MEASURING COMMUNITY MOBILISATION

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ABSTRACT

Community mobilisation (CM) is a transformative approach used to create social change on complex issues. CM has been used in practice for many years; however, until recently, had little presence in the academic literature. Increasing interest from academics and practitioners in CM has led to questions about definition, the domains of CM and how best to measure it. There are a number of challenges to measuring CM due to the lack of consensus on definition, the complexity of the construct, and the lack of available literature and measurement tools specific to CM. The need to develop quantitative tools to assess CM has been articulated in the literature and in the field. A new tool to measure CM in the context of family violence prevention and healthy relationship promotion is the key contribution of this thesis.

Aims

The aims of the study were to define the concept of CM, to identify the domains of CM and to develop a quantitative tool to measure CM in the context of preventing family violence and promoting healthy relationships. Further, the study aims included assessment of the ability of the tool to measure CM, investigation of the relationship between measurement of CM and community readiness (CR) and investigation of the impact of social context on CM.

Methods

The Aotearoa Community Mobilisation Questionnaire (ACMQ) was developed using the literature and a practice example. The methods used in the development process are presented in detail. Case study methodology was used to test the utility and validity of the ACMQ, to assess CM and the relationship between measurement of CM and CR and the impact of social context on CM in two urban communities in Auckland, Aotearoa New Zealand.

Results

The domains of CM were identified in the literature and used to develop the ACMQ. The statistical analysis of the ACMQ showed the tool has high internal consistency.

The results from the ACMQ assessment showed that Ranui had significantly higher agreement than Glen Innes on all scales. The CR assessment results showed that readiness increased in

both communities between the 2014 and 2016 assessments. Glen Innes had higher readiness scores to prevent family violence and promote healthy relationships than Ranui at both assessments.

Conclusion

The study began to establish the utility and validity of the ACMQ to measure CM to prevent family violence and promote healthy relationships in the Aotearoa New Zealand context. The tool can now be validated with different population groups and in different contexts.

Results of the ACMQ assessment suggested that Ranui had higher CM than Glen Innes. The results of the CR assessment indicated that Glen Innes had higher CR than Ranui. These results were not expected. It was expected that the community with the highest CM scores would also have the highest CR scores. Initially, it appeared that these results conflicted; however, further analysis showed that the results can be explained by the type of participants used in each tool (community members or key informants), the ability of the tools to assess formal and informal community efforts to address an issue, and the importance and impacts of social context on CM.

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Puamiria Amelia Janice Maaka
1st July 1964 – 2nd December 2018

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LIST OF ABBREVIATIONS

ACMQ	Aotearoa Community Mobilisation Questionnaire
CAUs	Census Area Units
CM	Community mobilisation
CMM	Community Mobilization Measure developed by Lippman et al. (2016)
CR	Community readiness
CRT	Cluster randomised trials
GI	Glen Innes
HEART	Healthy Relationships in Tāmaki, The HEART Movement
IPV	Intimate partner violence
KMTW	Ka Mau Te Wero
MELAA	Middle Eastern, Latin American, African
PCA	Principal components analysis
PIS	Participant information sheet
RAP	Ranui Action Project
SCAF	Strong Communities Action Fund
SRMR	Standardised root mean square residual
TIES	Tāmaki Inclusive Engagement Strategy
TRC	Tāmaki Regeneration Company
TTP	Tāmaki Transformation Programme
WHO	World Health Organization

GLOSSARY

Aotearoa	Original Māori name for New Zealand meaning Long White Cloud
Aotearoa New Zealand	Use of the Te Reo Māori and English names to acknowledge the partnership between Māori and Tauiwi defined by Te Tiriti O Waitangi (the Treaty of Waitangi) the founding document of our country
Grass roots	Refers to the actions of ordinary citizens, rather than leaders or paid employees, to mobilise
Haka	Māori ceremonial dance
Iwi	Māori tribe
Kaumātua	Māori elders, leaders
Kaupapa	Purpose, topic, focus, theme
Koha	Gift, present, offering or contribution
Māori	Indigenous people of Aotearoa New Zealand
Mana whenua	Rights and power associated with long-term occupation of tribal lands
Manukura	Manager
Marae	Māori meeting house
Ngā mihi	Translated as thank you. A deep acknowledgement of a person or people
Noho marae	Overnight stay in a traditional Māori meeting house
Pā	Māori village
Pasifika	People of Pacific Island descent
State housing	Government owned housing rented at low-cost to people on low incomes
Tāmaki	East Auckland
Taonga	Treasure
Tauiwi	All those who settled in Aotearoa New Zealand after Māori
Tautoko	Support, encouragement
Te Ao Māori	Māori worldview
Waitakere	West Auckland
Waka	Traditional Māori canoe
Whānau	Extended family group

CONFERENCE PRESENTATIONS

Community matters! International Conference on Preventing Intimate Partner Violence, May 2015, Hamburg, Germany.

The HEART Movement and early research results.

World Community Development Conference, February 2017, Unitec, Auckland.

Community Mobilisation: An approach to achieve agenda 2030?

Regional Wānanga on Primary Prevention of family and sexual violence – from theory to practice, March 2017, Hoani Waititi Marae, Oratia, Auckland.

Using public health approaches to address family violence.

World Community Development Conference, June 2018, Maynooth, Ireland.

The Aotearoa Community Mobilisation Questionnaire.

Measuring Community Mobilisation on Complex Social Issues.

Reframing Issues to Enable Transformative Change.

Society for Social Work Research Conference, January 2019, San Francisco, USA.
Symposium: Engaging Communities to Challenge Domestic Violence: An International Comparison with Dr Mimi Kim, Professor Sabine Stövesand and Cristy Trewartha.

Preventing family violence by mobilising communities in Aotearoa New Zealand: theory, practice and research results.

PREFACE

Community mobilisation is a long-term approach used to address complex issues. In this study, community mobilisation is measured in the context of family violence prevention and the promotion of healthy relationships. A number of influences have led to this research focus.

Firstly, as a new graduate I worked with children and young people with 'challenging behaviours'. I could see that there were many common challenges in these young people's lives. Many of these challenges were widespread social issues and I became interested in learning what was being done to address these big issues. This led to me adopting a public health and community development perspective, and shifting my focus from working with individuals to working at the community- and societal-level.

Family violence was one of these big issues. I was aware of the impacts of family violence personally and professionally, and that it was not often discussed in any depth, despite how much it affected people's lives. As a result, I accepted a role in family violence prevention at Auckland Regional Public Health Service. In this role I learned that there was well-developed theory available to guide a public health prevention approach, but there was little documentation of practice or evidence about working with communities. It was a matter of learning the way forward using the theory as a guide and documenting practice along the way. In this role I learned about the power of working within communities when there was a readiness to address family violence. From there my interest in community-based prevention deepened.

I later moved to the Ministry of Social Development where I worked on the national Campaign for Action on Family Violence (the It's not OK Campaign). There I managed a fund that supported local communities to initiate their own prevention projects and to take the messages from the national social marketing campaign into their communities. For most communities, this was the first time there had been resources available to focus on prevention of family violence, and it was an opportunity for a diverse range of practitioners and community members across Aotearoa New Zealand to learn more about what might work to make change. The potential for social change was apparent through the focus on engaging everyday people in their communities and working far beyond the traditional reach of family violence organisations.

However, I became increasingly frustrated about the lack of evidence to inform practice. This frustration led to my decision to specialise in family violence prevention and to help build the evidence. My academic work has informed my practice and writing over the years and through this I discovered the Ugandan community mobilisation initiative SASA! run by Raising Voices (Michau, 2007; Michau & Naker, 2003). The SASA! initiative showed real promise, and this led to the focus of my master's dissertation on investigating effective community mobilisation approaches and measurement of CM (Trewartha, 2010). The lack of tools to measure community mobilisation identified in my master's research then led to this doctoral study.

The motivation for measuring community mobilisation was also a response to a practical need in the field. Working with community groups and family violence networks around Aotearoa New Zealand, practitioners said they wanted to be able to measure the impact of the work they were doing but had limited or no resources to do so. I wanted to develop a measurement tool that was easy and inexpensive to administer. It also seemed that a quantitative tool would be most useful for practitioners in moving beyond anecdotal and qualitative evidence which they found had limited impact when talking with funders and decision makers. A quantitative tool could enable learning about the phenomenon of community mobilisation, as well as comparison between communities, and an ability to assess change over time. This local need for quantitative measurement was echoed internationally by Michau (2012) and a new measurement tool is the key contribution of this thesis.

Along with my professional journey, I have personally come to understand how pervasive family violence and unhealthy relationships are, and how we can all learn more about how to have healthier relationships. Family violence has affected numerous people I know and love. It is very uncommon for people to seek help to address their experiences of family violence. I have come to understand that for people to feel OK to talk about the issue openly and to seek help, it is necessary to reduce the stigma of this issue and change social norms that silence the problem.

I see myself as part of a social movement in Aotearoa New Zealand that aims to stop family violence and make healthy relationships the new social norm. I believe that we have got a very long way to go to achieve this. What I can see from my work in this field since 2005, is that if we want to see meaningful change on this issue we must change our communities and our society.

CHAPTER 1: INTRODUCTION

Community mobilisation (CM) is a transformative approach used to create social change on complex issues. It is a long-term multifaceted strategy that uses capacity building to engage large numbers of community members in local action for change. CM is an emergent field. It has been used in practice for many years, but until recently, has had little presence in the academic literature. This has led to a diversity of CM approaches and little agreement about how CM is defined and what it involves. The increasing interest from academics and practitioners in CM has led to questions about how best to approach measurement. The long-term and complex nature of CM means that measurement is a challenge. This thesis engages with that challenge and is a pragmatic response to a need identified in practice and the literature to develop quantitative measures for CM.

This research is an extension of an earlier review of the literature on measurement of CM that sought to identify tools to assess CM (Trewartha, 2010). No specific CM measures were available in 2010, but the Community Readiness (CR) assessment (Plested, Edwards, & Jumper-Thurman, 2006) was identified as an effective measure of CM. However, the CR assessment is not a specific CM measure and the need for a specific CM measure remained.

The main contribution of this thesis is a new quantitative tool to measure CM—the Aotearoa Community Mobilisation Questionnaire (ACMQ). The development of this tool is presented in detail. The first step towards development of the tool was to identify the domains, or significant elements, of CM in the literature. Six domains of CM were identified. Identification of the domains of CM was an important contribution to the definition, implementation and measurement of CM. The domains of CM formed the foundation of the ACMQ tool. In this research, case study was used to assess the utility and validity the ACMQ.

In this study, both the ACMQ and the CR assessment were used to assess CM in the context of preventing family violence and promoting healthy relationships in two urban communities in Auckland, Aotearoa New Zealand. The literature that addresses both CR and CM is very limited, and this is the first known study to assess both CR and CM. This is an important contribution to the literature as it addresses identified gaps in the evidence by building knowledge on these two related constructs. The ACMQ assesses the domains of CM and uses grass roots community members as participants, both of which are essential to measuring CM in communities. The CR assessment supports measurement of CM through investigation of

community readiness to address an issue and the impact of the wider community context on CM efforts. Participants in the CR assessment are key community informants, and this is an important difference between the two tools. The use of both the ACMQ and the CR assessment in this research supports comprehensive measurement of CM and made it possible to investigate the relationship between measurement of CM and CR.

Research aims

The purpose of this study was to investigate the measurement of CM in the context of family violence prevention and promotion of healthy relationships in two urban communities. The research aims were to:

1. Define the concept of CM
2. Identify the domains, or significant elements, of CM
3. Develop a quantitative tool to measure CM in the context of preventing family violence and promoting healthy relationships
4. Assess the utility and validity of the tool to measure CM using case study design in two communities in Auckland, Aotearoa New Zealand.
5. Investigate the relationship between measurement of CM and CR.
6. Investigate of the impact of social context on CM

Overview of the thesis

This thesis is organised into nine chapters. This chapter introduced the research and the research aims.

In Chapter 2, a literature review is presented. CM is positioned as a specific community development (CD) strategy. Key terms of community, CD and CM are defined and described, and the history of CD is summarised. The conceptual roots of CM are identified, and the contributions of Paulo Freire are outlined and critiqued. The literature on CM, the challenges of measurement and examples of CM measurement are then presented. The concept of CR is then introduced and the literature on CR presented. Following this the issue of family violence is introduced. Family violence is defined, and the causes and impacts of this issue are described. The concept of healthy relationships is introduced and the lack of evidence on this topic is highlighted. The evidence to address family violence using a public health and primary

prevention approach is then outlined. The rationale for using CM as a public health and primary prevention approach to address family violence is explained.

In Chapter 3, the postpositivist methodology that informs this research is presented. The history and assumptions of postpositivism are described and critiqued. In this study, postpositivism was used to inform a quantitative case study approach. Case study methodology is described and critiqued. The two-case case study design used in the research is then introduced. In the final part of this chapter a discussion of reflexivity and my roles as both a practitioner and researcher in this study are examined.

In Chapter 4 the study methods are detailed. This includes a description of the two assessment tools used in this study, the ACMQ and the CR assessment, the study participants, recruitment and procedure. The process of analysing the data collected from the two assessments is described, as is the process used to complete the case comparison analysis. The ethical considerations for this study are then described.

In Chapter 5 the process of developing the ACMQ is presented. This description includes the process of completing two structured literature reviews to identify definitions of CM, the domains of CM and approaches and tools to measure CM. The process used to analyse the domains and to compare the domains identified in the literature with a practice example is outlined. A description of existing measurement approaches is presented, and how these existing approaches were used to inform the development of the ACMQ is explained. The details of the formulation of the ACMQ are presented. This includes the process of piloting and analysing the tool, and the rationale for the changes made to improve the tool in the development process.

In Chapters 6 and 7, case studies of the Auckland communities of Glen Innes and Ranui are presented. The case studies include history of the communities, demographic profiles, community strengths and challenges, CD initiatives implemented in the communities and descriptions of specific activity to prevent family violence and promote healthy relationships that occurred during the study period. The results from the ACMQ and CR assessments are then presented and analysed. Quotes from the CR assessment participants are used to provide contextual information to the case studies. An analysis of the impact of the community context on the results is then presented.

In Chapter 8 the case comparison is presented. The results of the ACMQ and CR assessments are analysed and discussed using the contextual information presented in the case studies.

In Chapter 9 the development and implementation of the ACMQ are discussed. The main findings, strengths and limitations of the research are highlighted and discussed. The relationship between measurement of CM and CR is discussed, and emergent concepts from the results about CM measurement are offered. The next steps for research on CM measurement are identified and final conclusions are presented.

Use of language

Māori are the people of the land (tangata whenua) or Indigenous people of Aotearoa New Zealand. Throughout this thesis, I use Te Reo Māori (the Māori language) words to describe things that are unique to Māori and to our context in Aotearoa New Zealand. A glossary of these terms is provided (see p. xv).

In the preface I included a personal introduction of the places and the people I come from in Te Reo Māori. This is included for those who read Te Reo, and is not translated to acknowledge this as a taonga (treasure).

CHAPTER 2: LITERATURE REVIEW

Introduction

In the preface, the path that led to this research measuring CM was explained. In this chapter, the literature that informs CM and family violence prevention is presented. This chapter plays an important role of situating CM within the broader literature, and identifying and describing the theoretical based of CM, which is currently quite limited. First, the term community is defined and the challenges and criticisms of this concept are explained. CM is then positioned as a specific strategy under the broader discipline of CD, and the history and principles of CD are outlined. The conceptual roots of CM are identified, in particular the contributions of Paulo Freire. The term community mobilisation is then defined and described, and some of the challenges with defining CM are explained. This leads to a summary of the literature on measurement of CM and the challenges of measurement. The concept of CR is introduced and the literature on assessment of CR and CM is presented. The issue of family violence is presented, which is the context in which CM was investigated in this study. Family violence is defined and described, including the prevalence, causes and consequences of family violence. Healthy relationship promotion is introduced as a relatively new focus in the family violence literature and in practice to prevent family violence. This is followed by an explanation of the rationale for taking a public health prevention approach to address this issue, as CM is identified as an emergent but promising approach in the literature recommended for further investigation.

Community

The first step in presenting and discussing the literature on CM is to define and describe the concept of *community* as the place or construct within which CM occurs. The term community is often used to identify groups of people with something in common and to distinguish differences between groups. As such, shared values, identity and interdependence are important aspects of community (Norton, McLeroy, Burdine, Felix, & Dorsey, 2002), as are relationships and social behaviour generated in communities, which provides groups and individuals with meaning, identity and a sense of belonging (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011; Willmott, 1989). However, community is a difficult concept to define as the term is used in many different ways, which are informed by differing theoretical perspectives (Goeppinger & Baglioni, 1985; Kagan et al., 2011; Mayo, 2000). This has led to definitions and

theories of community that are diverse, and at times contradictory (Valentine, 2001). In this section, early uses of the term community, definitions of community and the challenge that complexity brings to defining community are presented.

