).

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\(^{40}\) The achievement level "excellent" refers to overall level of success for the "reach" criterion (see Appendix C).
This result was supported within the focus group discussions, with most being aware of the campaign. All focus groups were able to successfully provide examples of rheumatic fever campaign unprompted.

The survey found that the majority of the target audience (74 percent) was able to remember the campaign on TV without having to be prompted, and another 9 percent were able to remember the TV campaign when prompted.

When considering the different TV advertisements, the most widely remembered TV resource without requiring a prompt was the twin brothers talking about rheumatic fever (47 percent), followed by a boy going to the hospital for an operation (21 percent). When prompting individuals, between 23 to 44 percent remembered the different TV ads.

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41 Survey questions: “Just as a final check, I’m going to describe some of the ads that have been shown on television recently about rheumatic fever. Please tell me if you remember seeing any of these ads” and “Can I just check, have you seen or heard any ads about how a sore throat can lead to rheumatic fever and heart damage, in any of these other places”.

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42 Survey questions: “Just as a final check, I’m going to describe some of the ads that have been shown on television recently about rheumatic fever. Please tell me if you remember seeing any of these ads” and “Can I just check, have you seen or heard any ads about how a sore throat can lead to rheumatic fever and heart damage, in any of these other places”.

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43 Survey questions: “Just as a final check, I’m going to describe some of the ads that have been shown on television recently about rheumatic fever. Please tell me if you remember seeing any of these ads” and “Can I just check, have you seen or heard any ads about how a sore throat can lead to rheumatic fever and heart damage, in any of these other places”.

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28
The survey similarly found that most were able to recall specific messages. When asked what the key campaign messages were, most believed it was about taking children with a sore throat to the doctor (67 percent), followed by messages that sore throats should be treated (31 percent), sore throats are serious (28 percent) and don’t ignore sore throats (25 percent). Messages about rheumatic fever were noted by fewer participants, with 13 percent or less saying something about rheumatic fever.

The focus group results were similar in that most recalled that sore throats can lead to rheumatic fever. Some focus groups were also able to recall that sore throats can lead to heart damage.

![Figure 13: Unprompted recall of campaign messages](image)

Figure 13: Unprompted recall of campaign messages (as evidenced in the survey of target audience)

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42 Survey questions: “Can you describe what you saw?” (TV ad, unprompted recall) and “I’m going to describe some of the ads that have been shown on television recently about rheumatic fever. Please tell me if you remember seeing any of these ads” (prompted recall).

43 Some ads, such as the “twin brothers talking about rheumatic fever”, have been played during both the 2014 and 2015 campaign, whereas others, such as “a mother talking about her son having rheumatic fever” only ran as an online video in 2014.

44 Survey question: “What would you say were the main messages of the ads, what were the ads trying to say?”

45 Survey question: “What would you say were the main messages of the ads, what were the ads trying to say”
Two of the focus groups (in Hamilton), however, had no recall of the campaign messages and only recalled "sore throats". Recall of antibiotics messages was very low for all focus groups. Although the survey results showed that message recall was high for the sore throat messages, this focus group finding suggests that further support may be necessary to ensure the target audience remembers all messages and calls to action as part of regional activities.

Although focus groups were able to recall campaign messages, most participants’ recall of campaign advertising was limited to a small number of TV ads, materials seen at GPs/medical centres, hospitals or schools (for example, posters, digital screens) and some, but not many radio ads.

The activities that supported the success in reaching the target audience included having a provider with the right expertise, incorporating an understanding of what works (and does not work) with resources from the 2014 campaign, overall industry and sector experience as well as community knowledge collated from HPA’s engagement with DHBs (who engage with local communities and PHOs).

3.5. Understanding of the campaign was good\textsuperscript{46} amongst Māori and Pasifika audiences

The campaign supports a good understanding of the association between sore throats and rheumatic fever, which was the primary message of the campaign. Fewer individuals understand the secondary message of completing a course of antibiotics.

3.5.1. Most of the target audience understood the association between sore throats and rheumatic fever

As shown in section 3.3.1, the campaign messages successfully focused on getting sore throats both checked and treated, focusing on the link between sore throats and rheumatic fever. The CATI survey results show that 97 percent of the target audience has heard of rheumatic fever.\textsuperscript{47} The survey results further illustrated this success in that 81 percent of the target audience understood that a sore throat can cause rheumatic fever, and also understood that rheumatic fever can damage your heart (91 percent). This result was corroborated in the focus group discussions, where the majority of focus groups understood the association between sore throats and rheumatic fever (i.e. that sore throats can lead to rheumatic fever).

\textsuperscript{46} The achievement level “good” refers to overall level of success for the “understanding” criterion (see Appendix C).

\textsuperscript{47} Survey question: “Before today have you ever heard about a disease called rheumatic fever?”

The focus of the campaign visuals, messaging and banners as well as community discussion of rheumatic fever supports understanding of key messages.
Figure 14: Target audience understanding of the association between rheumatic fever and sore throats (as evidenced in the survey of target audience)

The focus group discussions also revealed the campaign materials that contributed most to message understanding were the visuals around “the scar” and the Katoa twins, and wording and visual representation of the “Sore throats-Rheumatic Fever-Heart damage”.

It should also be noted, however, that some focus groups did not clearly understand the association between sore throats and rheumatic fever, and this coincided with their lack of campaign message recall (i.e. could only recall “sore throats”).

When these key messages were clear, understanding of the association between sore throats and rheumatic fever was further supported by community efforts. Noticeable community support included parent awareness of rheumatic fever cases in schools and subsequent discussion with other parents about this, school nurses contacting parents to gain permission to have their child/children swabbed for Strep A, and rheumatic fever messages at GPs and medical centres.

3.5.2. The target audience understood the importance of getting sore throats of at-risk children checked by health professionals

One key campaign message related to the importance of getting sore throats in at-risk children checked by a health professional.

Most of the focus group participants understood rheumatic fever could result from not getting sore throats checked by health professionals, and it was important to have sore throats checked. Despite knowing the association between sore throats and rheumatic fever, some participants felt that they could further appreciate its seriousness if they had a better understanding about what rheumatic fever actually was (i.e. what caused it and what its symptoms are). They believed that having a deeper understanding would promote having sore throats checked by a health care professional. This suggests that future rheumatic fever campaigns could consider developing resources to promote discussions within the community to further support the adoption of desirable behaviours.

3.5.3. Although a secondary campaign message, few of the target audience understood the importance of completing the full antibiotic course for children and youth who have a Strep A throat infection

Another campaign message focused on the importance of completing the full antibiotic course for children who have Strep A throat infection. The resource review showed some resources conveyed this message, although with less coverage than the link between sore throats and rheumatic fever. Specifically, messages about completing a course of antibiotics were present in one visual ad and some English radio ads.

Survey questions: “Can a sore throat cause rheumatic fever?” and “Can rheumatic fever damage your heart?”
Few focus groups understood the need for children to take antibiotics to prevent rheumatic fever, and just over one-third of target audience groups reported that children and young people need to follow a full antibiotics course to prevent sore throats from developing into rheumatic fever.

For two groups, knowledge about the importance of using antibiotics came from sources other than the campaign. One group attributed their knowledge about antibiotics to contact with school nurses (supported by the evaluation focus group discussion), and another group attributed it to a member of the group’s personal experience of rheumatic fever (also supported by the evaluation focus group discussion).

The future campaign may consider further developing the antibiotic messages and ideally through using materials to support antibiotic adherence.

3.6. Unintended consequences and lessons

The 2015 campaign aimed to raise awareness and understanding of rheumatic fever among Māori and Pasifika families in order to contribute to a broader programme of work aiming to reduce incidence of rheumatic fever. There are a range of lessons and good practice that decision-makers can take from this campaign. These include:

- The collaborative process of re-cutting and developing materials as a team and taking advantage of an array of expertise within HPA, the Ministry and GSL Promotus. This team included the government official in charge of the RFPP, media and cultural experts, and relationship managers. The process enabled alignment of the campaign within RFPP, and relevance with the target audiences, allowing the resources to be conceptually tested across all these expertise prior to release;

- The campaign teams highlighted the importance of key capabilities, showing respect for individuals and further respecting relationships; and although there were some overlaps in knowledge across the teams (e.g. marketing expertise within the Ministry, HPA and the provider) these wider skills enabled faster sign-offs;

- The procurement process strengthened the relationships between the Ministry and HPA, and staff from both organisations built trust while gaining agreement on what was valuable for the campaign success;

- Effective time management processes are important when working in large teams such as this, including the “right” expertise at the “right” time which enabled an efficient process for all those involved; and

- Respecting the individuals and whānau within the resources, and the sharing of their personal experiences is essential when working with whānau. It is not only important to maintain positive relationships, but this respect is critical to maintain the mana of New Zealand communities. Engaging in this respectful process was also important when reusing or re-cutting materials relevant to the “talent”.

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Although there were a number of examples of good practice and outcomes, there were also those practices that were not successful. It is important to learn from these including:

- Materials that are adaptable for local use supports buy-in and uptake. However, interviews and workshop feedback suggested some material dimensions (or open spaces allowing local editing) did not enable use to the extent that may have been expected. Resources can be more beneficial if the intended users can use them to the fullest extent;

- Communication regarding the availability of the materials, and providing these to the user groups (upon request) can be further improved. Although regular and multiple efforts were made to update DHBs, it is important to consider how the communication channels can be strengthened to ensure the right people are receiving, accessing and using the information;

- Building community support and use of the materials is key to ensure messages are embedded within the target population, the campaign is sustainable and enduring beyond the funding periods, and complex health-seeking behaviours are adopted; and

- Making clear expectations among all key players (the Ministry, HPA and GSL Promotus), such as through developing and negotiating a rubric (e.g. Appendix C) at the campaign outset, would be useful to further support success of campaign planning, development and implementation.
4. **MONITORING FINDINGS**

This section is descriptive rather than evaluative. Although these outcomes were considered out of scope for the current evaluation, they are important measures for planning and monitoring future rheumatic fever prevention activities.

Throughout this section data are provided as:

- subheading statements, describing the achievement level of each desired outcome as part of rheumatic fever prevention; and
- side-text statements (as green text), identifying the processes that support and inhibit the specific outcome, and activities requiring further development.

4.1. **Māori and Pasifika families are responding to the campaign**

The target audience is responding to the campaign. When asked in the CATI survey whether or not they have engaged with a list of behaviours (read aloud to them) as a result of seeing or hearing any of the advertising about rheumatic fever, most (88 percent) have responded in some way.

Many responded by seeking medical help or advice for a child with a sore throat (green rows in Figure 15), with 68 percent taking a child with a sore throat to a doctor or nurse to have it checked, 32 percent phoning a doctor or nurse and 12 percent calling Healthline about a child with a sore throat. 49

Others responded by talking to individuals about rheumatic fever or providing advice themselves (blue rows in Figure 15): 48 percent reported that they talked to others about rheumatic fever, and 50 percent said they advised others to visit a health professional when a child had a sore throat; 33 percent talked to a health care professional about rheumatic fever, and another 31 percent talked about the ads.

Other families sought out or shared the information on the internet (orange rows in Figure 15), with 23 percent saying they searched for information about rheumatic fever on the internet because of the ads, 15 percent said they went to the rheumatic fever website and 10 percent said they liked or shared the information online.

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49 Focus groups suggested that very few of the target audience remembered the Healthline phone number (0800 611 116).
4.2. The campaign messages have potential to be shared amongst more of the community to greater effect

Some findings suggest that campaign messages could be more widely shared between community members.

The focus groups found some individuals reported within the focus groups that they were talking about the campaign advertising with others. There was frequent discussion within the focus groups that suggested participants did not initiate or engage in meaningful discussion with family members or other parents unless they heard about rheumatic fever cases in schools or viewed campaign advertising with others. Conversation about rheumatic fever was mostly incidental for many group participants and few had actually heard about rheumatic fever from others.

4.3. Half of the target audience intends on engaging in prevention and/or treatment approaches

Half the target audience within the focus groups reported having the desired campaign attitudes about sore throats, recognising the severity of sore throats and

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50 Survey question: “Which of the following, if any, have you done as a result of seeing or hearing any of the advertising about rheumatic fever? Have you...”
rheumatic fever. Nearly two-thirds of the target audience focus groups reported that they would be responsible for taking action about rheumatic fever and completing the course of antibiotics. They reported that rheumatic fever is a real possibility if their child gets a sore throat. A message taken on board by a number of groups was that “it’s not worth the risk” to not be proactive about seeking medical care for sore throats, and included “take no chances”, “duty of care”, and being “a good parent”.

Individuals within four of the eight group discussions indicated that they intend/plan to get their children’s sore throats checked by a health professional. Intended behaviour changes reported by a number of target audience participants included shifting from relying on traditional remedies (including seeking advice firstly from “the old people” such as parents or grandparents) to deal with sore throats, to being willing to take their children straight to the doctor without delay. Once participants were made aware of the availability of free clinics, which occurred during the focus group discussions, they felt further supported to adopt the desired behaviours.

A few of the focus group participants attributed their adoption of the desired behaviours either entirely or primarily to the campaign. For others, the tipping point for adopting the desired behaviour was attributed to the evaluation focus group discussions. These discussions encouraged participants to adopt the desired behaviours because they supported participants to realise the seriousness of rheumatic fever, and the risks of not acting in an appropriate way. This was particularly so when participants shared their personal experience of rheumatic fever with the group.

4.4. There has been a small increase in health seeking behaviour regarding sore throats to Healthline during the campaign

Healthline data from 2014 shows a significant increase in the average number of calls received during the campaign when compared to the six week period before the campaign, with 3.6 times as many calls about sore throats coming into Healthline during the campaign period. In 2015, however, there was no significant increase in the number of sore-throat related calls to Healthline, with just over 1.3 times as many calls during the same campaign length periods than before.