Early use of the term community has been traced to the 14th century French word *comuneté* and the Latin word *communitatem*, meaning fellowship and positive social relationships (Sichling, 2008; Yeo & Yeo, 1988). Later, German philosopher Ferdinand Tönnies (2001) contributed to the definition of community in his text *Community and Society* (1887) in which he defined two types of social existence. The first, *community* formed through kin relationships and shared fellowship where people lived together cooperatively. In contrast, he described *society* in the new post-industrial era as impersonal, lacking cooperation or social cohesion, and focussed on commerce. Despite these early definitions, Willmott (1989) states that the concept of community only came into common use in Britain in the 1950s.

Previously, definitions of community largely referred to geographic communities (Mayo, 2000; Omoto & Malsch, 2006; Ross, 1967; Willmott, 1989), and much of the literature describes this type of community. However, communities of identity (e.g. ethnicity, religion) or shared interest are now also discussed (Mayo, 2000; Ross, 1967). A geographic community describes the population of a particular area, and it is mostly used to describe a small, local area, such as a neighbourhood (Willmott, 1989). The terms *geographic community* and *neighbourhood* are often used interchangeably. The emphasis of definitions of geographic communities is on place, and the connections between the people who live in that place that develop through use of shared space and resources (Kagan et al., 2011; Stoecker, 2013). Proximity and shared use of territory are thought to be important aspects of geographic communities that influence people's lives (McKnight & Block, 2010; Valentine, 2001), but the extent to which proximity influences people and the relationships they form is not known (Norton et al., 2002). There is also more to geographic communities than place. The term community also implies feelings of connectedness and solidarity that are developed and strengthened over time through shared interests or experiences (McKnight & Block, 2010; Valentine, 2001).

Some definitions of community describe a harmonious ideal where residents know each other, are closely connected and choose to interact with each other socially, have a shared sense of belonging and identity and provide support for each other (Cater & Jones, 1989). Critics suggest that these sort of utopian concepts of community can be overly romantic, privileging

unity and harmony over difference and diversity (Valentine, 2001). These definitions do not acknowledge the different levels of contact and connection between neighbours, or the conflict and diversity that are part of communities. Wilmott (1989) says that utopian definitions do not reflect the true nature of communities as complex, multidimensional and dynamic. More importantly, utopian notions of community that privilege unity over difference can be oppressive to minority groups (Sichling, 2008; I. M. Young, 1990).

As such, Young (1990) suggests a more useful approach to defining community is to be open to difference, rather than to celebrate sameness. As Martin (2002) states, within neighbourhoods, often the only commonality is location. Ledwith (2011) offers a definition of community that celebrates difference as "a complex system of interrelationships woven across social difference, diverse histories and cultures, and determined in the present by political and social trends" (p. 34). This definition states that community is built across difference, not through sameness, and acknowledges that communities do not exist in a vacuum but are connected and respond to what is happening within and outside themselves.

The perception of a decline in close social ties within geographic communities has been noted since the 1800s (Tönnies, 2001). In modern times, relationships are increasingly less constrained by geography and communities tend to be defined by shared interests and identity, and may connect online or in person (Sichling, 2008). An identity community can be defined as a community connected around a social identity, such as the lesbian-gay-bisexual-gender diverse community. Here, identity is the primary connection, and this does not assume homogeneity. A community of interest can be defined as a group of people who share an interest or characteristic (Willmott, 1989). The definitions of the different types of community often overlap, for example, an identity or interest community can also be geographically based. Likewise, individuals can belong to multiple communities simultaneously.

The complexity of the concept of community is an important challenge for definition. Community is not a fixed object, but rather a complex, multidimensional concept (Kagan et al., 2011; Norton et al., 2002). This means that community can be understood as a constantly moving open system with an unlimited number of influences (Buchanan, Miller, & Wallerstein, 2007; Kim, 2005). This may mean that a geographic community defined by a specific territory does not always match the definition that community residents use, as the residents' definition may change depending on the situation. It also means that in attempting to understand

changes within a community there must be an awareness of external influences, some which may be known and many which may not. Understanding community is complex because it involves social processes and abstract aspects such as shared beliefs and sense of belonging, which are feelings that can be difficult to articulate and to quantify (Kagan et al., 2011). While these aspects of community are abstract, Kagan et al. (2011) argue that they are important in understanding the concept of community, as feelings of belonging, for example, are meaningful and have direct effects on our experiences of inclusion or marginalisation. Due to this complexity, Valentine (2001) questions if the concept of community is rendered meaningless. However, Minkler (2012) states that despite the complexity, understanding local communities is becoming increasingly important to mitigate 21st century health and social problems that she says stem in part from the lack of local community connections.

In this study, a geographic community will be defined as a group of people who live in the same location and are connected through shared identity based on this location, use of shared resources (e.g. supermarkets, parks, libraries, schools), and to some degree, social connections. A geographic community is not homogenous; within it many sub-communities exist. Members of a geographic community may feel more strongly connected to an identity or interest community than to the geographic community they live in. This definition does not assume that people in communities share the same values, practices and beliefs, but does assume that there is some shared sense of identity and social norms amongst members of geographic communities.

In summary the concept of community is complex and contentious, especially the tendency towards utopian conceptualisations of community that position conflict and difference as negative rather than normal aspects of community. The importance of geographic communities has changed over time, and there is still much to understand about how the communities we live in affect our lives, partly because our experiences of communities are feelings and perceptions which are hard to articulate and measure.

For this study it is important to engage with the many understandings and conceptualisations of community as the construct within which this study is sited. It is common for the term community to be used without definition, which has the risk of conceptualising communities as homogenous settings rather than complex systems of interactions between diverse peoples and place. As such we must first understand community before we can understand

measurement of CM. With the various definitions and complexities of the concept of community established, the next section describes CD as a discipline used to address issues that communities in their many forms face.

Community development

Community development (CD) and community work are terms used to describe work in communities to address issues of concern to community members. These terms are highly related, and in the literature is it common for authors to use these terms interchangeably as there is no agreement about the use of the two terms (Twelvetrees, 2008). In North America, the term *community organising* is commonly used to refer to CD (Minkler, 2012). Here I will mainly use the term CD as an umbrella term to describe this work. The main emphasis of CD is "the process of assisting people to improve their own communities by undertaking autonomous collective action" (Twelvetrees, 2008, p. 1). There are many differences in the ways CD is defined, conceptualised and implemented (Stoecker, 2013), but despite the diversity in theory and practice, CD shares common values of "respect, justice, democracy, love, empowerment, 'getting a better deal for people'" (Twelvetrees, 2008, p. 11), and "trust, mutuality, reciprocity and dignity" (Ledwith, 2011, p. 3). This section is not an in-depth discussion of CD, but instead presents the broad frame within which CM is situated as a specific CD strategy.

CD does not have a single history (Stoecker, 2013). Nonetheless, the origins of CD and community work documented in English language literature were in the late 1800s and were associated with the Victorian Benevolence Movement in the United States where wealthy people and Christians acted to support those living in poverty (Baldock, 1974; Ledwith, 2011; Shields, 2017). Also in the late 1800s the settlement movement in the United Kingdom and United States was characterised by middle class people and university graduates moving into shared housing in working class areas in order to contribute to these communities through action on class and gender inequalities (Baldock, 1974; Ledwith, 2011; Shields, 2017). Jane Addams was a leader of the American Settlement Movement whose pioneering community work from Hull House, a settlement house in Chicago, has continuously been used as an exemplar, and led to her being identified as the foundress of social work (Shields, 2017). Addams used survey methods to assess and map the health and social needs of the people

living in poverty in the community around Hull House, and used her influence as a wealthy and well-connected woman to gain resources and address these needs.

Community work emerged again in the 1960s in the United Kingdom as an approach for community members to identify and address their own needs, and CD later developed as a type of community work focussed in local neighbourhoods (Ledwith, 2011). Community work was further defined in the *Gulbenkian Report* as the processes of analysing social situations and developing relationships between groups to create social change (Calouste Gulbenkian Foundation, 1968). This report was criticised for its simplistic explanation of community work, but despite this, was also seen as an important building block for CD (Baldock, 1974; Ledwith, 2011).

In the 1970s, CD work was often political and was informed by socialism and the work of Marx, Gramsci and Freire (Ledwith, 2011; Twelvetrees, 2008). CD addressed class inequalities perceived to have been created by capitalism and addressed gender inequalities through feminist action. During this time, CD also emerged as a distinct occupation focussed on creating social change (Ledwith, 2011). The socialist focus of CD in the 1970s was reframed by the 1990s to address all forms of discrimination and exploitation and was less politicised (Twelvetrees, 2008).

There are different approaches to CD, and distinctions between these approaches can be made by whether the impetus for CD comes from within or outside the community. Ross (1967) identified three approaches to CD that are still very relevant today. The first is where agents external to the community implant a technique or programme into the community. This approach to CD is common internationally, particularly in developing countries where CD is funded and at times implemented by international and donor agencies, for example, building fresh water infrastructure. This is not the case in New Zealand which is largely removed from international CD perhaps because of our geographical distance from other countries and classification as a high-income country. The second is a multiple approach where a team of external experts are brought into a community to provide a wide range of services to address needs that are created through a new system being introduced into a community. The Tāmaki Regeneration Company (TRC) described in Chapter 6 is an example of such an approach. The third approach is the inner resources approach, where communities are supported to identify their own issues, and work collectively to address these issues. Here the focus of the CD

initiative is developed through community discussion. This third approach aligns best with the focus of this thesis on CM.

The inner resources approach involves community members joining together to have their needs recognised and addressed, and to take action on political and class issues. As such, Ledwith (2011) states that CD has radical roots. Radical CD directly addresses the structural causes of power, discrimination and injustice, rather than the symptoms or issues that arise from these inequalities. Ledwith (2011) believes that Paulo Freire's concept of praxis, the unity of theory and practice, is key to radical CD and getting to the causes of inequalities. She observes that over time, CD has become less radical and has largely been mainstreamed into government. Sichling (2008) argues that this mainstreaming has occurred through increased government support for CD approaches and decentralisation. However, Ledwith (2011) does not agree, and critiques this mainstreaming as government not engaging with structural and systemic issues and making them the problem of communities to address. Ledwith (2011) defines radical CD as an empowering approach that uses critical consciousness to foster collective action for social and environmental justice. A radical CD approach is aligned with CM and the critical questioning required for transformative social change. This sort of deep questioning is arguably most comfortably held by communities, rather than institutions and governments, which are often seen as power holders and defenders of the status quo. However without engagement of the perceived power holders in the same critical questioning it is unlikely that transformative social change can be achieved, so perhaps a broader understanding of community which includes all actors in communities is needed to affect change.

Much of the international progression of CD is similar in Aotearoa New Zealand, but there are also some unique differences. In New Zealand, CD work is informed by and respects the relationship of Māori as tangata whenua, the Indigenous people and guardians of the land, and Tauiwi, all those who came after Māori (Munford & Walsh-Tapiata, 2006). This relationship means that CD is informed by Māori health and wellbeing models developed by Sir Mason Durie and Dr Rangimarie Turuki Rose Pere, among others. These models demonstrate the importance of whānau (including ancestors), physical, mental and spiritual wellbeing, the physical environment, context, time, participation in society and cultural identity in individual, whānau and community wellbeing. Colonisation disrupted the established customs and practices for CD of iwi Māori, and in the 1970s and 1980s, work by Māori and Pākehā led to the

re-positioning of Te Tiriti O Waitangi (the Treaty of Waitangi) as the foundation document of Aotearoa New Zealand and re-prioritised the relationship between Māori and Tauiwi (Aimers & Walker, 2016; Chile, Munford, & Shannon, 2006). This influenced CD practice and a stronger emphasis was placed on understanding the influences of colonisation on Māori, proper consultation with Māori, and support for by-Māori-for-Māori efforts (Aimers & Walker, 2016).

Other factors unique to Aotearoa New Zealand as a small, mainly rural nation, was the need to rebuild communities following World Wars I and II (Aimers & Walker, 2016). The rapid urbanisation that followed the wars created issues for Māori and Pacific peoples around health, housing and cultural alienation (Chile, 2006). Later in the 1960s and 1970s ,feminism was very important in grass roots social movements. The women's movement used consciousness raising and political activism to create change, including the establishment of women-led organisations such as Women's Centres, Women's Health Collectives, Women's Refuge and Rape Crisis in the 1980s and 1990s. This was an important time for CD and saw the resurgence of Māori self-determination, rights-based work led by Pacific peoples and youth, and the establishment of neighbourhood CD work (Aimers & Walker, 2013). Chile (2006) claims that since the 1980s, the shift towards neoliberal socioeconomic reform has reduced the emphasis on CD, and Aimers and Walker (2016) further contend that since then, CD has been largely mainstreamed into government and shifted towards individualised service provision. This mirrors international observations of CD referred to previously. The emphasis on individualised service provision rather than CD to address social issues is particularly worrying, as it focuses efforts on addressing symptoms rather than causes of issues. Using individualised services to address social issues shifts 'our collective problem' to 'your individual problem', and removes the potential of collective action to disrupt oppressive power and decision making. Also, the emphasis on individualised services may be due in part to the complexity of social issues and the perceived inability to demonstrate change using a CD approach, but as Chile (2006) states, is usually informed by political ideology rather than evidence. The importance of collective and large scale approaches to address complex issues like family violence is described later in this chapter.

Despite broad agreement about what CD entails and that it has been successfully used to create social change, the reduced emphasis on CD and shift in focus to individualised approaches since the 1990s is noted internationally (Ledwith, 2011). Currently CM, a specific CD strategy, is of increasing interest as an approach to address complex issues (Contreras-

Urbina et al., 2016; Garcia-Moreno et al., 2015). As such it was important to contextualise CM within the broader theory and development of CD here as CM is not a stand-alone approach, it has grown as a specific strategy from within this wider tradition of CD. The reduced emphasis on CD since the 1990's has led to theoretical gaps for academics and practitioners, and hence the focus here on describing CD and making a clear link between CD and CM. Without providing this theoretical and historical base CM could be conceptualised as a technical solution, disconnected from the principles of CD and community building which are the process elements that enable transformative change. These elements are described further in the section on Paulo Freire below. In the next section, the conceptual roots linked specifically to the development of CM are identified, described and critiqued.

Conceptual roots of community mobilisation

The conceptual roots of CM can be traced to the work of Cloward and Ohlin (1960), for their shift in focus from the individual to community and societal influences on behaviour; Arnstein (1969) for her contributions to understanding community participation; Alinsky (1969, 1971) and Freire (1992, 2000a, 2000b). These writers have each made significant contributions to understanding the relationship of the individual to their communities and society, the impacts of the surrounding community on individual and group behaviours, and a movement towards engaging community members in social change efforts. In this section, the contributions and challenges of Alinsky's approach will be described briefly, and then Freire's contributions to CM will be explored in more detail.

Alinsky

The work of American community organiser Saul Alinsky and his book *Rules for Radicals* (1971) is widely cited in CM literature. In the Alinsky tradition, the organiser is an outsider who listens to the concerns of the people to identify the key community issues and then "agitate(s) to the point of conflict" to move people into action (Martinson & Su, 2012, pp. 116-117). Alinsky (1971) defined a good issue as one that is simple, specific and winnable. Alinsky emphasised winning battles to build community confidence, and his approach was characterised as conflict-oriented, pragmatic, and male-dominated, where public space was used to confront those with power, and to take power back for neighbourhoods and workers (Martin, 2002). As such, Alinsky's style of activity involved recruitment of large numbers of people to campaign on specific issues (Su, 2009).

While Alinsky's approach can be used effectively to address specific issues, it is questionable how well suited it is for addressing complex social issues (Martinson & Su, 2012). Alinsky (1971) stated that his work focussed on addressing power inequalities and shifting power from the few to the masses to enable democratic processes. However, Martinson and Su (2012) argue that Alinsky did not engage with ideological issues or systems and structures of power, but instead focussed on a target—usually a person or an organisation. This focus, along with an over reliance on the organiser as the driving force and hence the failure to build leadership capacity in communities, means that it is questionable what long-term change is possible using the Alinsky approach (Martinson & Su, 2012). Although Alinsky is commonly cited in CM literature as a key contributor, I argue that his approach is of limited value in addressing complex social issues, although his techniques are potentially very useful to address specific challenges within a CM approach. In the next section, Paulo Freire's approach is described which has been used by diverse groups and on a wide range of problems, and is better aligned with CM on complex social issues. As Ledwith (2011) states, although much of their work was complimentary, Alinsky's work did not have the theoretical base of Freire.

Freire

Paulo Freire's work, especially his concept of conscientisation, is credited as being fundamental to CM (Campbell, 2013; Parker, 1996). In his classic text *Pedagogy of the Oppressed* (1968), Freire describes an approach to education for social change that develops critical consciousness and the ability to act to change systems and structures. This approach was developed in the context of working to liberate people from poverty and social inequalities, enforced by oppressive political regimes and class structures particularly in Brazil and Chile in the 1950s and 1960s (Freire, 1992). Freire was also informed by the work of Hegel and Marx (Freire, 2000b), specifically Hegel's master-slave dialect and Marx's theory of praxis (Morrow & Torres, 2002).