Healthline also received calls from individuals regarding a child (aged 0-14 years) with symptoms of a sore throat. In both 2014 and 2015, there was a significant increase in the average number of these enquiries during the campaign in

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51 Comparing the 2014 and 2015 campaign aims to support the Ministry and Healthline in their estimates of resource needs for the 2016 campaign.
52 95 percent confidence interval of the difference parameters does not contain 0, with the lower limit 5.5 and the upper limit 32.1.
53 95 percent confidence interval of the difference parameters contains 0, with the lower limit -3.7 and the upper limit 1.9.
54 95 percent confidence interval of the difference parameters does not contain 0, with the lower limit 25.9 and the upper limit 117.3.
55 95 percent confidence interval of the difference parameters does not contain 0, with the lower limit 6.76 and the upper limit 39.24.
comparison to the average number of calls in the six weeks preceding the campaign. Specifically, there were 2.8 times as many calls to Healthline during the campaign (average of 110 calls per week), compared to the previous six weeks (average 39 calls per week) in 2014, and in 2015, there were 1.4 times as many calls were received during the campaign (average 77 calls per week) than the previous six weeks (average 54 calls per week).

4.5. Many families are reportedly engaging in health seeking behaviour regarding sore throats

The CATI survey showed 79 percent of the target audience reporting that they have taken their child to a doctor the last time they had a sore throat. Of those that said they had sought treatment, 50 percent did so within 24 hours and 89 percent did so within 48 hours.

Figure 16: Target audience reports of having taken their child(ren) with a sore throat to the doctor (as evidenced in the survey⁵⁶ of target audience)

In the future, it would be important to test these claims against actual doctor visits, as the reports here are self-reported behaviours, and as such, may be susceptible to response bias.⁵⁷ Potential approaches for future research could include collating such information directly from a selection of doctors during a fixed period of time, or asking groups of school children to report the presence of sore throats (and visits to the doctor) over a short period of time.

⁵⁶ Survey question: “Thinking back to the last time [If sum of S4=1 one of your children] / [If sum of S4= more than 1 one of your children] had a sore throat, did he or she see a doctor or nurse”

⁵⁷ Response bias is when the respondent gives a response that they think the interviewer wants to hear.
5. DISCUSSION AND CONCLUSIONS

The campaign was efficient, relevant and effective, with few improvements that could further support the overall prevention objectives.

Comprehensive awareness raising campaigns about rheumatic fever have been associated with reductions in rheumatic fever.\textsuperscript{58} \textsuperscript{59} \textsuperscript{60} In New Zealand, raising awareness is particularly relevant amongst Māori and Pasifika communities, given higher rates of rheumatic fever reported in 2014 for Pasifika and Māori families (26.8 and 9.3 per 100,000, respectively).

The 2015 Rheumatic Fever Awareness Campaign effectively reached the target audience, beyond the numbers expected. It is also positive that the campaign is remembered by the target audience (Māori and Pasifika families with children and youth aged 4 to 19 years old), and that most of this key audience has heard of rheumatic fever and understands the key messages linking sore throats and rheumatic fever. There does, however, remain a need for further focus on improving overall awareness about the antibiotics messages.

Awareness and understanding were supported by the relevance of the campaign, which used the appropriate language, messaging, and imagery to capture people’s attention. The campaign focused on the information needs of the target audience, conveying messages about the link between sore throat and rheumatic fever. The communication channels were also relevant and appropriate to reach the vast majority of this target audience.

Strategic communications are also important to educate people in ways that are cost-effective, building upon other communities’ efforts. Responsible finance management is a key government priority, particularly given the continued financial constraint of the New Zealand government and competing health issues. The 2015 rheumatic fever campaign was efficient in this regard, as it recycled and built upon previous campaigns; made use of the relationships and expertise within the wider team; and identified multichannel integration of messages across a multiplicity of stakeholders. The campaign resources were used by various agencies. These community-placed resources were seen by the target audience, primarily within health service providers, adding value to the overall campaign. There are further opportunities to broaden the uptake and use of these resources in other locations beyond existing programmes working in this area; this is particularly important if the campaign is to access those that may not typically go to a health service provider.

Although sector agencies used the resources and Māori and Pasifika families discussed rheumatic fever, further supporting community ownership and discussion...
could add value to the overall campaign in future. Building community discussion and ownership is a key area to develop as part of wider rheumatic fever prevention.

**Most campaign activities supported success, with few improvements necessary to further support efficiency, relevance and effectiveness.**

Activities are generally included within a campaign to support success, and the current campaign is no exception. There were many processes that supported campaign relevance, efficiency and effectiveness. Across the procurement and planning stages of the campaign, documentation (e.g. contracts, agreements and plans) supported alignment and relevance to wider RFPP activities. The campaign process, as well as these documents, identified key areas of expertise that support effective reach and understanding of campaign messages. These competencies included media knowledge and cultural competency, which are key to ensuring relevant resources for the target audience. The selection of the experienced provider provided the added knowledge of having developed and delivered the previous rheumatic fever campaign.

The procurement process also built trust between the key players - the Ministry and HPA - and ensured the provider had the requisite skills to develop resources and identify mechanisms that are relevant to the target audience. However, the procurement process is time-consuming and consequently costly for all players.

Trust was further built upon within the planning stage by engaging all relevant staff in a "kick-start" meeting at the outset of the campaign. This trust and recognised expertise within the delivery team supported faster sign-offs throughout the campaign, and ultimately faster delivery. Although trust enabled responsive service delivery, the current contracting dates and planning periods also resulted in a rushed delivery. Earlier planning would benefit the campaign development teams, and potentially increase campaign success.

The use of media data, marketing expertise as well as previous campaign evaluations supported the selection of the most relevant and effective materials, and the selection of appropriate investments into the different delivery mechanisms. Further value was added through the relationships and purchasing expertise held within the HPA and GSL Promotus, ensuring the campaign achieved value for delivery. The associated review process of campaign resources also ensured the campaign remained aligned and relevant to the RFPP.

The campaign reused or recycled previous campaign resources, which was a very cost-effective way to develop and deliver the 2015 campaign. Reusing materials supports efficiency. Also, all resources were reviewed to ensure current year relevance in terms of message accuracy and alignment. All resources would require further review if any changes are made to the 2016 campaign in terms of prioritised key messages and intended delivery mechanisms.

Prerecorded featurettes also provided a useful way to allow radios to easily schedule in play time, but these ads may benefit from being scripted to ensure efficient use of time and resources.

The current sector engagement process is very good for reaching DHBs, in particular making them aware of the resources available to them. However, greater
engagement in the development stage of the campaign may be required to further enable adaptability of the campaign and uptake of these resources. Furthermore, even broader engagement through new communication channels or supporting current channels with examples may further improve alignment (from “good” alignment to “excellent” alignment) and subsequently amplify the reach of the campaign resources and understanding amongst target audiences.
6. RECOMMENDATIONS FOR IMPROVEMENT

Overall, the campaign was efficient, effective and relevant according to the range of expectations. Target communities understand the key messages, the campaign materials and modes of delivery are relevant to the target audience and these resources effectively reached those at greatest risk. Furthermore, the campaign resources are efficiently used, and the associated processes are aligned to other activities.

There are nevertheless some improvements that can be made to the campaign processes that would further support efficiency and relevance of the 2016 campaign. Further to this, although the campaign contributed to awareness and understanding of rheumatic fever, there are still gaps which would limit effective and systematic changes in necessary behaviour. These gaps currently exist in appreciating a deeper knowledge of rheumatic fever, understanding antibiotics role in rheumatic fever, and perpetuating local use and further discussion of rheumatic fever within the community.