Freire specifically critiqued the Brazilian education system which he said perpetuated powerlessness and oppression, and described this system as the *banking model* of education, where experts deposited knowledge into their students as if they were "empty vessels" (Freire, 2000b, p. 72). He believed this model prevented people from engaging with the causes of their powerlessness. To counter this model, Freire developed a dialogical style of education while working with illiterate farmers on agrarian reform. His approach positioned students as

subjects of their own learning and focussed on liberation through a process he called conscientização (conscientisation), defined as "learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality" (Freire, 2000b, p. 35).

Freire's work examined what it means to be human and how oppression limits our ability to be fully human. For Freire, becoming more fully human was an ontological need and an ongoing process of evolution, not a state to be attained. Freire, like Curle and others, theorised a humanitarian spiritual aspect to change. In Curle's (1971) words "it may be impossible to make peace unless we all become more fully human" (p. 25). In contrast to humanisation, Freire theorised that dehumanisation came about through social practices that oppress people. Liberation from oppression and dehumanising practices was a fundamental aspect of his work (Freire, 2000b). He saw oppression as dehumanising both the oppressor and the oppressed. Freire asserted that those who oppressed others were as much in need of liberation as those they oppressed, and to be truly transformative, both the oppressed and the oppressors must be transformed (Freire, 2000a). Freire was a utopian thinker and believed that becoming more fully human was the way to achieve liberation for all.

For Freire, becoming more fully human involved a process of conscientisation and praxis. Conscientisation is a collective process, where groups of people come together and use dialogue to understand their lived experiences. He positioned all participants in group dialogue as both learners and teachers. Conscientisation involves more than gaining and sharing knowledge—it is a process that builds a sense of identity within the group, and increases understanding of the shared experiences and challenges that all group members face. The process then works to develop collective efficacy, the belief that people can act together to make change (Israel, Checkoway, Schulz, & Zimmerman, 1994). This belief is built through the ongoing application of Freire's concept of praxis, a simultaneous process of "reflection and action upon the world in order to transform it" (Freire, 2000b, p. 51; Shor & Freire, 1987).

Freire asserted that his approach was not about applying a specified set of methods or techniques; instead it was an approach to working with people to understand their social world that was highly contextual and dependent on the issues a community faced and the social, political, historical and cultural context. Freire observed that those who were oppressed often saw oppression as inevitable and used the process of conscientisation to expose oppression

and how it dehumanised people. This process used dialogue and codification, the use of pictures of everyday situations, to understand oppressions and to denounce the structures and practices that oppressed. From this new understanding of oppression and how it dehumanised people, praxis was used to create and announce transformative solutions that would humanise both oppressors and the oppressed (Freire, 2000b).

This approach to transformative social change through conscientisation, dialogue and praxis led to Freire's work being recognised as an important contribution to CM theory and practice (Campbell, 2013; Parker, 1996), and has been very influential in informing work to empower communities to make change (Goodman et al., 1998; Israel et al., 1994; Wallerstein & Bernstein, 1994). The process of conscientisation has been used in CM to empower marginalised groups to understand their circumstances and to act collectively to liberate themselves from oppression (Campbell, 2013). Freire's concept of collective conscientisation moves beyond the focus on the individual, and links individual, organisational and community levels of empowerment by positioning the individual within their social, economic and political context (Israel et al., 1994). This has been seen by many as a key technique to enabling transformation and liberation from oppressive social structures, norms and beliefs (Campbell, 2013; Kim-Ju, Mark, Cohen, Garcia-Santiago, & Nguyen, 2008; P. May, Miller, & Wallerstein, 1993).

Critique

Freire's approach has been criticised from several angles, with the most serious criticisms centred around an analysis that his approach is used to continue to dominate rather than liberate those who are oppressed (Roberts, 2000). Specifically, Bowers (1983) criticism is of Western dominance. He stated that the Freirean approach imposes Western thought on Indigenous peoples and perpetuates Western domination through emphasising progressive change over preserving traditional practices. Berger's (1974) critique is also about dominance, specifically class dominance. He questioned Freire's use of conscientisation and disputed the idea that people in lower classes needed privileged intellectuals to help them understand their reality, and accused Freire of imposing the views of the higher classes on the lower classes. Berger asserted that those who are oppressed understand their situations better than any outsider. However, Roberts (2000) refuted these claims and stated that the Freirean approach encouraged people to question their social reality, rather than impose thoughts or to do away with traditional customs and beliefs.

The Freirean approach is also criticised from other angles. Ellsworth (1989) and Campbell (2013) questioned Freire's universalist metanarratives of change and stressed the importance of local and small narratives. For Ellsworth, universalist assumptions deny the different experiences of those who are not privileged through race, gender and class, and she stated that group dialogue can serve to maintain oppressive practices rather than disrupt them. Despite Freire's aim to create unity across diversity, he continues to face criticism about his position on race, class and gender, despite efforts to address these issues in his later work (Roberts, 2015).

Campbell's (2013) critique of Freire is specific to CM and the relevance of Freirean thought to addressing contemporary problems. Campbell stated that CM has radical theoretical roots and acknowledges the considerable contributions Freire's work has made to CM. While she cautioned against the use of CM without adoption of Freirean concepts and analysis of power, Campbell (2013) stated that his work was developed in a vastly different world and questions the relevance of "grand narratives of emancipatory social change" (p. 9) for current CM in an environment dominated by global financial capitalism. She questioned the applicability of Freire's emphasis on giving marginalised groups a voice, when in many cases, power holders are now global companies who are anonymous to the communities they impact. Campbell (2013) noted that many recent CM initiatives informed by Freirean theory have not achieved sustained change, and identifies the power of small-scale bottom-up collective movements to build social environments that support change. It seems that small-scale movements were how Freire's work began, and perhaps all CM work needs to begin, small and slowly until enough community members are participating that it becomes a collective movement. Perhaps a failing of modern CM is that efforts are focussed on achieving aspirational outcomes within time frames that are too short, and more emphasis needs to be placed on long-term incremental change. Considering these criticisms, it is important to acknowledge that while Freire's thinking is very important for CM, like all theory, it is imperfect. Those who use Freirean thought to inform their work must be cognisant of these criticisms and work to improve on where Freire left off to be truly transformative.

For this thesis it is important to describe Freire's work and contributions to CM to ensure CM is understood as a transformational process, not a technical or programmatic solution. It is easy to move to the "what" of CM and to think simplistically, before understanding the "how" or process elements and principles that enable transformation. Freire's work emphasises that

change must happen within each of us to enable collective change. More specifically for this study the importance of Freire's concept of conscientisation to CM is made apparent in the identified domains of CM and the development of the measurement tool detailed in chapter 4. In the next section, CM will be defined and discussed in more detail.

Community mobilisation

In this section the concept of CM is defined and described. Then the challenges of measuring this complex construct are outlined.

CM does not have its own specific theoretical or conceptual base, and draws on broader theory that informs CD, community participation, community organising and liberation movements (Gavalotti et al., 2012; Lippman et al., 2013; Tedrow et al., 2012). CM is an approach which has been used for many years in practice, but until recently had little presence within the academic literature (Trewartha, 2010; Vijayakumar, 2018). Sanders (1949) documented an early example of an urban CM initiative in the United States in the 1940s. Later, in the 1960s CM was used to address government policy reform on substance abuse issues in the United States; however, there was little reference to CM in the literature until the 1990s (P. May et al., 1993). The development of the *Ottawa Charter* began a movement in public health that shifted the focus from individual behaviours to the social determinants of health (World Health Organization & Canadian Public Health Association, 1986), and CM approaches began to be used to address public health issues (Kim-Ju et al., 2008; P. May et al., 1993). Vijayakumar's (2018) analysis of the PubMed database showed that CM is now increasingly featured in academic articles, and that 42% of the articles in PubMed on CM were published between 2011 and 2015. The majority of published research on CM is from Africa (Heilman & Stich, 2016) and India (Vijayakumar, 2018) and addresses HIV/AIDS screening, treatment and prevention. There are a number of examples of CM initiatives that have a dual focus on preventing intimate partner violence (IPV) and HIV (Heilman & Stich, 2016). Many of the published articles on CM are on initiatives implemented by international development agencies and research teams in developing countries. However, there are few examples of mobilisation in developed countries, where CM initiatives that address sensitive topics such as family violence are uncommon (Glenn et al., 2018; Heilman & Stich, 2016). Academic contributions to the CM literature are now starting to address the gaps in theory and definition

that were identified in the 1990s (P. May et al., 1993). An intention of this research was to contribute to the development of CM theory and definition.

Definitions of community mobilisation

The term community mobilisation is often used in the literature without definition, and where it is defined, there is variation due to the diverse theories of society and disciplines that inform CM. There is a need to a build a shared definition of CM as the term is currently used to describe a diverse range of community-based approaches (Lippman et al., 2013; Tedrow et al., 2012). This leads to confusion about what CM involves, and what should be measured to assess its impact. Despite the variation in current definitions, key aspects of CM are now emerging in the literature.

There is growing agreement in the literature that CM is an approach intended to create social change on complex issues (e.g. Campbell & Cornish, 2010; Michau, 2012). The emphasis on social change requires the use of transformative strategies that engage community members in discussion about the issues they face and the causes of these issues. As such, adoption of a Freirean approach is common in CM. Freire's techniques of dialogue, conscientisation and praxis are important elements of CM intended to create social change by transforming social norms, behaviours and practices, and creating new ways of being (Campbell & Cornish, 2010; C. Evans, Jana, & Lambert, 2010). Another key aspect of creating social change is that large numbers of people must be involved to create a critical mass of community members working towards change (Michau, 2012). This involves ongoing engagement of an increasing number of community members in local activism over long periods of time.

It is widely acknowledged in the literature that CM is a complex and multifaceted approach (e.g. Kim-Ju et al., 2008; Lippman et al., 2013; Michau, 2012). CM involves engaging multiple audiences and groups concurrently. Each group can have a different level of readiness for change and preferred approaches and places for engagement, meaning it is necessary to use multiple strategies to engage different groups within a community. Some strategies may be short-term and intensive such as social marketing campaigns, while other strategies can be long-term. An example of a long-term and complex strategy is developing community members as leaders in CM efforts. This is a common strategy and requires multi-layered support, as community members need time and space to learn and grow, including addressing the aspects of themselves that are part of the old social norms, behaviours and practices that

they seek to change. This can be a very uncomfortable process and means that CM is time-intensive, process oriented and complicated (Kim-Ju et al., 2008). The complexity of CM also means that it can be hard to describe and measure as there are multiple levels of activity, in many different settings being implemented simultaneously.

An important feature of CM is that it is a capacity building approach which builds the skills of community members to identify their needs and priorities, and to develop and implement a strategy for change (Campbell, 2013; Michau, 2012). Capacity building is key to the sustainability of long-term CM initiatives (Howard-Grabman & Snetro, 2003; Michau, 2007). This is due to the wide range of skills needed to run CM initiatives, and large numbers of people required to activate and build capacity in diverse networks. CM uses a broad approach to develop the capacity of a diverse range of local people to mobilise their own networks. In CM, community members are involved in all aspects of developing and implementing an initiative, meaning decision making does not sit only with existing leaders and paid staff. Therefore, an important feature of capacity building is leadership development to ensure community members have the skills and resources they need to lead their own efforts (Michau, 2012). Building capacity across a community also means that once a community has had some success addressing one issue, it is likely that community members will use their skills to address other community concerns (Tedrow et al., 2012; Vijayakumar, 2018).

While the literature on CM has developed over recent years, academics have stated the need to be able to define CM in more detailed terms, specifically, the need to identify the domains or key elements of CM to support better definition, implementation and measurement (Gavalotti et al., 2012; Lippman et al., 2013; Tedrow et al., 2012). Lippman et al. (2013) published the first known attempt to identify the domains of CM. They reviewed literature on social movements, community empowerment, CD and community capacity, and their analysis resulted in the identification of six key domains of CM which were then tested in community settings. The identified domains of CM were: shared concern; community consciousness; organisation and networks; leadership; collective actions; and, social cohesion. The identification of the domains of CM by Lippman et al. (2013) was an important step forward in the continuing development of the definition of CM which should serve to support better implementation and measurement. The work by Lippman et al. (2013) will be discussed in detail in Chapter 5 as identification of the domains of CM is also a key contribution of this thesis.

In summary, key features of definitions in the literature indicate that CM is a transformative approach used to create social change on complex issues, social norms and behaviours, and power structures. It is a long-term and multifaceted strategy that uses capacity building to engage large numbers of community members in local action for change. While there is support in the literature that these key features are central to the definition of CM, there is room for more debate as the literature on CM develops. The identification of key domains of CM by Lippman et al. (2013) contributed to this debate and marked an important progression in the literature. The definition of CM is ongoing, and the domains can be used to develop the definition further. In the next section, the challenges of measuring CM are presented.

Measurement of community mobilisation

The evidence on measurement of CM is growing; however, there are many challenges and issues around measurement that have been identified in the literature and are yet to be resolved. The lack of consistent definition of CM has led to uncertainty about what should be measured (Cheadle et al., 1998; Draper, Hewitt, & Rifkin, 2010; S. F. Jackson et al., 2003). Another challenge is that CM involves constructs which are hard to measure, such as leadership and collective action (Cheadle et al., 1998). Tedrow et al. (2012) noted the need for tools to be developed specifically to measure CM, and stated that until then, the impact of CM interventions could only be indirectly assessed. In this section, the challenges of measuring CM are described and then the rationale for use of the CR assessment (Plested et al., 2006) to support measurement of CM is presented.

Challenges of measuring community mobilisation

There are many challenges to measuring CM. An important first consideration is whether CM is measured at the individual- or community-level. CM involves combined efforts at the individual- and wider community-level, and there has not yet been substantial debate in the literature about what level of measurement, individual or community, or a combination of both, is most effective to assess CM. The level of measurement that is appropriate to a study is dependent on whether the research aim is to assess an aspect or aspects of CM, or to assess the overall impact of a whole CM strategy. To assess the impact of a whole CM strategy a community-level measure is likely to be most useful. However, it is difficult to measure community-level change and even more difficult to measure change in social norms at the community-level (Abramsky et al., 2012; Michau, 2012). Therefore, current attempts to

measure community-level change commonly use individual participant responses that are aggregated as a proxy measure for a community. There has been little debate in the literature about whether aggregation of individual responses to measure CM is appropriate, and this issue needs further discussion (Lippman et al., 2016).

Another challenging aspect of measuring CM initiatives, and community-based approaches generally, is that it is difficult to attribute change to the initiative because there may be other initiatives operating and contextual factors that impact on a community such as social and political activity (Harvey, Garcia-Moreno, & Butchart, 2007; Ledwith, 2011; Tedrow et al., 2012). This means that although measurement may show change, it is difficult to ascertain whether the CM initiative or other factors in the community context contributed to that change. Contextual factors may support or detract from the success of the initiative, and so Watson-Thompson et al. (2008) suggest that measurement on targeted indicators may not provide much insight into complex issues without measurement of the broader social and environmental context that contribute to the issue. This is an important point for CM, and suggests the need to take a broader view of the contextual influences for both implementation and measurement strategies.

Attempts to measure the impact of CM are also criticised for the lack of measurement of outcomes (Michau, 2012). Outcome measurement is difficult due to the lack of appropriate measurement tools and because it requires long time frames. Campbell (2013) states that this criticism and the focus on measuring outcomes fails to engage with the complexity of CM. She says outcome measurement implies that change is linear and inevitable, when it is not, as we do not yet know what works to make change on many complex issues. In light of this, Michau (2012) states that alongside efforts to develop outcome measures, it is also important to be able to measure incremental change to aid understanding of where change is occurring, to ensure initiatives are making progress, and to communicate progress to communities, stakeholders and funders.

There is also debate in the literature about whether quantitative or qualitative measures are most appropriate for assessing CM. It is likely a mix of quantitative and qualitative approaches, and a range of strategies that are required (Michau, 2012), and caution is suggested when relying only on quantitative measures (Cheadle et al., 1998). Abramsky et al. (2012) stated that when cluster randomised trials (CRTs) are used to assess CM, quantitative data should be

supplemented with qualitative data that assesses implementation processes and impacts to enhance understanding of how change occurred, and how findings can be applied to other settings. Despite this, Michau (2012) argued the need for quantitative measurement tools to be developed to assess CM, as this would enable practitioners to move beyond collecting only qualitative data.