The data presented in the evaluation (aligned below to each report subsection) supports the following suggestions to improve the efficiency, relevance and effectiveness of the 2016 campaign:

**Campaign planning**

1. **The Ministry and HPA modify the timing of the campaign planning phase**

   The campaign was effective and relevant, and as such, the campaign would best continue planning to ensure the right skills are included at the right time (section 3.1.3), involving all those from the outset to build trust (section 3.1.4), while taking advantage of media data, research and expertise relevant about the target audience (section 3.1.2). It would also be best to continue to ensure processes and associated documents focus on alignment (section 3.3.1). In order to do that more efficiently in the future, the evaluation recommends that procurement and planning stages begin earlier to enable staff to deliver the campaign and to meet all deadlines with little difficulty (section 3.1.3).

   An earlier start of the planning phase would best be negotiated and agreed by all parties involved in the implementation process, and aligned with DHB communication departments, to support all staff in delivering an effective and aligned campaign efficiently.

**Campaign development**

2. **The HPA and Provider further develop / reuse resources, particularly to support awareness of antibiotic adherence message**

   The campaign can further support messages about antibiotic adherence, an area that requires further understanding and prioritisation among target audiences (sections 3.4.1, 3.5.3). The 2015 campaign can support this material development by building on the successful practices (e.g. health
literacy and cultural expertise) and learning from those practices that were less successful (e.g. by giving consideration to scripting of new materials before they are recorded).

3. The HPA and Provider design a 2016 campaign that enables community ownership while taking advantage of the resource materials that are currently available

The 2015 campaign resources raise awareness and understanding of key rheumatic fever messages. Continuing to use these relevant materials (section 3.1.1) while supporting local use of materials for raising awareness is cost-effective (section 3.1.2), although some resources may need to be adapted slightly to ensure use amongst stakeholders (section 3.2.1). Local use and local ad placement is particularly important to support understanding and desirable behaviour amongst individuals who may not typically go to the doctor or health centre (section 3.2.1). Furthermore, engaging local communities in conversations about rheumatic fever is also important to generate interest (sections 3.3.3, 3.3.4) and understanding the importance of seeking health advice when a child has a sore throat (section 3.5.2). A deeper understanding, often the result of conversations, would further promote health seeking behaviours (sections 3.5.2, 4.2).

The resources can be further developed to generate discussion within the communities, supporting community ownership of rheumatic fever messages and sustainability of the messages beyond the campaign. Some ways that this recommendation may be implemented are:

   a. identify successful use of the campaign resources or programmes within communities, and share these examples across all relevant DHBs;
   b. support local use of resources, by redirecting resources to provide posters and/or postcards or other relevant resources to schools and businesses;
   c. develop a tool-kit that health professionals and community members can use to support sustainability of resources beyond the current campaign period;
   d. develop materials to encourage children to complete antibiotics regime (e.g. rewards such as sticker-calendars or charts tracking antibiotic adherence);
   e. develop guides to promote local discussions (e.g. providing a list of key questions that health providers can engage with patients); and
   f. build campaign resources and use into other community-based contracts (e.g. "dramatic fever"\(^{61}\)).

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\(^{61}\) "Dramatic Fever" was a theatrical performance delivered to 48 schools in South Auckland and Northland. The performance conveys hard-hitting rheumatic fever prevention messages.
Campaign implementation

4. The Ministry and HPA engage more broadly within the regional communities

The engagement process is key to ensure local use of resources to a positive effect (section 3.1.2). HPA engaged with DHBs, making them aware of the resources (section 3.2.1). Although further engagement, particularly with the "right" people as well as with broader community groups (section 3.2.1) in addition to the provision of resources to these groups, may be valuable (section 3.3.4).

To support broader uptake of the resources, it would be important that the HPA and Ministry continue to engage with organisations and further engage with wider communities to ensure greater uptake and use of materials, particularly if those materials are intended for local use. Some options for implementing this recommendation are:

a. understand and contact the relevant individuals within organisations (e.g. DHBs) to support the rheumatic fever messages, using local contacts to gain this information;

b. identify ambassadors to support messages within communities;

c. leverage off of current relationships with wider health and community networks; and

d. support the engagement with new distribution channels, such as schools and local Māori networks, to support awareness and understanding within communities.

In addition, it would be beneficial for the Ministry and HPA to consider a procurement process that further supports overall campaign efficiency while maintaining AoG processes and ensuring the preferred provider offers all the necessary capabilities required to deliver an effective and relevant campaign (e.g. media, cultural and health literacy expertise and experience). When identifying the appropriate approach, it would be important to consider the AoG processes and principles relevant to supplier selection, and weigh the success of the previous campaigns along with the intended "novelty" of next year's campaign and associated price to determine the appropriate procurement approach.
## APPENDIX A: EVALUATION FRAMEWORK

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Desired achievements</th>
<th>Performance indicators</th>
<th>Source of information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How effectively has the campaign reached the target audience?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reach</strong></td>
<td>The campaign is remembered</td>
<td>• Māori and Pasifika parents and caregivers of children aged 4-19, across 11 DHBs report that they have seen/heard the advertising campaign</td>
<td>• Survey</td>
</tr>
<tr>
<td></td>
<td>The campaign reaches those at high risk of rheumatic fever, their families and communities and people who care for them</td>
<td>• The target audiences report they have seen/heard the advertising campaign</td>
<td>• Survey</td>
</tr>
<tr>
<td><strong>Which mode of delivery (or combinations) has achieved the greatest reach, and supported success?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reach</strong></td>
<td>The campaign reaches those at high risk of rheumatic fever, their families and communities, and the people who care for them</td>
<td>• The selected modes of delivery are effectively reaching the target audience</td>
<td>• Survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The selected modes of advertising campaign supports success (target audience share and use the advertising to positive effect)</td>
<td>• Survey</td>
</tr>
<tr>
<td><strong>Has the mode of delivery and content been relevant and appropriate to the target audience (e.g. culturally appropriate)?</strong></td>
<td></td>
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<tr>
<td><strong>Relevance</strong></td>
<td>The campaign uses appropriate language and messaging for the cultural context</td>
<td>• Māori and Pasifika families report they can access/understand the message easily, in consideration of language and medical jargon (health literacy), regardless of first language</td>
<td>• Survey</td>
</tr>
<tr>
<td>Criteria</td>
<td>Desired achievements</td>
<td>Performance indicators</td>
<td>Source of information</td>
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<td>-------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• The campaign is delivered to the target audience using appropriate language</td>
<td>• The campaign is simple and interesting for target communities</td>
<td>• Document review</td>
</tr>
<tr>
<td></td>
<td>• The campaign is simple and interesting for target communities</td>
<td>• Target audience reports the campaign is interesting and easy to understand</td>
<td>• Survey • Focus group • Interviews</td>
</tr>
<tr>
<td></td>
<td>• The campaign material is delivered through media suitable for the target audience</td>
<td>• Māori and Pasifika audiences report the delivery mechanisms (e.g. TV, radio) are the most appropriate to reach them</td>
<td>• Survey • Focus groups • Interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Campaign delivery mechanisms include a variety of approaches to reach audiences</td>
<td>• Document review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The ads are placed appropriately (e.g. TV ads are placed around programmes popular with target audience)</td>
<td>• Document review</td>
</tr>
<tr>
<td>Alignment</td>
<td>The campaign incorporates partnership and collaboration with key relevant agencies or networks to ensure that all messages and activities, and the timing of the delivery, are aligned</td>
<td>• The awareness campaign aligns its messages and delivery mechanisms with other on-going, related activities and relevant organisations across sectors</td>
<td>• Document review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The awareness campaign is reported to be aligned / embedded within other related and on-going activities</td>
<td>• Interviews</td>
</tr>
<tr>
<td>How effectively is the target audience able to remember the key campaign messages?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach</td>
<td>The campaign is remembered</td>
<td>• The target audience are able to successfully provide examples of rheumatic fever campaign (unprompted)</td>
<td>• Survey • Focus groups</td>
</tr>
<tr>
<td>Criteria</td>
<td>Desired achievements</td>
<td>Performance indicators</td>
<td>Source of information</td>
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</table>
|                        | • The target audience are able to remember key campaign messages (unprompted)                                                                                                                                          | • Reached audience successfully identify that sore throats can lead to rheumatic fever (unprompted).  
• Reached audience understand that if you do not get your sore throat checked you could get rheumatic fever (prompted).                                         | Survey  
Focus groups                                           |

**To what extent is the target audience able to understand the key campaign messages?**

| Understanding          | The target audience understands the association between sore throats and rheumatic fever                                                                                                                               | • Reached audience know that children and young people need antibiotics to prevent sore throats from developing into rheumatic fever (campaign secondary message).       | Survey  
Focus groups                                           |
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<tbody>
<tr>
<td></td>
<td>• The target audience understands the importance of getting sore throats in at-risk children and youth getting checked by a health professional</td>
<td></td>
<td>Focus groups</td>
</tr>
</tbody>
</table>
| **Monitoring:**        | The campaign results in health seeking behaviour regarding sore throats                                                                                                                                             | • Increase in the number of (targeted) people seeking sore throat advice and/or treatment from free sore throat management services (schools, rapid response clinics) or other primary care channels.  
• Reached audience report positive behaviours as a result of hearing/seeing the campaign                                                                                                             | Data analysis  
Survey                                             |
| **Behaviour intent**   |                                                                                                                                                                                                                       |                                                                                                                                                                                                                      | Focus groups                                           |
|                        | The campaign results in an increase in the target audience completing their course of antibiotics                                                                                                                    | • Target audience reports completing their course of antibiotics                                                                                                                                                     | Survey                                             |

**To what extent is the campaign likely to contribute to the expected medium and long term outcomes?**

| Reach                  | The campaign is remembered                                                                                                                                                                                          | • The target audience recalls the messages of the campaign  
• Most Māori and Pasifika families report, through                                                                                                                     | Survey                                             |
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Desired achievements</th>
<th>Performance indicators</th>
<th>Source of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>The campaign messaging focuses on both getting sore throats checked and treated</td>
<td>• The campaign materials consistently and clearly illustrate a focus on both getting sore throats checked and treated</td>
<td>Document review</td>
</tr>
</tbody>
</table>
| Monitoring:       | The target audience intends/plans to get their sore throats checked by a health professional | • The target audience have desired attitudes about sore throats, recognising the severity of sore throats and rheumatic fever.  
• The target audience reports a significant impact on the way they think about sore throats  
• The target audience report that rheumatic fever is a real possibility if their child gets a sore throat  
• The target audience report that they are responsible for taking action (e.g. seeing a doctor) | Survey  
Focus groups                   |
| Behaviour intent  | The target audience would intend to complete a full course of antibiotics               | • The target audience have desired attitudes about sore throats, recognising the need to complete a course of antibiotics.  
• The target audience reports a significant impact on the way they think about completing a course of antibiotics  
• The target audience report that they are responsible for taking action (e.g. completing a course of antibiotics) | Survey  
Focus groups                   |
<p>| Does the campaign represent value for money, and to what extent? |                                                                             |                                                                                                                                                                                                                         | Interview                       |
| Value for Money   | The campaign resources are allocated efficiently and effectively according to outputs (what was delivered) and outcomes (what was achieved) | • Campaign products are believed optimal and comprehensive/relevant for achievement (few / no unnecessary/useless products)                                      |                                |</p>
<table>
<thead>
<tr>
<th>Criteria</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• DHBs report the campaign material is usable, allowing them to focus their rheumatic fever prevention budgets on local efforts.</td>
<td>• Interview</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Agreed outputs are delivered</td>
<td>• Document review • Interview</td>
</tr>
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APPENDIX B: EVALUATION METHODS

Review of relevant Rheumatic Fever Awareness Campaign documents and literature

The evaluation undertook an initial review of key documents relating to the awareness raising campaign. These were provided by the Ministry and HPA to support an understanding of the campaign context. All documents were also reviewed according to the evaluation framework (Appendix A), using these data as a source of evidence.

The document review specifically included the following 8 relevant documents:

- *Programme Marketing and Communications Output*, between the HPA and GSL Promotus (22 Jan 2015).
- *Project Plan: Rheumatic Fever Awareness Campaign*, by the HPA and Ministry RFPP team (24 Nov 2014).
- *Rheumatic Fever 2015 Media Recommendations* (no date).
- *Rheumatic Fever Media Schedule 2015*, by GSL Promotus and the HPA (version 9, no date).

A brief literature review was then undertaken on a selected range of published literature provided by the Ministry. The review focused on key criteria areas for the 2015 Rheumatic Fever Awareness Campaign, as determined by the contractual documents, determining if there was evidence to support these foci. The criteria included: alignment; relevance of messages, images and delivery mechanisms; reach of campaign; and awareness and understanding of key messages.

The sources of literature used include the following:


The desk-based review of documents and literature enabled the evaluation team to develop an in-depth understanding of the 2015 campaign and its objectives and operations. As previously mentioned, this informed the development of the evaluation criteria and indicators (Appendix A) as well as the draft rubric (Appendix C). These information sources provided an overall framework which the campaign was evaluated against.

Review of administrative data

The evaluation team sought to identify pertinent data relating to campaign, and the costs associated with production and distribution. The following administrative data were deemed relevant and provided by the Ministry:

• Sore throat guidelines and Health Topics 2015, by Healthline (received 22 May 2015).

• Healthline data up to 10 August 2014, by Healthline (received 22 May 2015).

• Graph Sore Throat topics Apr 2013 – Aug 2014, by Healthline (received 22 May 2015).

Additionally, the following administrative data were provided by GSL Promotus and the HPA:

• Media expenditure by delivery mechanism, by GSL Promotus (received 7 Sept 2015).

• Rheumatic fever 2015 resource requests, by the HPA (received 21 Aug 2015).

The provided data were assessed against the evaluation framework. These data informed the overall assessment of the campaign alignment, value and behaviour.

Review of campaign materials

The evaluation team reviewed the 2015 campaign materials to support an understanding of the campaign. Overall, 47 of the 55 materials (available at http://www.hpa.org.nz/2015-campaign-materials-and-resources) were reviewed, and included campaign posters, digital screen, online videos, TV ads, English radio,
postcards and a banner. The materials that were not reviewed in this analysis were those radio ads in Te Reo Māori, Tongan and Samoan, and one video that could not be viewed (Dr Lance O’Sullivan on rheumatic fever).

The data also informed the evaluation of the campaign alignment, relevance and understanding.