In 2016, Lippman et al. (2016) published the first known quantitative measurement tool for CM in the context of HIV prevention, the Community Mobilization Measure (CMM). When this doctoral study began, there were no published tools that could be used to assess any CM initiative and to compare the impact of different CM approaches across communities (Trewartha, 2010). The only tools that were available at that time measured specific CM initiatives, such as a CM survey developed by Cheadle et al. (1998) to evaluate a neighbourhood-based youth health project in Seattle. Another example is the tool developed by Thomas et al. (2012), which was used to assess implementation of a CM initiative to prevent HIV that was implemented in 32 districts in India. Lippman et al. (2013) developed the CMM by identifying the domains of CM and developing a tool around these domains. In doing this, they made an important development which enabled measurement of the construct of CM, rather than aspects of a specific CM initiative. Lippman et al. (2017) have published results of the use of the CMM. At the time of writing, no other published studies using the CMM were identified.

This section demonstrates the challenges of measuring CM and the early stage of development of the field CM measurement. This study contributes to this emergent field and has been developed cognisant of the gaps identified in the literature to date for specific CM measures.

Community readiness

This study assesses both CM and community readiness (CR). CR is defined as the degree to which a community is prepared to take action on an issue (Plested et al., 2006, p. 3). The concept of readiness comes from the work of Prochaska, DiClemente and Norcross (1992) on stages of change in addiction treatment. Their transtheoretical model was adapted to assess stages of community rather than individual change (Oetting et al., 1995). Despite the initial focus on addiction treatment, the concept of CR for change is understood to be applicable to community-based prevention initiatives generally (Oetting et al., 1995). Donnermeyer et al. (1997) state that community prevention efforts are not successful unless the community is ready to, or supportive of, addressing an issue. Plested et al. (2006) assert that while readiness

is measurable, it is very issue specific and may vary across different groups within a community. They state that understanding of the levels of readiness is essential for the development of successful strategies and interventions for community change.

In the literature, the support for assessing readiness is largely focussed on the implementation of effective community-based initiatives (Oetting et al., 1995). The premise of measuring a community's readiness for change is that it supports development of interventions that are appropriate for that community at that time, and therefore enables more effective community change initiatives (Oetting et al., 1995). Assessment of CR aids understanding of how important an issue is to the community and the level of readiness in the community to address an issue. Oetting et al. (1995) state that this is essential, because without readiness to address the issue, change efforts will be unsuccessful. Measuring CR also contributes to understanding the attitudes and norms around an issue, which can be used to determine how an issue is addressed which is important for community acceptance of an initiative. Ideally, CR is assessed before a community starts to address an issue to inform the development of an initiative. It can also be used in an ongoing way to assess change over time and to inform improvement of initiatives (Oetting et al., 1995; Plested et al., 2006).

Three CR assessments are available in the literature. Beebe, Harrison, Sharma and Hedger (2001) and Chilenski, Greenberg and Feinberg (2007) have also developed tools to assess CR. The purpose of both of these tools was to assess the effectiveness of specific programmes to prevent substance abuse. This limits the use of these tools to measurement of these programmes. In contrast, the CR assessment developed by the Tri-Ethnic Center (Oetting et al., 1995; Oetting et al., 2014; Plested et al., 2006) was developed to assess readiness on any issue and measures the combined efforts of a community to address an issue, not a single programme.

The development of the CR assessment (Plested et al., 2006) was informed by two research traditions—psychological readiness for treatment and CD. The CR assessment uses key informant interviews to measure six dimensions of readiness: community efforts; community knowledge of efforts; leadership; community climate; community knowledge of the issue; and, resources related to the issue. Interviews are scored to produce numeric results on each CR dimension which equates to an overall stage of CR. The stages of CR are: 1. No awareness; 2. Denial/resistance; 3. Vague awareness; 4. Preplanning; 5. Preparation; 6. Initiation; 7.

Stabilisation; 8. Confirmation/expansion; and, 9. High level of community ownership. The CR assessment is a well-developed tool, built on a strong theoretical and research base and has been applied to a wide range of community issues internationally (Trewartha, 2010). The CR assessment was used in this research and more detail about the method of implementing a CR assessment can be found in Chapter 5.

To date, there are few examples in the literature where CR assessments have been used to develop or assess CM initiatives, and there is emergent evidence on the importance of assessing CR to develop and measure CM (Basic, 2015; Bhuiya et al., 2017; Glenn et al., 2018). Basic (2015) reported on CR assessments in three communities implementing the *Communities That Care* youth substance abuse and delinquency prevention CM initiative. In this study, a modified version of the CR assessment (Plested et al., 2006) was used to conduct focus groups with professionals involved in the initiative. The methods and results of this study were not reported clearly and baseline assessments were not completed. Basic (2015) states that the results of the study showed that communities differ widely on their understandings of issues that affect them, and must be ready to support a CM initiative for it to be successful. Basic (2015) states that a CR assessment is an essential step in initial planning and implementation of a CM initiative which is often overlooked.

Bhuiya et al. (2017) assessed CR in a community implementing a CM initiative to prevent teen pregnancy. Semi-structured interviews were completed with 25 community stakeholders who were professionals working with youth in varied settings. Each interview comprised of 10 questions on four aspects of CR adapted from the CR assessment (Plested et al., 2006). The aspects of CR assessed were attitudes and knowledge of the issue; perceived level of readiness; resources; and, leadership. A complete CR assessment was not implemented, and the reported results consisted of themes from the interviews rather than CR scores. From the interview themes, the researchers made a judgment that the community was at stage 4 of the CR assessment—preplanning. The CR results were used to develop strategies to increase readiness to address the issue, and the authors recommended CR assessment to support successful implementation of CM initiatives.

Glenn et al. (2018) completed a retrospective evaluation of Project Envision—a CM initiative to prevent sexual violence. The evaluation involved a literature review, a document review and key informant interviews. CR assessments were initially completed to select the communities

where the CM initiative would be sited, but further CR assessments were not completed. Glenn et al. (2018) concluded that alongside assessing readiness in the community for a CM initiative, it was also necessary to assess the readiness of organisational partners involved in implementing the CM initiative. They found that for many practitioners, the concept of CM was new and difficult to understand which affected the success of the initiative.

These three studies are the only identified examples that had a focus on both CM and CR. The definition and conceptualisation of CM and CR within the articles was limited. In the Basic (2015) and Bhuiya et al. (2017) articles, CM was not well defined or even used consistently throughout. Both Basic (2015) and Bhuiya et al. (2017) used modified versions of the CR assessments and did not report rigorous methods. As the literature on CM and CR is very new and underdeveloped, a specific aim of this study is to investigate the relationship between measurement of CM and CR to contribute to knowledge on effective CM and measurement.

Family violence

In this section, the issue of family violence is presented as the context in which CM is measured in this study. Family violence will be defined and described, the rationale for addressing family violence as a public health issue will be presented, as will the evidence in support of CM as a promising strategy to prevent family violence.

Locally and internationally there are many terms used to define specific types of violence within families and intimate relationships. In Aotearoa New Zealand, the terms family violence and domestic violence are often used interchangeably to refer to violence in families and those in intimate relationships (New Zealand Family Violence Clearinghouse, 2007b). The *Family Violence Act* 2018 (Ministry of Justice, 2018) and Te Rito (Ministry of Social Development, 2002) (the previous New Zealand Family Violence Prevention Strategy) both refer to family violence. The term is inclusive of same- or different-sex partners, parents, children, siblings, and elders, whether or not they live together, and also non-family members who share a home or have a close personal relationship (Ministry of Justice, 2018; Ministry of Social Development, 2002). The *Family Violence Act* 2018 criminalises all forms of violence against family members and those in intimate relationships. Family violence is defined in the Act as physical, sexual and psychological abuse. Psychological abuse includes intimidation, threats to harm, harassment, damage to property and financial abuse (Ministry of Justice, 2018). The Act includes allowing children to witness, or putting them at risk of witnessing, family violence. The

Act also states that family violence is often a pattern of abusive behaviour and criminalises acts that may seem minor or trivial in isolation when they form an abusive pattern. The definition of family violence in Te Rito is "a broad range of controlling behaviours, commonly of a physical, sexual, and/or psychological nature which typically involve fear, intimidation and emotional deprivation" (Ministry of Social Development, 2002, p. 8) and emphasises the control and fear that are central features of family violence.

In this thesis, the term *family violence* is primarily used. The term family violence has been criticised for its failure to acknowledge the reality that most violence that happens in the home is men's violence against women and men's violence towards children (Ministry of Social Development, 2002). However, the emphasis on family violence is pragmatic here because of the focus on prevention of all forms of family violence, not one specific type of violence such as men's violence against women partners. Prevention work differs from work that responds to family violence, where attention to a specific type of violence and strategies to address it are necessary to keep victims safe. The inclusion of all forms of family violence, as specified, acknowledges the benefits of working with the synergies across different forms of violence, for example, addressing social norms that tolerate or condone violence in any form (World Health Organization, 2014). It was also appropriate to use the term of family violence as this was a community study and the term family violence is commonly used in Aotearoa communities. Although people do talk about child abuse and sexual abuse, terms such as intimate partner violence are not widely used or understood outside the family violence sector.

The focus on all family violence could be seen as a limitation as the issue is large and complex, and this is acknowledged; however, this focus is appropriate for the Aotearoa New Zealand context and this study of CM to prevent family violence in communities which measures community perceptions about the whole problem of family violence, and not specific types of violence. This focus is unusual in the literature as there are no overall measures of family violence, and as such, the prevalence statistics that are reported in this chapter are on specific types of family violence. Definitions of the specific types of violence are included in the glossary (see p. xiv). Where evidence is cited, the specific type of violence that is measured is also reported, but when not referring to a specific piece of research or example the term family violence will be used. There is much controversy about how family violence is measured and many issues with measurement of this problem (Gulliver & Fanslow, 2012). These issues include the limitations of reliance on administrative data, under reporting of family violence,

the lack of national prevalence measures and how psychological violence is measured, to name a few. These controversies and challenges are acknowledged, but are not the focus of this thesis.

The nature and extent of family violence

The prevalence and seriousness of family violence in Aotearoa New Zealand has been discussed for many years. In 1987, the New Zealand Government inquiry into violence, known as the Roper Report, described family violence as an epidemic, and stated that violence in the home accounted for an estimated 80% of violent crime (Roper, 1987). More than half of all violent crime in New Zealand is still family violence related (Ministry of Women's Affairs, 2013), and family violence accounts for half of all murders in New Zealand (New Zealand Police, 2002, 2006). Family violence is a gendered problem. Internationally, women are more likely than men to be the victims of IPV and family violence homicide (New Zealand Family Violence Clearinghouse, 2007a; World Health Organization, 2010b). Data from the New Zealand Family Violence Death Review Committee (2017) showed that between 2009 and 2015 there were 91 intimate partner homicides in New Zealand, 68% of victims were women, and 32% were men, 76% of offenders were men and 24% were women. This data shows that men are more likely to be killed by other men than by women, and that women most often kill in self-defence. A New Zealand study by Fanslow and Robinson (2004) as part of the WHO Multi-country Study of Women's Health and Domestic Violence, used a population-based cluster-sampling scheme and face-to-face interviews with 2,855 women and found that approximately one in three participants, or 33% of women, reported experiencing at least one act of physical or sexual violence in their lifetimes by a male partner. More recently, the New Zealand Crime and Safety Survey, a nationwide face-to-face random household survey conducted in 2014, found that 26% of women and 14% of men reported experiencing at least one act of violence in their lifetime (Ministry of Justice, 2015).

The definition of family violence used here includes abuse and neglect of children and young people. Data from the New Zealand Family Violence Death Review Committee (2017) showed that between 2009 and 2015, 56 children were killed by a family member and 117 children or young people were present when a family member was killed in a family violence event. Over 80% of children killed through abuse and neglect in New Zealand were under five years old and almost 80% of the offenders were male. Māori children under four years old were four times

more likely to be killed through child abuse and neglect than non-Māori children. Further, a 2012 New Zealand study (Adolescent Health Research Group, 2013) of 8,500 young people randomly selected from participating secondary schools reported that in the prior year, 14% of participants had witnessed adults in their homes physically hurting children and 7% said they had witnessed adults hurting other adults.

Family violence occurs in all ethnic groups and across all levels of society; however, some Indigenous and marginalised groups are disproportionately affected by violence. Violence occurs in same-sex relationships at similar or higher rates to different-sex relationships (Dickson, 2016). However, gender diverse people (Dickson, 2016) and dis/abled people (Hager, 2017) experience IPV at much higher rates than cis-gendered and non-dis/abled people. In New Zealand, Māori are three times more likely than non-Māori to be the victims or offenders in intimate partner homicides (Family Violence Death Review Committee, 2017). Results of the WHO Multi-country Study of Women's Health and Domestic Violence (Fanslow, Robinson, Crengle, & Perese, 2010), showed that Māori women reported higher lifetime prevalence of physical or sexual IPV (57%) than European/Other women (34%), Pacific women (32%) and Asian women (12%). These differences were not dependant on sociodemographic characteristics or geographic location.

In Aotearoa New Zealand, family violence accounts for 41% of frontline police officers' time (SCOOP Independent News, 2015). The level of reporting to police shows an upward trend—in 2016 there were 118,910 family violence investigations by police, almost twice the number of investigations in 2007 (New Zealand Family Violence Clearinghouse, 2017). Thirty-five percent of the investigations in 2016 resulted in an offence being recorded and 15,994 police safety orders were issued that aim to protect a victim from a perpetrator. It is important to note that increased reporting to police and other services cannot be used to understand prevalence rates for family violence, but may indicate increased acceptance of seeking help when family violence is occurring. Purposeful attempts have been made in New Zealand to encourage people to seek help. In 2008, a year after the national It's not OK Campaign was launched to change attitudes and behaviours toward family violence, police saw a 29% increase in calls for family violence which they partly attributed to the Campaign (Point Research, 2010).

IPV persists as a problem in every country in the world (World Health Organization, 2005). However, New Zealand has relatively high rates of IPV for a high-income country. The Multi-

Country Study of Women's Health and Domestic Violence showed that international prevalence rates for IPV ranged from between 15–71% (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006) and on average affect one in three women in their lifetime globally (Heise & Kotsadam, 2015). The New Zealand study completed in 2002 as part of the Multi-Country Study of Women's Health and Domestic Violence (Fanslow & Robinson, 2004) provides the only means to compare New Zealand's rates of IPV internationally. A report by UN Women (2011) using the WHO study data, showed that New Zealand women had the highest reported lifetime prevalence of physical IPV of the developed countries that participated in the study. New Zealand is classified by the WHO as a high-income country (World Health Organization, 2013), and data from the WHO study showed that the average lifetime prevalence of physical and sexual violence in high-income countries is 23.2%, considerably lower than New Zealand's rate of 33%. There is no doubt that in Aotearoa New Zealand we have a major issue with family violence.

Causes and consequences

Family violence is a complex issue and has multiple contributing causes (Heise, 2011). A major contributor to family violence is patriarchal belief systems that support gender roles which privilege men's power over women, discriminate against women and are used to control women (Ministry of Social Development, 2002). Patriarchal dominance includes the use of cultural practices and social norms to perpetuate violence against women and children (World Health Organization, 2010b). At their worst, these social norms function to, for example, reinforce men's control and abuse of women as natural and acceptable. Social norms can be demonstrated overtly or very subtly and are woven through our language and practices in ways that can make them difficult to isolate.

Aotearoa New Zealand's history of colonisation is an important factor in understanding the occurrence and prevalence of family violence (Kruger et al., 2004; Wilson, 2016). Colonisation involved the forceful alienation of Māori from their land, loss of language and culture. The imposition of Western ideas of nuclear families and individualism disrupted traditional life for many whānau Māori and broke down whānau structures that protected women and children from violence (Dobbs & Eruera, 2014; Wilson, 2016). This includes the imposition of patriarchy and male dominance over women which disrupted the high status of Māori women and Māori gender roles that were complimentary and reciprocal (Dobbs & Eruera, 2014). The historic and

contemporary impacts of colonisation, racism and social marginalisation on Māori contribute to high rates of whānau violence (Dobbs & Eruera, 2014; Kruger et al., 2004). It is also possible that colonisation, the New Zealand Wars and the normalisation of violence in New Zealand society contributes to the high rates of family violence in Pākehā families, although this has not been evidenced.

The broader community and societal environment also contribute to family violence. Violence is more prevalent in communities with weak sanctions for those who use violence and where there is a lack of institutional support from police and justice systems (World Health Organization, 2007a). Income and economic factors including poverty and unemployment contribute to stress and are associated with higher rates of family violence (World Health Organization, 2007b, 2010a). There are also factors at the individual level that increase the likelihood of violence including psychological issues, such as childhood exposure to violence in the home, and abuse of alcohol and other drugs (Heise, 2011; Ministry of Social Development, 2002; World Health Organization, 2007a).