**Interviews with key stakeholders**

We undertook key informant interviews with a range of stakeholders to collect rich qualitative data on perceptions related to the implementation of the 2015 Rheumatic Fever Awareness Campaign. The key informant interviews included individuals involved in the development and implementation of the awareness raising campaign to inform the evaluation. Specifically, this involved 12 separate individual or small group interviews with:

- Ministry personnel involved in the RFPP (4 interviews with 5 individuals);
- HPA staff (3 interviews with 5 individuals);
- Healthline staff (1 interview with 2 individuals);
- GSL Promotus (1 interview); and
- DHBs within the targeted regions (3 interviews with 4 individuals).

The interviews were conducted using a semi-structured approach to enable issues to be discussed in depth, and to focus on the aspects of the campaign that are most relevant to the groups.

The scope of the interviews covered the evaluation questions, focusing on the evaluation framework most relevant to them and their role in rheumatic fever. For example, interviews with the Ministry and HPA staff discussed the process of developing and implementing the awareness raising campaign, whereas interviews with clinical personnel discussed the extent to which these staff are seeing increased presentation of sore throats and perceptions and whether this can be attributed to the campaign.

The interview guide was developed around the agreed evaluation framework to ensure the interviews cover the necessary issues. Most interviews were conducted as face-to-face discussions, but two were conducted via telephone given the timing and location of some participants.

Two interviewers conducted all but two interviews. In these cases, a second interviewer was not available for the specific interview time. All information was discussed with the interviewers, and collated into an analysis spreadsheet immediately after each interview to ensure all evidence was captured. The analysis spreadsheet enabled triangulation of these results during the reporting phase.

All evaluation participants signed an interview consent form that outlined the purpose of the interview, how the information is to be used and privacy commitments.

**Focus groups with families**
The evaluation team undertook focus groups with the target audience to provide rich qualitative data contributing to ‘explanation building’ around the evaluation findings. Specifically, the team conducted eight focus groups with parents (aged 19-40 years) of Māori and Pasifika children and youth (aged 4-19 years) from different DHB areas in which the programme was being implemented. The eight focus groups were conducted with:

- Parents/aiga, Pasifika, Porirua DHB;
- Parents/whānau, Māori, Porirua DHB;
- Parents/aiga, Pasifika, Counties Manukau DHB;
- Parents/whānau, Māori, Counties Manukau DHB;
- Parents/aiga, Pasifika, Auckland DHB;
- Parents/aiga, Pasifika, Waikato DHB;
- Parents/whānau, Māori, Waikato DHB; and
- Parents/whānau, Māori, Tairāwhiti DHB.

The focus groups had between 4 to 11 participants and lasted approximately 90 minutes.

We recruited participants using a professional recruitment company, which was particularly effective in accessing “hard to reach” populations, as well as a technique termed “snowballing” (i.e. participants and staff telling us about other people they think may have useful experiences to share with the evaluation team).

The aim of the focus groups was to facilitate an interactive group discussion that brought out different information than might be expected in a series of one-to-one interviews. As people listen to each other and this can trigger new thoughts.

The focus groups collected evidence against each of the key evaluation criteria (i.e. reach, relevance, recall, understanding, knowledge, behavioural intention) but were based on open questions that help to understand participants’ experiences in rich detail. Our role was to facilitate the discussion and ensure that all participants had opportunity to talk about their experiences.

All participants were provided with a modest gift or koha for participating in a focus group ($40 supermarket voucher).

**CATI survey of target audience**

Telephone interviews were carried out by Research New Zealand, whose staff engaged with parents/carers aged 20-40 years with children and youth aged 4 to 19 years with at least some involvement in decisions about when to take a child in their care to the doctor or a health nurse.

Evidence from Statistics New Zealand showed that the majority of low income families have landline phones; 77 percent of all households earning less than $10,000 per year have a landline phone. Similar proportions, or slightly greater, of those in slightly higher income families also have landline phones.
The New Zealand General and Māori Electoral Rolls were used as the sampling frame for this research as this is the most comprehensive and up-to-date register of New Zealanders aged 18 years and over.

Access to the Electoral Rolls was granted through a formal application process via the Electoral Commission’s Enrolment Services.

The information contained in the Electoral Rolls enabled us to draw a nationally representative sample of electors aged 19-40 years based on DHB area. The Rolls also enabled us to identify Māori households (by using the ‘Māori descent’ indicator) and to specifically target meshblock areas known to have higher than average proportions of Pacific households (based on information sourced through the 2013 New Zealand Census of Population and Dwellings).

Once the original sample was drawn from the Electoral Rolls it was then sent to Acxiom, one of New Zealand’s key list providers. Acxiom tele-matched the sample in order to obtain contact phone numbers (as phone number details are not contained in the Electoral Rolls). Telematching was completed by data matching the names and addresses from the Electoral Roll sample against the NZ Consumer Base (which contains contact information from LINZ, LTNZ, NZ Post and various consumer marketing tools). All matched phone numbers are then verified by Yellow against current white pages listings.

The final sample was stratified across the 11 DHB areas specifically targeted by the Rheumatic Fever Campaign to ensure an appropriate regional spread. Quotas were also set (based on ethnicity and DHB) to ensure representative numbers of Māori and Pasifika parents/caregivers were interviewed in each area (see Table 1). These quotas were based on population data sourced through the 2013 New Zealand Census of Population and Dwellings).

**Survey design**

For comparability, the CATI survey design was initially modelled on HPA’s Research and Evaluation team’s questionnaire, which was used for the evaluation of the 2014 Rheumatic Fever Awareness Campaign evaluation. The content was then adapted by Allen + Clarke, in consultation with the Ministry of Health and the wider evaluation team, to the current evaluation needs.

When the questionnaire was finalised, Research New Zealand scripted the survey instrument for administration as a CATI survey. As part of this process, the Researchers responsible for the project and the Survey Scripting Team worked closely together in order to test and double-check the internal (technical) integrity of the questionnaire.

**Interviewing process**

Researchers responsible for the project prepared a set of written briefing notes used to facilitate a briefing with the team of call centre interviewers before the interviewing commenced.

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Up to five attempts were made to contact each household, on different days and at different times. If an interview was not secured after 5 attempts, that phone number was replaced with the phone number for the next household on the list. Interviews were completed on both land lines and mobile phones, with respondents able to schedule appointments in order to complete their interview at a more convenient time.

To be eligible for the survey, all respondents had to live in one of the 11 DHB areas of interest, be of Māori or Pasifika ethnicity, aged 20 to 40 years, be responsible for a child or youth aged 4 to 19 years and have at least some involvement in decisions about when to take that child to the doctor or health nurse.

In total, n=257 interviews were completed by telephone, between 2 September and 14 November 2015. The average interview length was 13.3 minutes. All interviewing was completed from the Research New Zealand CATI-enabled call centre. This is a purpose-built facility with 37 permanent work stations.

Table 1 (overleaf) summarises the number of interviews achieved against the regional targets that were set based on Māori and Pasifika population estimates for each of the 11 DHB areas.

<table>
<thead>
<tr>
<th>No. of respondents interviewed (Total n= 257)</th>
<th>Percentage of responders interviewed %</th>
<th>Survey targets, based on population estimates %*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>40</td>
<td>16%</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>39</td>
<td>15%</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>54</td>
<td>21%</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Lakes District</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td>Northland</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>Tairāwhiti</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Waikato</td>
<td>33</td>
<td>13%</td>
</tr>
<tr>
<td>Waitemata</td>
<td>18</td>
<td>7%</td>
</tr>
</tbody>
</table>

Quality assurance processes and standards

Research New Zealand is accredited with the industry-wide Interviewer Quality Standards (IQS). Research New Zealand has held its accreditation for over 13 years and is independently audited each year.
Quality Assessors verified a minimum of ten percent of each interviewer’s work by intercepting their calls. In addition, Research New Zealand confirmed by listening to interview recordings to validate that interviewers had correctly coded responses to a minimum of 5 questions.

After the first and second night’s interviewing was completed, the data was extracted and examined by the Researcher responsible for this project to confirm the routing was working as intended, to check the quality of the verbatim comments being recorded and to check to see if the interviewers had recorded any concerns or notes at the end of the survey. This process was repeated periodically thereafter, until the fieldwork concluded. All interviews were recorded to provide an additional level of quality control.

The table below provides a breakdown of the call outcomes achieved for this survey.

### Table 2: Call outcome summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible</strong></td>
<td></td>
</tr>
<tr>
<td>Total completed interviews (C)</td>
<td>257</td>
</tr>
<tr>
<td>Selected respondent refused to participate in research (B)</td>
<td>370</td>
</tr>
<tr>
<td><strong>Ineligible</strong></td>
<td></td>
</tr>
<tr>
<td>Non-qualifier/Quota filled</td>
<td>5,293</td>
</tr>
<tr>
<td>Business number</td>
<td>61</td>
</tr>
<tr>
<td>No such number/disconnected</td>
<td>1,263</td>
</tr>
<tr>
<td><strong>Ineligible total (A)</strong></td>
<td>6,617</td>
</tr>
<tr>
<td><strong>Unknown eligibility</strong></td>
<td></td>
</tr>
<tr>
<td>No answer</td>
<td>1,267</td>
</tr>
<tr>
<td>Language barrier</td>
<td>167</td>
</tr>
<tr>
<td>Household refusal (eligibility unknown)</td>
<td>1,377</td>
</tr>
<tr>
<td><strong>Unknown eligibility total (D)</strong></td>
<td>2,811</td>
</tr>
</tbody>
</table>

**Response rate**

In total, n=257 respondents participated in the Rheumatic Fever Survey. This represents a response rate of approximately 30 percent.

The response rate represents the proportion of eligible households contacted during the survey period which provide an eligible respondent. The response rate is determined by assigning each household to one of four eligibility classes and is calculated as follows:

\[
\text{Response Rate} = \frac{C}{C + B + D(B+C)/(A+B+C)}
\]

Where:
A = ineligible households
B = eligible non-responding households
C = eligible responding households
D = households with unknown eligibility

Confidence intervals

Results based on the total sample of n=257 respondents are subject to a maximum margin of error of ±6.1 percent (at the 95 percent confidence level). This means, for example, that if 50 percent of respondents reported that they had seen the Rheumatic Fever Campaign advertisements, we could be 95 percent sure of getting the same result, ±6.1 percent, had we interviewed everyone in the population.

Table 3: Sample demographics for 257 telephone interviews

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old are you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 years old</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>22 years old</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>24 years old</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>25 years old</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>26 years old</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>27 years old</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>28 years old</td>
<td>10</td>
<td>4%</td>
</tr>
<tr>
<td>29 years old</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>30 years old</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>31 years old</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td>32 years old</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>33 years old</td>
<td>21</td>
<td>8%</td>
</tr>
<tr>
<td>34 years old</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>35 years old</td>
<td>31</td>
<td>12%</td>
</tr>
<tr>
<td>36 years old</td>
<td>26</td>
<td>10%</td>
</tr>
<tr>
<td>37 years old</td>
<td>24</td>
<td>9%</td>
</tr>
<tr>
<td>38 years old</td>
<td>24</td>
<td>9%</td>
</tr>
<tr>
<td>39 years old</td>
<td>24</td>
<td>9%</td>
</tr>
<tr>
<td>40 years old</td>
<td>15</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>First of all, thinking about the people in your household, can you tell me who you usually live with? Do you...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live with your own children, step children, foster children or whāngai</td>
<td>253</td>
<td>98%</td>
</tr>
<tr>
<td>Any other children (that belong to someone else in the household)</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>Do you have Flatmates (unrelated to you)</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Do you live with your Parents</td>
<td>55</td>
<td>21%</td>
</tr>
<tr>
<td>Grandparents</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Partner/husband/wife</td>
<td>168</td>
<td>65%</td>
</tr>
<tr>
<td>Siblings</td>
<td>22</td>
<td>9%</td>
</tr>
<tr>
<td>Or extended family members/whānau</td>
<td>21</td>
<td>8%</td>
</tr>
<tr>
<td>Live alone</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Refused</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

Can you confirm that you are the parent or caregiver of a child aged 4 to 19 years?

Which of the following best describes your household’s income over a year? This includes the earnings of everyone in your household plus any...
And which of the following statements best describes your involvement in decisions about when to take a child in your care, to the doctor or health nurse?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are main person who decides when they need to see a doctor or nurse</td>
<td>154</td>
<td>60%</td>
</tr>
<tr>
<td>You are jointly involved with others in your family in these decisions</td>
<td>97</td>
<td>38%</td>
</tr>
<tr>
<td>You have some involvement in these decisions</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>You have no involvement at all in these decisions</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Including your own children, your partners or any foster children you may have, how many children usually live in your home aged:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 4 years</td>
<td>105</td>
<td>41%</td>
</tr>
<tr>
<td>4 to 8 years</td>
<td>192</td>
<td>75%</td>
</tr>
<tr>
<td>9 to 12 years</td>
<td>135</td>
<td>53%</td>
</tr>
<tr>
<td>13 to 16 years</td>
<td>84</td>
<td>33%</td>
</tr>
<tr>
<td>17 to 19 years</td>
<td>31</td>
<td>12%</td>
</tr>
</tbody>
</table>

Q20 And what is your employment status? Are you currently...

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working full-time</td>
<td>123</td>
<td>48%</td>
</tr>
<tr>
<td>Working part-time</td>
<td>57</td>
<td>22%</td>
</tr>
<tr>
<td>Not in paid work but looking for a job</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>Not in paid work because of an illness</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Receiving a benefit or income support</td>
<td>35</td>
<td>14%</td>
</tr>
<tr>
<td>A homemaker/caregiver</td>
<td>63</td>
<td>24%</td>
</tr>
<tr>
<td>A student</td>
<td>37</td>
<td>14%</td>
</tr>
<tr>
<td>Retired</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Refused</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Which of the following ethnic groups do you identify with?

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand European</td>
<td>87</td>
<td>34%</td>
</tr>
<tr>
<td>Māori</td>
<td>179</td>
<td>70%</td>
</tr>
<tr>
<td>Samoan</td>
<td>57</td>
<td>22%</td>
</tr>
<tr>
<td>Cook Island Māori</td>
<td>22</td>
<td>9%</td>
</tr>
<tr>
<td>Tongan</td>
<td>17</td>
<td>7%</td>
</tr>
<tr>
<td>Niuean</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>Other Pacific Island</td>
<td>17</td>
<td>7%</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>7</td>
<td>3%</td>
</tr>
</tbody>
</table>

And can you confirm that you’ve lived in the [location] region since at least April this year?