Like the causes of family violence, the consequences are complex and can affect every part of a person's life (World Health Organization, 2014). At its most extreme, family violence can be fatal. The negative impacts of non-fatal IPV on the physical, mental, sexual and reproductive health of women are well documented (World Health Organization, 2013). These impacts can be short-term or very long-term continuing to affect women's lives long after the violence has stopped and have multiple impacts intergenerationally. Long-term impacts can include chronic physical and mental health issues, disability and behavioural consequences such as harmful use of alcohol and other drugs (World Health Organization, 2013). The social impacts of IPV for women include homelessness, financial insecurity and social isolation when women leave their homes to be safe (VicHealth, 2017). Women's ability to work and engage in education are also seriously affected by IPV (Contreras-Urbina et al., 2016; VicHealth, 2017). Similarly, the impacts of family violence on children from abuse, neglect, and witnessing violence in the home are far reaching. Children who have suffered maltreatment are more likely to experience a wide range of health, social and educational issues (Murphy, Paton, Gulliver, & Fanslow, 2013). IPV is also understood to have severe negative impacts on the emotional and social wellbeing of a whole family, and to significantly impact on adults' ability to parent well (World Health Organization, 2010a).

The costs of family violence are high and include human, economic and health system costs (Graffunder, Noonan, Cox, & Wheaton, 2004; World Health Organization, 2014). While it is very difficult to quantify the human costs of family violence, the economic cost of IPV and child abuse in New Zealand was estimated at between NZD$4.1 and NZD$7 billion per annum in 2014 (Kahui & Snively, 2014). This estimated cost accounts for individual health impacts, costs to the health, justice and social welfare systems, lost productivity and increased consumption related to IPV and child abuse.

This section demonstrates the size, complexity and wide ranging impacts of the issue of family violence in Aotearoa New Zealand. This evidence also signals the need for new approaches to address this issue which has been long understood, but continues to be highly resistant to change.

Healthy relationships

This research investigates CM in the context of both family violence prevention and healthy relationship promotion. Family violence prevention usually refers to stopping new occurrences of violence from occurring and changing social norms. However, in practice there is a growing interest in promoting healthy relationships between intimate partners and family members. The focus on promoting healthy relationships in this research came from the Glen Innes community rather than from the literature, and their determination to focus on achieving positive goals—not only reducing negative statistics.

The evidence on the promotion of healthy relationships, or positive relationships, as a family violence prevention strategy is relatively new and very limited. The lack of evidence on healthy relationships is partly because the focus on healthy relationships is a paradigm shift from traditional investigation of pathologising behaviours to a new investigation into positive behaviours (Rogers, Rumley, & Lovatt, 2018). The concept of healthy relationships is referred to in the literature but is not defined. It is not easy to define what a healthy relationship is due to the complexity of relationships, and because healthy and unhealthy relationship behaviours exist on a continuum (Tharp et al., 2013). Young (2004) states that there is a need for definitions of healthy relationships to be developed and debated. However this presents a challenge as what is considered to be healthy varies widely amongst people and communities. Perhaps rather than a definition of healthy relationships, the components of healthy relationships would be a more helpful starting point for knowledge building.

In the literature, healthy relationship research is largely focussed on adolescents and the prevention of dating violence and promotion of sexual health through educational programmes in school settings. The evidence of the effectiveness of the Safe Dates programme (Foshee et al., 2004) and similar school-based programmes, was one of the first primary prevention strategies on IPV to show change. This led to school-based programmes being recommended and contributed to development of school-based programmes internationally including a number in Aotearoa New Zealand (Ball, 2013; Beres, 2017; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). However, literature on public health interventions that promote healthy relationships at the community- or societal-level is extremely rare. The evidence that does exist often assesses one-off or short-term initiatives.

Promotion of healthy relationships may be a protective strategy for family violence prevention, but there is little evidence to support this due to the early stages of investigation into this work. The public health literature on protective factors, including healthy relationships, is very underdeveloped (Krug et al., 2002). Tharp et al. (2013) note the need to develop conceptual models of healthy relationships to advance public health initiatives in this area. This research contributes to evidence building on CM to promote healthy relationships, and is thought to be a rare example of measurement of activity to promote healthy relationships at the community rather than individual level.

Public health and primary prevention

This research is informed by public health and primary prevention theory and evidence. The size of the issue of IPV means it is a global public health and human rights issue (Contreras-Urbina et al., 2016). There is growing evidence that shows IPV is predictable and preventable, and that well-planned public health strategies can reduce interpersonal violence and prevent violence (Garcia-Moreno et al., 2015; Krug et al., 2002; World Health Organization, 2014). In violence prevention literature, a public health approach is a science-driven, population-based, interdisciplinary and intersectoral approach based on the ecological model which emphasises prevention (Krug et al., 2002). Ecological models were first introduced in the late 1970s by Garbarino and Crouter (1978) and Bronfenbrenner (1979). They are often used in violence prevention literature to demonstrate how a combination of risk factors across the individual, relationship, community and societal levels contribute to interpersonal violence occurring (Krug et al., 2002) (see Figure 1). The ecological model is also used to demonstrate how

addressing and preventing violence requires intervention across the levels of the model because of the complexity of the problem (Shepard, 2008; Watson-Thompson et al., 2008; World Health Organization, 2004).

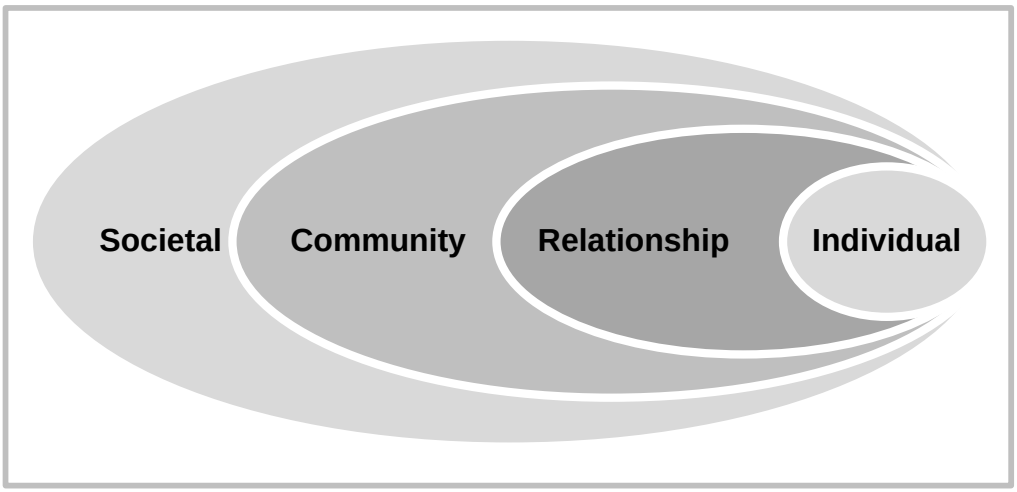

Figure 1: The ecological model (from Krug et al., 2002, p. 12)

Efforts to prevent rather than respond to violence have only been made over the last four decades and evidence is still emerging; however, prevention is recommended to address the underlying causes and reduce the overall rates of violence (Graffunder et al., 2004; World Health Organization, 2007b). Primary prevention is a public health strategy that refers to the development, implementation and evaluation of universal interventions that target whole populations or communities regardless of levels of risk, to reduce violence and stop new incidents of violence from starting (World Health Organization, 2007b). Due to the high prevalence of family violence, primary prevention is a recommended strategy to address the causes and risk factors for perpetration and victimisation (Heise, 2011; World Health Organization, 2010b). The World Health Organization states that the majority of efforts to address violence have focussed on secondary and tertiary prevention that respond to violence after it has occurred including crisis services, health and justice sector responses. This has created an imbalance in activity and calls for greater focus on primary prevention (World Health Organization, 2007b). Secondary and tertiary prevention is focussed on action within the individual and relationship levels of the ecological model. A public health approach advocates for universal interventions that are implemented at the community and societal levels (World Health Organization, 2010b). The importance of emphasising primary prevention in efforts to address violence have been voiced continuously by the Centers for Disease Control

and Prevention and the World Health Organization as an essential strategy (Graffunder et al., 2004; Krug et al., 2002; World Health Organization, 2005, 2007b, 2009).

However, the field of primary prevention of IPV is still in its infancy and there is limited evidence on interventions (Abramsky et al., 2014; Heise, 2011). While internationally, many countries fund violence prevention, the level of investment in prevention does not match the size of the problem (World Health Organization, 2014). For example, the need to have a stronger focus on primary prevention in New Zealand was identified in 2002 (Ministry of Social Development, 2002), yet in 2013/14 the New Zealand Government spent only 1.5% (NZD$21 million) of the total budget of NZD$1.4 billion for family and sexual violence on primary prevention (Office of the Minister of Justice & Office of the Minister for Social Development, 2015), despite family and sexual violence costing New Zealand up to an estimated NZD$7 billion per year (Kahui & Snively, 2014).

While limited, there is evidence to support a public health approach to address violence that is focussed on primary prevention and working at the community-level. However, public health and primary prevention theory to address violence that is recommended by key public health organisations such as the World Health Organization does not outline how best to work in communities to make change. It is necessary to draw on disciplines that have expertise in working at the community-level, including CD and CM. CM is a primary prevention strategy that is ideally suited to working to address family violence due to the complexity of the issue. Shepard (2008) stated that early efforts to prevent family violence in the 1970s focussed on community mobilising and organising, and that the focus changed in the 1990s to supporting individual victims and perpetrators. More recently, dissatisfaction with individualised responses to family violence has led to an increased interest in CM (Jewkes, 2017). Although in its infancy, evidence on CM to prevent family violence shows promise (Abramsky et al., 2014; Abramsky et al., 2016; Contreras-Urbina et al., 2016; Garcia-Moreno et al., 2015; Pettifor et al., 2018).

There is only limited evidence of the impact of CM in the literature, partly because CM initiatives are often not measured (T. Thomas et al., 2012). While RCTs are widely regarded as the gold standard measure for biomedical interventions, they may not be effective measures of CM due its complex and multifaceted nature (Abramsky et al., 2012; Coote, Allen, & Woodhead, 2004). However, some examples of measurement of CM initiatives exist and more

recently, CRTs have been used to assess the impact of CM initiatives on complex issues including HIV and violence against women. CRTs pair similar communities and then randomly assign one to receive an intervention and one to act as a control. The participating communities are then assessed usually using quantitative surveys at two or more points in time.

The most promising evidence on CM to reduce IPV and HIV risk behaviours is from the SASA! study (Abramsky et al., 2014). This study was a CRT implemented in four intervention and four control communities between 2007 and 2012, and used cross-sectional surveys of a random sample of community members (Abramsky et al., 2014). Results showed lower social acceptance of IPV amongst women and men, more acceptance that women can refuse sex, lower prior year experience of physical and sexual IPV for women, increases in supportive responses to women who experienced IPV and a lower number of congruent sexual partners in the previous 12 months for men in the SASA! intervention communities. There were large differences between intervention and control communities, with 50% less experience of physical IPV for women and congruent sexual partners for men in the prior year in intervention communities. This was the first CRT on these topics in sub-Saharan Africa to show impacts of CM intervention at the community-level (Abramsky et al., 2014). Kyegombe et al. (2014) reported qualitative findings of positive changes in gender norms within relationships, including increased gender equality and reduced acceptance of violence at the community-level in SASA! intervention communities. This study is a rare example of the use of both quantitative and qualitative measures of CM.

However, Abramsky (2012), Michau (2012) and Lippman et al. (2017) identified challenges of using CRTs to measure CM. Abramsky et al. (2012) highlighted challenges of community randomisation, unrealistic time frames to assess change and the limitations of generalisation due to the importance of social context. Michau (2012) stated that it was not clear if CRTs were able to assess the complexity of CM initiatives, and also questioned the ability of the groups implementing CM initiatives to run CRTs which require substantial resourcing and specialist research skills. Michau (2012) called for tools that do not require specialist skills to administer; a call that this study responded to.

There is much that is yet unknown about CM and measurement of CM. Due to the limited evidence, it is not yet known if CM is a cost-effective strategy. There are two available

examples of calculating the cost effectiveness of CM approaches to preventing IPV (Jan et al., 2011; Michaels-Igbokwe et al., 2016) and while both showed favourable results, with limited evidence and the complexity of measurement, results were inconclusive. While evidence on CM to address family violence is limited, examples such as the SASA! study are very promising.

This section identified CM as a public health prevention strategy. Public health theory and evidence is key to understanding the rational for using CM to address this complex issue. It is largely within the public health literature that CM is promoted as a promising approach to address family violence. However within the public health theory, the depth of understanding of the processes used to implement CM is not present. Knowledge about implementation sits with the CD theory and practice, and for this reason it is important to understand the contributions from both the public health and CD fields to conceptualise CM.

Summary

In this chapter, CM was introduced as a specific CD strategy that is informed by collective movements for social change, and especially Paulo Freire's concepts of conscientisation, dialogue and praxis. The literature on CM is limited as it is a relatively new area of research, and as such, there are many questions that are yet to be answered and much need for debate in the literature. The recent identification the domains of CM (Lippman et al., 2013) was an important step towards improved definition, implementation and measurement. The challenges of measuring CM were outlined, and the CR assessment was presented as a useful tool to support measurement of CM and to investigate the relationship between measurement of CM and CR. In the second part of this chapter, family violence was presented as the focus issue for this study of CM. The nature and extent of family violence was explained. The concept of healthy relationships was then introduced as a new area of research and practice in family violence prevention. Family violence was then positioned as a public health issue and the case was made for using a primary prevention and CM approach as an emergent but promising strategy to address this problem. The broad nature of this literature review was necessary to site the study within a range of disciplines and concepts that informed an innovative approach used in this research to investigate CM, CM measurement and family violence prevention. In the next chapter, the research methodology is presented.

CHAPTER 3: METHODOLOGY

In this chapter the methodological assumptions that informed this research are described. The research was informed by postpositive methodology and used survey within case study research. This methodological framework was employed to pilot the ACMQ, to assess CR in two communities, to investigate the relationship between measurement of these two concepts and the impact of social context on CM. The characteristics and criticisms of the methodological approaches are outlined and the implications of this for knowledge production are described. This chapter includes a discussion of reflexivity which positions me as the researcher within my research, and describes how this influenced my decisions about the methodology and methods used.

Postpositivism

Articulation of a methodology conveys the researcher's understanding of how knowledge is produced and their understanding of reality. The choice of research methodology is dependent on the purpose of the research and the research question. This informs what is studied, the methods used and how data is interpreted to gain knowledge. Allsop (2013) distinguishes between two broad approaches to methodology—positivist and interpretivist. Each methodology has its own epistemology or theory about how knowledge is produced. Research conducted under a positivist methodology operates on the assumption that knowledge is objective, can be produced by using rigorous research methods, and that knowledge builds through a process of theory testing and refinement (Allsop, 2013). Interpretivist research was developed because of the limitations of positivist research to explain human experiences and social behaviour. Interpretivists question objectivity, believe that research needs to incorporate subjective aspects to be meaningful, and that knowledge is produced from the data or responses of research participants. It is important to note that while Allsop (2013) presented positivist and interpretivist methodologies as a binary, Adams and Buetow (2014) state that methodologies can be conceptualised as existing on a continuum. This continuum includes a spectrum of possible methodological positions, from positivism through to idealist and constructivist positions. Movement along this continuum indicates a range of methodological decisions about objectivity or subjectivity, theory or data driven, and the level of separation or involvement of the researcher in the research (P. J. Adams & Buetow, 2014).

This study is informed by a postpositive methodology. Postpositivism was developed after positivist research which sought absolute truth from the study of the natural world in the 19th century (Creswell, 2014). Positivists believed that science was objective and that personal biases could be avoided using experimental research designs. These experimental designs sought to establish cause and effect relationships in nature. They were not designed to study human behaviour and had limited application in doing so due to the complexities of human behaviour. Postpositivism was developed in the late 19th and 20th centuries to address these limitations and to enable scientific study of human behaviour. Postpositivism is most commonly associated with psychological research and the development of quasi-experiments to study human behaviour (Creswell, 2014). It was developed based on the understanding that while an absolute truth exists, it is not possible to measure this truth when studying people and social processes, because our measurement approaches are mediated by language and do not give us the ability to directly assess these phenomena (Bryman, 2012; Creswell, 2014). Measurement is also understood to be imperfect, because we all hold bias and this impacts on what we study and the methods we use to study it (Lincoln, Lynham, & Guba, 2011). Rather than denying bias, postpositivist research manages bias by using study designs and data collection methods that minimise, but do not remove, bias. As such, our research methods only allow for approximations on the reality we study.

Postpositivist research is primarily concerned with testing theory (Creswell, 2014). In quantitative studies, research questions are derived from theory and used to study situations and relationships. Evidence is most often gathered using instruments that produce numerical data. This evidence is then used to further develop or abandon theory, and in turn contributes to theory development. From this, evidence is used to shape knowledge.

This study is informed by a postpositivist position which is very different from the phenomenon that is being studied, which is a transformative approach informed by Freirean thought. While a transformative worldview is characterised by engaging with the complexities of power, politics, change and emancipation, postpositivism is a reductionist approach that seeks to break ideas down into smaller units for measurement and statistical analysis (Creswell, 2014). Reductionists use precise observation of these smaller units to build an appreciation of the whole phenomenon. As such, positivist research is critiqued by feminist researchers as being a male oriented approach to research (Oakley, 2000) and by ethnic minority groups as ignoring their experiences (Johnson, 2013). However, the reason for adopting a postpositivist position

for this research is that there was an identified need to collect quantitative data to support evidence building on CM (see Chapter 2). This decision was also due to my role in the Glen Innes community developing and implementing a CM initiative, and this position was chosen to separate myself as much as possible from the research process to avoid bias. Using a reductionist approach was useful for this study as it enabled quantification of the complex concept of CM and production of quantitative data that could be used to assess CM alongside other concepts and approaches that have already been quantified. This study does not presume to be a complete approach to assessing CM, but as a new and developing field of research, this study contributes a much-needed and useful step towards quantification.

Assumptions in quantitative methods

Within the broader frame of a postpositivist interpretation of knowledge, this study employs quantitative research methods (Creswell & Creswell, 2018). Quantitative research was used to test the research question that CM could be reliably assessed using a quantitative measurement tool. As this is a relatively new area of research, the aim the study was to contribute to the ongoing process of improving understanding CM and measurement of CM. Quantitative research is appropriate for studies that are exploratory and seek to understand the extent of a problem or changes in patterns, and to generalise results beyond the study sample to the wider population (Bryman, 2012).

The aim of this study to develop a tool to assess CM led to the use of a quantitative approach to test the utility, validity and reliability of this tool. Developing a measurement tool was an important step for CM research as it enables investigation of CM, and the ability to compare CM between communities, rather than evaluate specific initiatives. A criticism of quantitative research is that it has limited ability to assess social reality which is complex and changeable (Allsop, 2013; Bryman, 2012). While this limitation is acknowledged, a pragmatic position was assumed in this study to meet the need to develop and pilot replicable and systematic approaches to CM measurement.

In this study, survey methods were employed within case study design. A survey is a systematic method often used to study attributes and opinions of a sample of a population using questionnaires and structured interviews. The data collected from a sample of individuals is then numerically coded and aggregated to generalise results to the wider population (Creswell, 2014; Groves et al., 2009). It is important that a sample is representative of the wider

population, as information from individuals is used to construct statistics that describe attributes, basic characteristics or experiences of the larger population (Groves et al., 2009; T. May & Sutton, 2011). Survey research is useful when it is not possible to observe the phenomenon to be studied, such as people's attitudes and perceptions, and to understand public opinion and how people's attitudes influence their behaviour (Ackroyd & Hughes, 1992; Groves et al., 2009). Survey research can help organise and clarify people's attitudes, but from a postpositivist position, it does not give direct access to these attitudes, but rather provides an approximation of these views. Survey research can be useful for accessing large numbers of participants and identifying central beliefs or experiences of a population. However, the use of language in surveys can be a barrier to understanding and interpreting questions and responses, and has limited ability to describe people's thoughts, feelings and experiences. The aggregation of individual responses has the function of creating some form of a normative view which hides the diversity of people's attitudes and experiences.

The ACMQ and the CR assessment are both forms of survey research. The ACMQ is a self-completion questionnaire that a participant answers without assistance (Bryman, 2012). There are a number of advantages of using self-completion questionnaires. As there is no interviewer present, there is less risk of interviewer introduced bias, such as the way questions are asked (T. May, 2011). Self-completion questionnaires are appropriate for ethically and politically sensitive issues, as people's responses can be collected anonymously and they are not influenced by the presence of an interviewer (de Leeuw & Hox, 2008; T. May, 2011). Self-completion questionnaires are also low-cost, quick to administer and convenient for participants to complete in their own time and location of their choosing (Bryman, 2012).

There are also a number of disadvantages of using self-completion questionnaires. Researchers have little control over completion of a questionnaire once it is distributed (T. May, 2011). It is also difficult to include a large number of items in the self-completion questionnaire, as long questionnaires can be unappealing and can led to respondent fatigue (Bryman, 2012). There are also issues with language, including the ability of the survey questions to describe the phenomena that is the focus of the study, and for participants to understand and respond to questions, especially if participants have limited understanding of the survey language and require assistance.

The disadvantages of not having an interviewer present are that no one is there to encourage participation, administer the survey, respond to questions, give instructions and explanations, to record answers or to probe for more information (Bryman, 2012; de Leeuw & Hox, 2008). For these reasons, self-completion questionnaires can have issues with response rate and data quality (de Leeuw & Hox, 2008). A low response rate may also mean it is not possible to assess sample bias (T. May, 2011). However, it is possible to avoid some of these problems by developing clear questions, straightforward instructions and pretesting the questionnaire (T. May, 2011).

Case study methodology

Within a postpositivist framework, this study is informed by case study methodology. Case study was adopted for this research because it has been established as an appropriate methodology to research complex phenomena in real-world settings (Harrison, Birks, Franklin, & Mills, 2017). Case study has been used in a wide variety of disciplines to answer diverse research questions, informed by different philosophical underpinnings. This has led to case study methodology developing as a pragmatic and flexible approach that can vary in definition and application (Harrison et al., 2017).

The roots of case study research are located in the social sciences, and associated with qualitative and very detailed ethnographic anthropological studies (Merriam, 2009). While case study is still mostly associated with qualitative research, quantitative methods have long been incorporated into case study research (Harrison et al., 2017). Yin (2014) is credited with strengthening case study methodology through blending quantitative approaches with qualitative approaches, incorporating quasi-experiments and developing structured processes for case study research (Harrison et al., 2017).

Case study is referred to as both a methodology and as a method in the literature which has caused some confusion (Harrison et al., 2017). Prominent case study researchers Yin (2014), Merriam (2009) and Stake (2006) assert that case study is a both methodology and a method. They say case study methodology is the overarching framework that informs case study research, and within this, various research methods can be utilised. As such, case study methodology does not define the methods used. Harrison et al. (2017) assert that to distinguish between these two aspects of methodology and method, researchers must clearly

state their methodological position and show how the assumptions of this position align with their chosen methods.

A case can be defined as “a phenomenon of some sort occurring in a bounded context” (Miles & Huberman, 1994, p. 25), and as a “specific, complex, function thing” (Stake, 1995, p. 2). A case is bounded in the sense that is has some specificity, such as the community and phenomenon being studied, and the time period it is studied within. A case study helps to develop an understanding of a real-world phenomenon and the important contextual factors of that phenomenon, from the perspective of the people experiencing it, in their natural context (Harrison et al., 2017; Yin, 2014). Therefore, case study methodology supports researchers seeking to present an “holistic and real-world perspective” (Yin, 2014, p. 4), and enables researchers to provide greater context to the research, allowing for critical analysis of the research findings in relation to that context.

Case study is a useful methodology for theory testing and theory development. Yin (2014) states that rigorous case study design involves theory development. This includes the development of theoretical propositions for the study and rival theories for the findings (Yin, 2014). Case study is often used to build theory; however, Stake (2000) suggests that the best use is “adding to existing experience and understanding” (p. 24).

Case study research is pragmatic in that it is common for researchers to use qualitative and quantitative data and using “what works” (Creswell & Plano Clark, 2011, p. 43) to answer the research question. According to Yin (2014), case study design is best suited to ”how” and ”why” research questions, where the researcher has little or no control of events and the focus of inquiry is on contemporary events. As such, it is better suited to complex rather than simplistic inquiry. A strength of case study research is that it draws from multiple sources of data rather than a single data source, meaning case study findings can be more precise and provide a more nuanced understanding of the phenomenon being studied (Yin, 2014).

Case study research has been criticised due to confusion of different types of case study (e.g. descriptive, scientific, legal), lack of understanding, and the dearth of theory and consensus within disciplines. Yin (2014) accepts the criticisms that some case study designs receive. Yin (2014) states that this is partly due to the paucity of methodological texts available until recently, and because of many examples of case study research that do not use systematic methods. Statistical data analysis is not a well-developed aspect of case study design, and has

led to researchers making conclusions using ambiguous evidence (Yin, 2014). Yin (2014) states that specificity and clarity in describing research aims and questions, methods and units of analysis, the bounds of the case, and interpretation of findings contribute to more robust and systematic case study research.

Another criticism of case study is that the comparative advantage of case study research is unclear in contrast with experimental methods (Yin, 2014). Case study design is not able to establish the effectiveness of interventions in the same way as RCTs or true experiments. Yin (2014) states while this is true, case studies can explore and explain how and why change occurred, which is not possible utilising RCTs. Case study research has its own distinct advantages, and can also be used with other methods to develop a more complete understanding of the impact of interventions.

An important criticism and ongoing debate around case study research is the generalisability (Gomm, Hammersley, & Foster, 2000; Yin, 2014) or transferability of results (Lincoln & Guba, 2000; Tashakkori & Teddlie, 2003). There is some confusion in the definition and use of these two terms in the literature. Stake (2000) and Lincoln and Guba (2000) question the application of positivist generalisation to social inquiry, and instead emphasise the reader's role in interpreting case study research. Stake (2000) argues that case study research contributes to naturalistic generalisation, where the reader determines the worth of a case study in relation to their prior experiences and existing knowledge. Some case study researchers argue that their research is not intended to produce generalisable results, and that some case studies have inherent value because the reader wants to learn about a particular case in-depth (Gomm et al., 2000; Stake, 1995). However, Gomm et al. (2000) acknowledge that it is likely readers will want to understand if the findings are applicable in another context, as a case can be understood as a "microcosm of some larger system or of a whole society" (p. 99).

In this research, case study was used to test the transferability of the methods rather than the results. Usually the quality of the description of the context of a case study is an important aspect of whether the results of a case study are transferable to another context. Qualitative and case study researchers often refer to philosopher Gilbert Ryle's (1971) concept of a "thick" description. Anthropologist Clifford Geertz (1973) built on this concept to describe ethnographic study, and the need to provide thick descriptions of cultural contexts to enable outsiders to understand the meaning of behaviours of other cultures. In contrast to a thick

description, a thin description is where study findings, especially quantitative findings, are presented without context, and provide little understanding of the meaning of behaviours and actions of those being studied (Geertz, 1973). A thick description must be detailed enough to enable the reader to understand the findings, although the findings themselves are not part of the thick description (Lincoln & Guba, 2000). Yin (2014) states that a thick description is not always necessary in case study research, especially not in the form of observational evidence that are common in some forms of qualitative research. However, the description must be thorough enough to explore how and why change occurred in the case.

Lincoln and Guba (2000) present case study research as transferable rather than generalisable. They state that the readers of a case study assess the transferability of the case to their context by assessing the level of similarity or fit between the contexts. The more similar the context, the greater the transferability between the case and the reader's context. Tashakkori and Teddlie (2003) state that from a pragmatic worldview, the focus is on transferability rather than generalisability. For this research, the aim is to contribute to analytical generalisation of theory (Yin, 2014), naturalistic generalisation (Stake, 2000) and transferability (Tashakkori & Teddlie, 2003), not statistical generalisation, and it is fully acknowledged that the reader and community members will decide how useful the findings are to their own context, not the researchers. The aim of this study was to produce an approach to measurement of CM, including methods and tools that are transferable to other communities. It did not set out to provide a thick description of the communities, but to provide enough detail to allow the reader to assess transferability. There is also inherent value in the case studies, as the case studies document and measure activity and perceptions of two communities on an issue and approach to measurement that has as yet to be documented.

In this research, case study methods were chosen to assess the utility, reliability and validity of the ACMQ tool to measure CM, to assess CR in two communities and to investigate the relationship between measurement of CM and CR, and the impact of social context. The community context the measures were implemented in is very important. Both the ACMQ and the CR assessment were designed for use in communities to convey the experiences of a community on a specific issue in time, place and social context. This study is an example of using quantitative methods within case study research. Using case study, quantitative results can be presented within the context they were collected in. The contextual information is then used to interpret and analyse the findings in a way that is not possible when quantitative

results are presented in isolation from the people and communities from whom they were collected. The use of case study also addressed some of the limitations of quantitative research when assessing complex social processes by contextualising the data in real-world community settings.

Study design

Case study can take many forms and often does not have a formal design. This research did use a formal design—a multiple or two-case case study design with two embedded units of analysis, Yin's type 4 design (Yin, 2014). The embedded units of analysis in this study were surveys—the ACMQ and the CR assessment (Plested et al., 2006). While case study made it possible to compare results between the two communities, this was not a quasi-experimental design due to the lack of researcher control.

Some authors suggest that single and multiple-case study designs use different methodologies, and others present comparative case study design as a distinct method. Yin (2014) states that single and multiple-case studies are variants of the same design, and asserts that multiple-case study designs are more robust than single case studies because they provide more potential for comparative analysis. In a two-case case study design, each case is presented individually and then a case comparison analysis is completed. Miles and Huberman (1994) state that first each case must be understood in its own right, and then case comparison analysis can be used as a means to understand how the outcomes of a case are affected by the local context in order "to develop more sophisticated descriptions and more powerful explanations" (p. 172) of the phenomenon being studied. Case comparison analysis can increase the transferability of findings through in-depth analysis of the impact of local context (Miles & Huberman, 1994).

Reflexivity

In this section, I describe how who I am and my experiences have influenced my choice of a postpositivist framework, case study methodology and quantitative methods. This includes description of issues of roles, power, influence, bias and insider-outsider status within the study communities.

As a researcher I bring who I am and what I know to my research. Acknowledging my position as a researcher in this study is important as it explains the lens through which I view my research, decisions I have made, how I understand my influence and bias and how this impacts

my interpretations of the findings (Rose, 1997). The concept of reflexivity is most often applied to researcher's roles in in-depth qualitative research (Bourke, 2014). While it is less often discussed by academics in public health, I think it is an important concept for all researchers to consider. Reflexivity involves the researcher reflecting on:

> How their role in the study and their personal background, culture, and experiences hold potential for shaping their interpretation, such as the themes they advance and the meaning they ascribe to the data. This aspect of the methods is more than merely advancing biases and values in the study, but how the background of the researchers actually may shape the direction of the study (Creswell, 2014, p. 186).

The first aspect of reflexivity to consider is my choice of quantitative methods for this study. This choice was informed by my professional experiences. In my work, it seems to be common that quantitative data is privileged over qualitative findings by decision makers. I have seen programmes and initiatives that collect quantitative data prioritised for funding over promising initiatives, at least in part because only qualitative findings were available, even when these quantified approaches were of low quality. As such, it can be difficult to advance innovative ways of working that are complex and challenging to quantify such as CM. These experiences informed my decision to contribute to quantification of CM by developing a measurement tool.

A discussion of reflexivity and researcher position is pertinent to this study because I held different roles in the two study communities. Stake (1995) suggests that researchers think carefully about their position in case study design including how involved they are; how they present themselves (as an expert or naive observer); and, whether they are neutral or critical observers. In Glen Innes, I was both a researcher and a practitioner. In Ranui, I was a researcher with no other role in the community. For this reason, most of reflections detailed relate to my roles in Glen Innes.

My role in the Glen Innes community changed numerous times from the beginning of my involvement in 2009 to the completion of my doctoral study. At times I held a dual role as a practitioner and a researcher. My introduction to the Glen Innes working group in 2009 was as a researcher and a family violence prevention practitioner. I was completing a Master's of Public Health investigating effective community mobilisation to prevent family violence. The findings of that research were later used to develop the CM initiative in Glen Innes. At that time, I was also working in a national role supporting communities to prevent family violence. Both of these roles meant I was positioned with a level of expert knowledge. I recognise that

having a level of expertise in family violence prevention brings a form of power that was not available to many other people in the study communities. On completing my master's research, I joined the Glen Innes working group as a collaborator. In September 2011, I was employed by the local organisation Te Waipuna Puawai as the coordinator of the local CM initiative—the HEART Movement. Outside of the working group and previous relationships, it was in this capacity that I was introduced to the community. When I started my doctorate in September 2012 and until 2014, I was both a practitioner and a researcher in Glen Innes. While the most visible role in the community was as the coordinator of the HEART Movement, my researcher role was also visible during data collection and when reporting research findings back to the community. After October 2014, when I handed over the HEART coordinator role, my primary role was as a researcher, and I joined the advisory group to the HEART Movement.

As a person paid to develop and implement the HEART Movement initiative in the Glen Innes community, and my research measuring CM, I clearly had an interest in the success of the initiative. Managing this bias in the research contributed to my choice of methods. I chose to develop a quantitative tool and to complete a quantitative study to reduce the influence of my power and bias in the community at the data collection and analysis stages. The data collection methods that I used meant that I did not interact directly with any research participants about the research. However, I acknowledge that the interpretation of the data and conclusions I drew from the data were influenced by my knowledge and experience.