63 Statistics on household income for different ethnic groups (specifically Māori and Pasifika) for this age group (aged 19-40 years old) could not be sourced within the time required. However, there are slightly greater proportions of respondents with the lowest household income (up to $20,000) from the survey (7 percent) than the general population in New Zealand (3 percent), as shown in the 2013 Census data, but proportionally less in the next highest household income level ($20,000 to $40,000) from the survey respondents (10 percent) and the general population (21 percent). The remaining categories were roughly similar.
<table>
<thead>
<tr>
<th>Region</th>
<th>Participants</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland (e.g. Avondale, Otahuhu, Glendowie, Herne Bay, Waterview)</td>
<td>40</td>
<td>16%</td>
</tr>
<tr>
<td>Counties Manakau (e.g. Manukau, Manurewa, Papkura, Waiuku, Pukekohe, Tuakau, Orua Bay, Waikarekuru)</td>
<td>54</td>
<td>21%</td>
</tr>
<tr>
<td>Hawke’s Bay (e.g. Napier, Hastings, Havelock North, Wairoa, Waikaremoana, Waipukurau)</td>
<td>13</td>
<td>5%</td>
</tr>
<tr>
<td>Hutt Valley (Upper Hutt, Lower Hutt, Wainuiomata, Eastbourne)</td>
<td>15</td>
<td>6%</td>
</tr>
<tr>
<td>Lakes District (Rotorua/Taupo/Turangi)</td>
<td>9</td>
<td>4%</td>
</tr>
<tr>
<td>Northland (e.g. Kaiwaka, Whangarei, Kerikeri, Kaitaia)</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>Taiahwiti (Gisborne)</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Waikato (e.g. Coromandel, Hamilton, Te Kuiti, Taumarunui, Tokorua)</td>
<td>33</td>
<td>13%</td>
</tr>
<tr>
<td>Waitemata (e.g. North Shore, Piha, Waioneke, Wellsford, Te Hana, Orewa)</td>
<td>18</td>
<td>7%</td>
</tr>
<tr>
<td>Wellington or the Kapiti Coast (from central Wellington to Waikanae)</td>
<td>39</td>
<td>15%</td>
</tr>
<tr>
<td>Bay of Plenty (includes Tauranga, Whakatane, Kawerau, Opotiki, Te Puke)</td>
<td>15</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Workshops and reporting**

The methodology included a findings presentation and sense-making workshop with the key stakeholders group. The purpose of the workshop was to discuss the preliminary evaluation findings, then jointly analyse and interpret these emerging findings, and suggest ideas for improvement for the various players.

Over 30 participants were invited to attend the workshop. Participation included key individuals from:

- GSL Promotus (5 staff);
- HPA (3 staff);
- Ministry of Health (7 staff); and
- District Health Boards (6 staff).

The individuals were separated into 5 discussion groups, and each group was facilitated by a separate evaluation team member. The groups each focused on one of three criteria: efficiency, effectiveness and relevance.
### APPENDIX C: EVALUATION RUBRIC

The rubric below establishes the standards against which the campaign will be evaluated. These identify what would be considered “excellent”, “good”, “adequate” and “poor” within the first six months after the campaign launch, and within two months of completion. All criteria additionally include a category “unable to be determined”, which is used when inadequate evidence are available to make a robust evaluative judgement. The highlighted cells below identify the level of achievement for the 2015 Rheumatic Fever Awareness Campaign for each criterion.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Excellent</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
<td>Campaign judged as exceeding expectations according to all criteria. Distribution of resources is ideal to achieve the outcomes.</td>
<td>Campaign judged as regularly meeting expectations. Some minor recommendations to improve distribution of resources to achieve similar outcomes.</td>
<td>Campaign judged as meeting most criteria expectations. Some minor recommendations to improve distribution of resources to achieve similar outcomes.</td>
<td>Campaign judged as not meeting most criteria expectations. Many changes necessary to the distribution of resources.</td>
</tr>
<tr>
<td><strong>Alignment</strong></td>
<td>No improvement necessary The campaign messages have clear alignment with other rheumatic fever activities, and campaign activities and timing allow use of the materials for local delivery, adding value to the campaign. DHBs are aware of the campaign, can access and use the materials for local delivery, where appropriate, adding value to the campaign.</td>
<td>There may be a few, minor improvements required The campaign messages have clear alignment with other rheumatic fever activities, and campaign activities and timing allow use of the materials for local delivery, adding value to the campaign. DHBs are aware of the campaign, can access and use the materials for local delivery, where appropriate, adding value to the campaign.</td>
<td>There are some improvements required The campaign messages have clear alignment with other rheumatic fever activities, and campaign activities and timing allow use of the materials for local delivery, adding value to the campaign. DHBs are aware of the campaign, can access and use the materials for local delivery, where appropriate, adding value to the campaign.</td>
<td>Very little, if any, alignment evidenced across the indicators.</td>
</tr>
</tbody>
</table>

---

64 *Meeting expectations* is defined according to the rubric category “adequate”.

---

Evaluation of the 2015 Rheumatic Fever Awareness Campaign
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Excellent</th>
<th>Good</th>
<th>Adequate</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach</td>
<td>The selected modes of delivery are successfully reaching the target audiences, with over 75% of the target audience having seen/heard the campaign. Over 15% of the target audience are able to recall the messages or explain the images, unprompted.</td>
<td>The selected modes of delivery are successfully reaching the target audiences, with over 65-74% of the target audience having seen/heard the campaign. Fewer remember the campaign messages without a prompt (10-15%), but most can when prompted.</td>
<td>Between 55-64% of the target audience has seen/heard the campaign. Many of these individuals are able to recall the campaign messages, at least when prompted.</td>
<td>Less than half of the target audience are aware or can recall the campaign.</td>
</tr>
<tr>
<td>Relevance</td>
<td>Target audience can relate with the campaign imagery and messaging, with no recommendations for improvement if asked. Campaign mediums are appropriate for target audience.</td>
<td>Target audience are largely satisfied with the campaign imagery and messaging, and mediums, although with some recommendations for improvements made.</td>
<td>Although many in the target audience are largely satisfied with the campaign imagery and messaging, and mediums, there are a considerable number of improvements noted.</td>
<td>Target audience struggle to relate to the imagery and messaging. The mediums are viewed by many as not appropriate for them.</td>
</tr>
<tr>
<td>Understanding</td>
<td>Of those who have seen the campaign, nearly all (e.g. more than 90% of survey respondents) can demonstrate an understanding of key campaign messages.</td>
<td>Of those who have seen the campaign, most (e.g. between 80-90% of survey respondents) can demonstrate an understanding of campaign messages.</td>
<td>Of those who have seen the campaign, many (e.g. between 70-80% of survey respondents) can demonstrate an understanding of campaign messages.</td>
<td>Of those who have seen the campaign, less than 70% can demonstrate an understanding of campaign messages.</td>
</tr>
</tbody>
</table>

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65 97% of respondents were aware of rheumatic fever, when collecting 2-3 months after campaign completion (2014 Rheumatic Fever Campaign Evaluation). These standards are lower, given the current evaluation will be collecting CATI data towards the end of the campaign.

66 Survey responses - Can a sore throat cause rheumatic fever; can rheumatic fever damage your heart.