Another aspect of reflexivity to examine is my insider-outsider status, which can be understood as the degree to which as a researcher you are a part of or accepted by the community or group that you are researching (Bourke, 2014; Humphrey, 2007). It is not a fixed state as it changes in different situations. As a researcher I was aware of my insider-outsider status in the two case study communities. In Ranui, I was an outsider researcher, but in Glen Innes, I was both an insider and an outsider depending on the situation. In the Glen Innes community, I was in some sense an insider, as a practitioner working for a trusted local organisation—Te Waipuna Puawai, and advocating for the community. This meant I felt very included and secure in my role as a practitioner. However, this insider status only went so far. I was not a community member and knew that I was not aware of, or invited into, aspects of community life and I was an outsider in this sense. As a middle class, educated, white, lesbian and non-religious woman working and researching in a predominantly brown, low socioeconomic, religious community, with little gay visibility, I was aware of my outsider status. When it came

to organising data collection and presenting research findings back to the community I felt like more of an outsider, particularly when I was no longer working in the community. All researchers should be questioned about their research, and it is appropriate to feel more like an outsider in this context. I am also aware that my practitioner role meant that my research was accepted and supported in a way that a true outsider would not experience.

In this chapter, the postpositive methodology and quantitative methods adopted for this study were explained and my position as a researcher was examined. These positions informed my choice of research methods which will be described in Chapter 5. In the next chapter, the development of the ACMQ is detailed.

CHAPTER 4: DEVELOPMENT OF THE AOTEAROA COMMUNITY MOBILISATION QUESTIONNAIRE

In this chapter, the development of the ACMQ is documented. The ACMQ is a new tool to measure CM. The ACMQ is a community-level measure which aggregates individual responses on six domains of CM: leadership; organisation; participation; shared concern; social cohesion; and, critical consciousness. It measures community members' attitudes, perceptions and involvement in activity in the community they live in, and community members' understandings of the attitudes and perceptions of their wider community in the context of preventing family violence and promoting healthy relationships. It is intended for use with large numbers of participants with no special knowledge or connection to CM efforts.

Developing the Aotearoa Community Mobilisation Questionnaire

The initial development of the ACMQ was informed by two comprehensive literature reviews, analysis of the literature and a practice example (see Chapter 6). In this chapter, the steps used to develop the ACMQ are detailed.

Literature reviews

In 2010, a literature review was completed to identify whether any tools to measure CM existed (Trewartha, 2010). In this review, no tools were identified that measured CM specifically, but one measurement tool was identified that met the criteria for inclusion and could be used to measure change in communities on a specific issue. The inclusion criteria were:

1. Comprehensiveness
    - Measures more than two dimensions of community functioning
2. Robustness
    - Theory-based
    - Measurement process clearly described
    - Valid and reliable
    - Well described tools and processes

3. Application and utility
    - Measures baseline and designed to use this data to inform planning and implementation of initiatives
    - Applied in a range of community settings and to various topics
    - Able to be utilised to measure CM on complex social issues

These criteria were used to identify tools that could assess the multifaceted nature of CM, noting that at that time the domains of CM had not yet been identified. The robustness, application and validity of existing tools were also assessed. The only specific CM tools that were identified were developed to measure a particular CM initiative, but could not be used beyond this context and therefore did not meet the criteria. From this analysis, one tool was identified that met the criteria and could be used to assess CM. The tool was the CR assessment (Plested et al., 2006). While the CR assessment was recommended for measurement of CM (Trewartha, 2010), it was not a specific CM assessment tool and the need for a specific CM tool remained.

Due to the dearth of specific literature on CM identified in the 2010 review, a second and more extensive literature review was completed in 2013 for this doctoral research. The second review searched beyond CM and investigated literature in eight related fields: community mobilisation; community participation; community engagement; community empowerment; community organising; community readiness; community involvement; and, community capacity. Some concepts, such as community participation, were relatively well-developed in the literature, meaning that the domains of the concept had been identified, defined and debated by numerous authors. This was not the case for the concept of CM, which meant that identifying and defining the domains of CM was a key step towards developing a measurement tool. The aim of the literature review was to identify:

1. Definitions of CM
2. Domains, or significant elements, of CM
3. Approaches, methods and tools to measure CM

The second literature review included literature published prior to November 2013. The databases utilised were EMBASE (1980–present), PsycINFO (1806–present), and PubMed (1946–present). The search terms used were: “community mobili*” OR “community participation” OR “community engagement” OR “community empowerment” OR “community

organi*" OR "community readiness" OR "community involvement" OR "community capacity". All searches were limited to results in titles only to ensure that the search term was a key focus of the article.

Inclusion criteria were developed to focus the literature review. To be included, articles had to meet one or more of the following criteria:

- Define CM
- Define domains, or significant elements, of the concepts used as search terms
- Include a measurement tool that could be applied to measuring CM
- Focus on general populations, rather than clinical populations
- Focus on assessing a complex issue (e.g. violence prevention or HIV prevention), rather than implementation of a discrete programme or activity (e.g. medication use)
- Available in full text English

The search identified 3,728 articles with the search terms in title (see Table 1). Of these, 523 articles met the criteria. The abstracts of all 523 articles were read to determine relevance, and those that met the inclusion criteria were kept (n=139).

Table 1: Results from literature search

Database	Search terms in title	Full text English available	Met inclusion criteria
EMBASE	1,459	193	16
PsycINFO	958	129	47
PubMed	1,311	201	76
Total	3,728	523	139

Identifying domains of community mobilisation

An analysis was completed of the relevant articles from the literature review to identify domains of CM. A domain was defined as a significant element of community functioning to make change, for example, leadership. In some articles, authors defined a domain, and in others, authors defined a domain and also presented the measurement scales they had developed to assess that domain. To be included, the domain had to be well defined. An example of this is:

> "Leadership: the extent to which appointed leaders and influential community members are supportive of the issue" (Plested et al., 2006, p. 7).

Articles were excluded from consideration if they defined domains that were only relevant to assessing one issue or one initiative. For example, the Community Readiness Survey (Beebe et al., 2001) was developed to measure attitudes to youth substance use and community readiness to support prevention efforts, but the domains were specific to evaluating the initiative the tool was developed to assess.

Twelve articles were identified that met one or more of the criteria specified (Butterfoss, 2006; Campbell & Cornish, 2010; Cheadle et al., 1998; Chilenski et al., 2007; Draper et al., 2010; Eng & Parker, 1994; Goeppinger & Baglioni, 1985; Goodman et al., 1998; Laverack, 2001; Lippman et al., 2013; Miao, Umemoto, Gonda, & Hishinuma, 2011; Plested et al., 2006). An analysis of these articles was conducted to identify domains that were named and defined. This analysis identified 69 defined domains. Of the domains identified, 42 included a scale or item that had been used to measure the domain.

Process of domain analysis

Once the domains were identified, my two supervisors and I completed a series of analyses. The purpose of the analyses was to identify the domains that were significant to CM. First, individually we familiarised ourselves with the 69 domains and definitions as specified by the original authors. Individually, we identified domains that were named by a number of authors, and were determined to be significant elements of CM. Then, we each sorted the domains into groups with similar definitions. Second, we met and discussed each domain, and again identified the domains that we considered to be significant elements of CM. Through this analysis, domains were discarded if they were perceived to be not relevant. For example, "social learning" (Miao et al., 2011) was discarded as we decided the definition of this domain was not clear enough to enable measurement. We then grouped domains together that had similar definitions, with the aim of reaching consensus about the domain groupings. For example, seven authors defined the domain of leadership and the definitions of this domain were similar enough to group these together under the label leadership. Discussion of the definitions of two other domains meant that they were also included in the group labelled leadership, as although the domain name was not clearly leadership focussed, the definition of these domains was related to or named leadership; these were women's involvement (Draper et al., 2010), and relational context" (Campbell & Cornish, 2010).

Through this process, seven domains were identified that each represented a significant element of CM. The domains were named: leadership; participation; critical thinking; resources; organisation; attitudes and beliefs; and, community knowledge. The domains, original domain names and the publishing authors are presented in Table 2.

Table 2: Domain, original domain name and author

Domain	Original domain name and author(s)
Leadership	Leadership (Chilenski et al., 2007; Draper et al., 2010; Goodman et al., 1998; Lippman et al., 2013; Plested et al., 2006) Develops local leadership (Laverack, 2001) Relational context (Campbell & Cornish, 2010) Women's involvement (Draper et al., 2010) Leadership and capacity building (Miao et al., 2011)
Participation	Participation (Butterfoss, 2006; Eng & Parker, 1994; Goeppinger & Baglioni, 1985) Citizen participation (Goodman et al., 1998) Initiative (Chilenski et al., 2007) Dialogue (Campbell & Cornish, 2010) Empowerment (Campbell & Cornish, 2010) Collective activities/actions (Lippman et al., 2013)
Critical thinking	Articulateness (Eng & Parker, 1994; Goeppinger & Baglioni, 1985) Conflict containment and accommodation (Goeppinger & Baglioni, 1985) Critical reflection (Goodman et al., 1998) Skills (Goodman et al., 1998) Increases problem assessment capabilities (Laverack, 2001) Enhances the ability of the community to ask why (Laverack, 2001) Critical consciousness (Lippman et al., 2013)
Resources	Resources (Goodman et al., 1998) Community efforts (Plested et al., 2006) Resources related to the issue (Plested et al., 2006) Strengthens links to other organisations and people (Laverack, 2001) Improves resource mobilisation (Laverack, 2001) Material context (Campbell & Cornish, 2010) Social capital (Campbell & Cornish, 2010) External support for programme development in terms of finance and programme design (Draper et al., 2010)
Organisation	Management of relations with the wider society (Eng & Parker, 1994; Goeppinger & Baglioni, 1985) Machinery for facilitating participant interaction and decision making (Eng & Parker, 1994; Goeppinger & Baglioni, 1985) Effective communication (Goeppinger & Baglioni, 1985) Conflict containment and accommodation (Eng & Parker, 1994) Social and interorganisational networks (Goodman et al., 1998) Creates and equitable role with outside agents (Laverack, 2001) Increase control over programme management (Laverack, 2001) Builds empowering organisational structures (Laverack, 2001) Monitoring and evaluation (Draper et al., 2010) Planning and management (Draper et al., 2010) Inclusivity (Miao et al., 2011) Organisational structures/networks (Lippman et al., 2013)

Domain	Original domain name and author(s)
Attitudes and beliefs	Commitment (Eng & Parker, 1994; Goeppinger & Baglioni, 1985) Self-other awareness and clarity of situational definitions (Eng & Parker, 1994; Goeppinger & Baglioni, 1985) Social support (Eng & Parker, 1994) Neighbourhood cooperation in solving problems (Cheadle et al., 1998) Sense of community (Goodman et al., 1998) Understanding of community history (Goodman et al., 1998) Community power (Goodman et al., 1998) Community values (Goodman et al., 1998) Sense of pride and identification with the neighbourhood (Chilenski et al., 2007) Efficacy (Chilenski et al., 2007) Attachment (Chilenski et al., 2007) Symbolic context (Campbell & Cornish, 2010) Social cohesion (Lippman et al., 2013)
Community knowledge	Community knowledge of efforts (Plested et al., 2006) Community knowledge about the issue (Plested et al., 2006) Community climate (Plested et al., 2006) Common vision (Miao et al., 2011) Shared concern (Lippman et al., 2013)

Comparison of the domains with a practice example

A comparison was completed of the domains identified in the literature review with a theory-based practice example of CM to identify whether there were any gaps in the academic literature compared to a comprehensively planned and evidence-informed practice example. The practice example was the Glen Innes CM initiative—the HEART Movement. Specifically, the comparison was with the outcomes included in the HEART Movement theory of change, or long-term plan. The HEART Movement and theory of change are described in Chapter 6. The theory of change outcomes were the key steps of change deemed to be necessary to mobilise a community to prevent family violence and promote healthy relationships by those working to develop the Glen Innes initiative. The comparison was undertaken to assess similarities and differences between domains and outcomes identified through these two approaches. The 17 outcomes from the theory of change were compared with the seven domain groupings identified from the literature. The comparison showed that six of the seven domains identified in the literature were represented in the outcomes of the theory of change, and only the domain of critical thinking was not. A domain related to critical thinking was identified eight times in the analysis of the literature: articulateness (Eng & Parker, 1994; Goeppinger & Baglioni, 1985); conflict containment and accommodation (Goeppinger & Baglioni, 1985); critical reflection, and skills (Goodman et al., 1998); increases problem assessment capabilities, and enhances the ability of the community to ask why (Laverack, 2001); and, critical

consciousness (Lippman et al., 2013). While critical analysis was not explicitly named in the theory of change, it was thought to be embedded in the outcomes of belief in a better way and the benefits of change and intolerance of unhealthy relationships. We therefore concluded that critical analysis was a significant element of CM.

Existing measurement approaches

In the 2013 literature review, seven measurement tools were identified from the search results. The approaches used by the developers of these measurement tools for administration and analysis are outlined in Table 3.

Table 3: Measures identified in the literature review

Author (Date) Concept measured	Method	Response type
Goeppinger and Baglioni (1985) Community competence	Telephone interview	Likert scale items
Eng and Parker (1994) Community competence	Key informant interviews	Likert scale items, open-ended questions with pre-coded answers, and true open-ended questions
Cheadle et al. (1998) CM	Key community informant telephone surveys Parent telephone surveys Youth self-administered survey Staff interviews	Closed- and open-ended questions
Laverack (2001) Community empowerment	Consensus decision using descriptive statements	Continuum
Chilenski et al. (2007) CR	Key stakeholder interviews	Likert scale items and pre-coded items
Oetting et al. (1995); Plested et al. (2006) CR	Key informant interviews scored using anchored rating scale	Closed- and open-ended questions
Draper et al. (2010) Community participation	Literature-based retrospective evaluation of case studies	Continuum

Five of the authors reported attempts to validate their tools ranging from simple "face validity" through to construct validation. Goeppinger and Baglioni (1985) developed a tool to measure community competence. They used multiple one-way analysis of variance and factor analysis,

and found that the tool partially measured six of the eight dimensions of community competence. They stated that lack of clear definitions was problematic for measurement, acknowledged that the tool was in the early stages of development, and that further work was needed to address these issues. Eng and Parker (1994) built on Goeppinger and Baglioni's measure of community competence and made some changes to the definitions of the eight dimensions of community competence. Eng and Parker (1994) used Cronbach's alpha to measure internal consistency of eight dimensions. Alpha scores ranged from 0.58 to 0.81. The authors reported that they were not able to make conclusions about construct validity due to the small number of key informants; nor were they willing to calculate an overall score for community competence as they were unable to ascertain if the domains of competence were of equal weighting due to the lack of empirical and theoretical evidence. Eng and Parker (1994) also stated that they had designed a tool to meet the needs of the communities they were assessing and warned against using it as a standardised tool.

Cheadle et al. (1998) developed a tool to assess CM around youth issues. The tool used a key community informant survey, a youth survey, a parent survey and staff interviews. The interclass correlation coefficient showed very low interrater reliability with only one item scoring above 0.1. The results of the analysis were weak, with only one aspect of the surveys (neighbourhood cooperation), showing a significant Pearson correlation.

Chilenski et al. (2007) developed a tool to measure CR to prevent youth drug use. Key community stakeholder interviews were completed. The authors used structural equation modelling to assess construct validity and reported that initial construct validity was established. A significant intraclass correlation coefficient was reported for three of the four scales used ($p<0.05$ for the initiative, effectiveness and readiness scales; $p<0.10$ for the attachment scale).

The CR assessment was developed by Oetting et al. (1995) to measure CR to address an issue and was later developed into a user manual by Plested et al. (2006). The tool used semi-structured interviews with key informants that were scored using anchored rating scales. Plested et al. (2006) reported face validity, interrater reliability (92%), and construct validity, which they said was demonstrated through a process of theory testing throughout development of the tool. However, the CR assessment has been criticised by Beebe et al.

(2001) for not using accepted psychometric principles in the development or evaluation of the tool.

Laverack (2001) developed the domains approach to measure community empowerment. This tool used group discussion to place communities on a continuum of community empowerment across nine domains. Laverack (2001) did not use any form of psychometric testing, but reported face validity. The analysis of this tool is weak, and the only available examples of use are by Laverack. This was the only tool identified that used group participation rather than individual participants.

Draper et al. (2010) developed a tool to measure community participation, building on Rifkin's earlier work (1988). Draper's tool assessed five domains of participation. Use of the tool was demonstrated through a retrospective case study analysis based on secondary evidence. No analysis of the tool was reported.

Analysis of the seven identified measurement tools showed that while the authors of five of the tools each made an attempt to validate their tool, the testing was not comprehensive. Therefore, it was not possible to make definitive conclusions about the ability of the tools to measure these concepts and there was no comprehensive measure of CM. The need for a new tool to measure CM remained.

Utilising existing items

Further analysis of the seven identified measurement tools was completed to determine if any scales contained within the tools were suitable for use in a new tool to measure CM. In total, 40 scales were identified and criteria were developed to assess whether or not these scales should be included in the ACMQ. Scales were discarded if:

- Reliability and validity were unclear
- Cronbach's alpha was lower than 0.70
- The focus was on assessing implementation or management of an initiative
- The focus was on knowledge held by organisations rather than community members
- They were not relevant to the purpose of measuring CM

After completing an analysis using these criteria, only three scales were retained that were relevant to the purpose of developing the ACMQ. These scales were Eng and Parker's (1994)

Conflict Containment and Accommodation and Commitment scales and Chilenski's (2007) Leadership scale (see Table 3). To enable measurement of all seven domains of CM it was necessary to develop new scale items.

In summary, a comprehensive literature review was completed to identify the domains of CM and measurement tools to assess CM. Seven domains of CM were established and compared with a evidence-informed practice example. Seven existing measurement tools were identified; however, none of the existing measurement tools were comprehensive measures of CM and it was necessary to develop a new tool to measure CM on a specific issue. The identified existing measurement tools helped to inform the development of the ACMQ, including adoption of the concept of domains and the utilisation of the dominant method of measurement—a questionnaire containing Likert scale type items. Only three existing scales were identified that were able to be used in the ACMQ, meaning it was necessary to develop new items to measure all seven domains of CM.

Formulation of the Aotearoa Community Mobilisation Questionnaire

The identified domains of CM formed the base of the ACMQ. It was then necessary to develop a scale to assess each domain. Chilenski's Leadership scale was included in the leadership domain scale. Eng and Parker's Conflict Containment and Accommodation scale was included in the organisation scale and their commitment scale was included in the attitudes and beliefs scale. It was necessary to develop new items to assess all domains of CM and to make the domain items specific to the prevention of family violence and promotion of healthy relationships. My supervisors and I developed items through discussion of the domains and the outcomes from the HEART Movement theory of change (see Table 4). We discussed what activities, attitudes or behaviours related to each domain and outcome of the theory of change and developed an item to assess this. For example, for the theory of change outcome healthy relationships visible, the item 'I see people in healthy relationships' was developed. Many questions stemmed from wording such as 'In my community….' or 'In [community name]…' to ensure participants would think about the place they lived when they responded.

Table 4: ACMQ domains, theory of change outcomes and existing scales

Domain	Theory of change outcome and existing scale
Leadership	Effective active leadership
	Leadership (Chilenski et al., 2007)*
Participation	Healthy relationships visible
	Ownership of the issue and action
	Diverse community engagement
	Accessible information, effectively communicated
Critical thinking	No theory of change outcome
Organisation	Skilled practitioners
	Strong collaboration
	Coordinated community response
	Organisational change and development
	Conflict containment and accommodation (Eng & Parker, 1994)*
Resources	Resources related to the issue
	Comprehensive community efforts
Attitudes and beliefs	Belief in a better way and the benefits of change
	Intolerance of unhealthy relationships
	Increased personal relevance
	Positive and receptive community climate
	Commitment (Eng & Parker, 1994)*
Community knowledge	Community knowledge of efforts
	Healthy relationship knowledge

*= Existing scales

When item development was completed, the two Eng and Parker sub-scales were discarded as they did not specifically measure the domains of organisation or attitudes and beliefs. The Chilenski et al. Leadership scale was the only scale included from the literature (see Table 4) in the pilot questionnaire.

Final domains and items to pilot

When developing the items for the ACMQ, it was clear that there was duplication of domains that we had developed, and the domains needed to be rationalised. The resources and organisation domains were judged to be very similar, and these domains were collapsed into an organisation domain. This change acknowledged that the survey participants were community members rather than organisational managers and practitioners, and it was unlikely they would know about the resourcing and implementation of community initiatives. Also, the community knowledge domain seemed unnecessary as items from other domains covered this area. The domains were reduced at this point rather than after piloting, as the

overlaps were too obvious to ignore. As a result of this process, the seven domains were reduced to five. The five domains were leadership; participation; organisation; critical thinking; and, attitudes and beliefs.

Aotearoa Community Mobilisation Questionnaire piloting process

Preliminary pilot study

To conduct a preliminary pilot of the ACMQ, I used convenience sampling and approached friends, family and colleagues and invited them to participate. As a result, 39 people completed the ACMQ preliminary pilot. People living in the case study communities were not eligible to participate as they were potential participants in the study proper. Participants were asked the community, or suburb, where they lived. Participants were asked to complete the questionnaire thinking about the community they lived in and to circle the one response that best described what they felt about each statement. For the preliminary pilot items and ACMQ questionnaire see Appendices 1 and 2.

Of the 39 participants who completed the pilot questionnaire, 84% of participants were female, and 16% were male. The ethnicity of participants was predominantly Pākehā (64%), then Māori (20%), Pacific (5%), Asian (5%), or Other (5%). Participants ranged in age from 18 to 78 years. Eleven participants were aged under 30 (18–29 years). Ten participants were aged under 40 years, nine under 50 years, and eight participants were aged over 50 years (50– 78 years). Time taken to complete the questionnaire ranged from 4 minutes to 30 minutes with the majority (59%) taking between 5 and 10 minutes.

Psychometric analysis (preliminary pilot data)

A principal components analysis (PCA) was completed on the preliminary pilot data using SPSS (IBM Corporation, 2010), followed by a confirmatory factor analysis using STATA (StataCorp., 2011) to test the reliability and construct validity of the questionnaire. The data was manually coded, entered into an SPSS data file and cleaned.

PCA summarises the relationships between variables into clusters, or principal components, that are combinations of the original variables (Pett, Lackey, & Sullivan, 2003). It is a variable reduction technique (Dunteman, 1989) that is used to identify linear components in the data, and how variables relate to components (Field, 2005).

PCA is best suited for continuous data (Kolenikov & Angeles, 2004); however, it can be and is often used with ordinal data provided the data meets the assumptions of PCA. The assumptions of PCA are:

1. Multiple variables, preferably continuous variables but can use ordinal
2. Linear relationship between all variables
3. No outliers
4. Large sample size (150 cases or 5–10 per variable) (Leard Statistics, 2015)

The data met the first assumption for multiple ordinal variables measured using a 5-point Likert type scale. The data met the second assumption for linearity as the correlation matrix showed all variables had a correlation of $r \geq 0.3$. There were no outliers in the data, meeting assumption three. The pilot data did not meet the fourth assumption of a large sample size (n=39); however, it was expected that the sample size in the study proper would meet this assumption.

An iterative PCA was completed in SPSS. The questionnaire scales were developed on the basis that there were five domains of CM, and while no a priori number of factors was set, it was anticipated that five factors would be identified. An initial unrotated factor analysis of 48 items was completed and Kaiser's criteria components with eigenvalues greater than one were retained (Dunteman, 1989). The scree plot (see Figure 2) of eigenvalues indicated a five-component solution, with the elbow of the scree plot curve at five components.

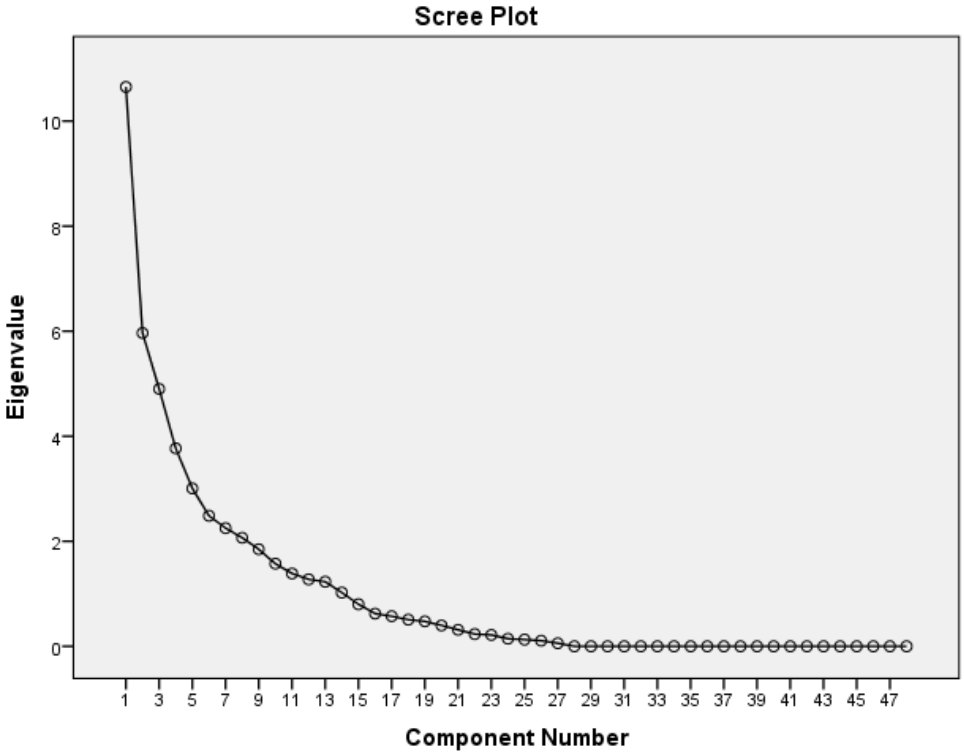

Figure 2: Scree plot of eigenvalues from pilot data

PCA with varimax rotation was used to enhance item factor loadings. Items with a factor loading higher than 0.4 on only one factor were considered to represent a component. Internal consistency of the components was assessed using Cronbach's alpha. Two factors included items related to information and services. Two factors included items related to attitudes. The fifth factor included items related to leadership.

A confirmatory factor analysis was then completed. This involves testing specific hypotheses about the underlying factor analysis model with respect to both the number of factors and the pattern of loadings on each factor (Dunteman, 1989). The STATA structural modelling package was used to confirm the component structure resulting from the PCA. Twenty-three items were removed to improve model fit, or to improve internal consistency of the scales. Twenty-five items remained.

After the removal of items, a four-factor solution was identified through structural equation modelling (see Table 5). The original two factors related to information and leadership combined to form one factor. The second factor included items related to leadership. The third factor included items related to attitudes, and the fourth factor to personal relevance. There was one latent variable with paths between leadership, information and services factors. There

was no apparent correlation between the factors representing personal relevance and attitudes.

Table 5: Eigenvalues, Cronbach's alpha and means of factor of ACMQ

Factor	Items in scale	Eigenvalues	Cronbach's α	M (SD)
Information and services	12	6.97	.92	33.14 (12.68)
Leadership	5	3.93	.82	12.72 (4.89)
Attitudes	4	2.60	.80	17.67 (2.57)
Personal relevance	4	2.44	.77	15.87 (3.15)

The Cronbach's alpha for item scales in a developing questionnaire should ideally exceed 0.70 (Rattray & Jones, 2007). The ACMQ preliminary pilot factors all exceeded 0.70. However, the internal consistency of the domain scales varied (see Table 6). All scales had acceptable internal consistency of 0.70 or above except for critical thinking.

Table 6: Internal consistency of preliminary pilot ACMQ scales

Preliminary pilot scales (number of items)	Cronbach's α
Leadership (7)	0.782
Participation (15)	0.836
Critical thinking (4)	0.500
Organisation (10)	0.855
Attitudes and beliefs (11)	0.690

Model fit was assessed using the following criteria:

- Chi square ($\chi 2$) < 0.05
- Standardised root mean square residual (SRMR) below .08
- Comparative Fit Index (CFI) of .90 or larger
- Tucker-Lewis Index above .90

Using these criteria, the preliminary pilot ACMQ lacked model of fit (see Table 7). This was likely due to the small sample size for the preliminary pilot study.

Table 7: STATA analysis of competing models for CM scales

Factors	$\chi 2$	df	SRMR	CFI	TFI
4 correlated factors	511.29	265	0.170	0.603	0.550
4 correlated factors, 1 higher order factor	506.50	263	0.152	0.607	0.552

The preliminary pilot study provided initial validation of the component structure for CM. The results indicated a four-component structure, with one latent variable. Each factor showed moderate to high internal consistency. The analysis of the ACMQ showed that further work was required to validate the tool.

Following the preliminary pilot analysis, 23 items were removed to improve model fit. However, of these 23 items, five items were replaced for the community pilot study. Of the items that were replaced, two items measured the participation domain, two items measured critical analysis, and one item measured the attitudes and beliefs domain. These items were replaced because few items remained in these scales to measure these domains, and to also test if the items performed better with a larger sample size. The ACMQ preliminary pilot study provided initial validation of the component structure for CM, with results indicating a four-component structure with moderate to high internal consistency for 25 items, and one latent variable.

Community pilot study

Following the preliminary pilot a community pilot study was completed. The ACMQ was piloted in Glen Innes and Ranui, between October and December 2014. In total, 188 participants across both communities completed the ACMQ community pilot in 2014. On completion of the community pilot, the psychometric properties of the ACMQ were reassessed using the same process used to analyse the preliminary pilot data. For the community pilot questionnaire see Appendix 3.

A PCA was completed using SPSS (IBM Corporation, 2010) to explore the number of components in the ACMQ. The criteria used to identify a component was an eigenvalue over one and factor loadings of over 0.4 on one factor only. Cronbach's alpha was used to assess internal consistency of the scales. An initial unrotated PCA of 25 items was completed. The number of components was unclear, as five components had eigenvalues over one and the scree plot of eigenvalues showed an elbow at between three and four components (see Figure 3).

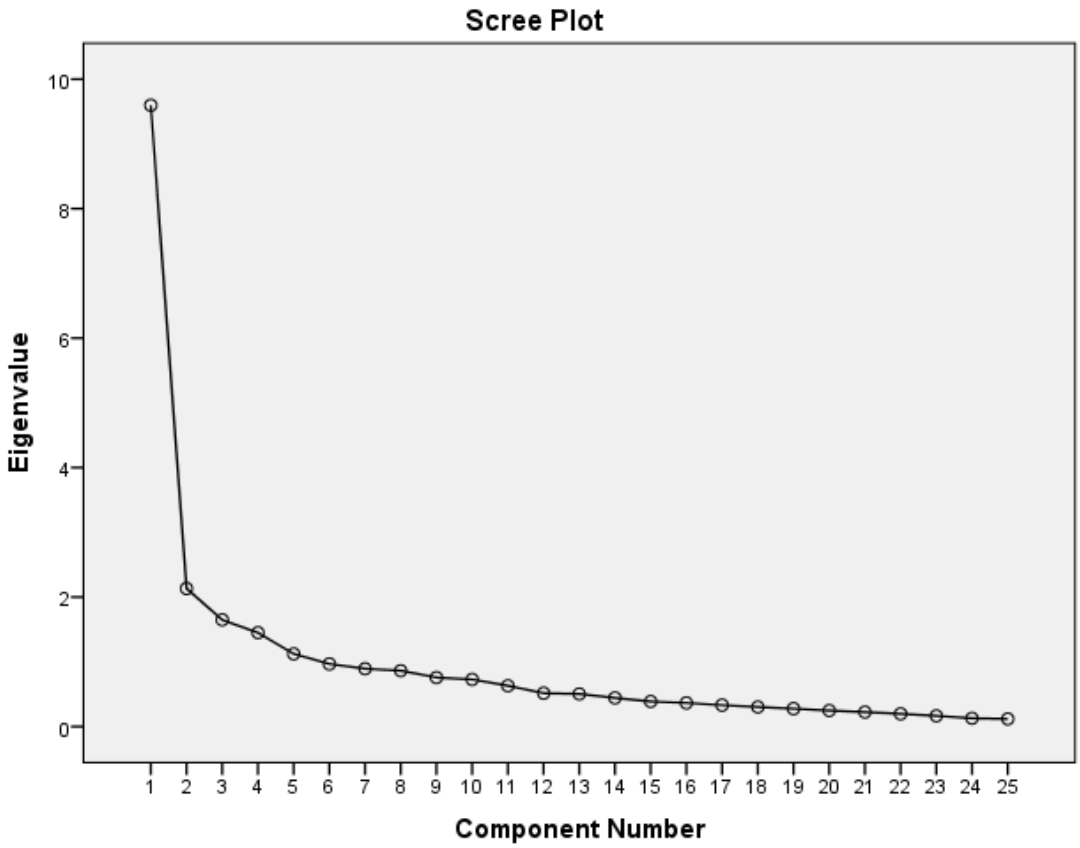

Figure 3: Scree plot of eigenvalues

A constrained four-factor solution with varimax rotation and Kaiser normalisation was used to enhance item factor loadings; however, item factor loadings were still unclear. The rotated component matrix showed that seven items had factor loadings over 0.4 on two items.

A constrained three-factor solution with varimax rotation was used to reduce factor loadings on more than one item. This increased factor loadings on most items and reduced the number of items with factor loadings over 0.4 on two items to just three items. Two items did not load on any factor over 0.4. The first factor identified contained items related to leadership, services and information. The second factor contained items related to leadership, knowing and seeing people in healthy relationships, family violence services, and doing something to prevent family violence. The third factor contained items related to attitudes to healthy relationships.

The internal consistency of each scale in the three-factor solution was assessed using Cronbach's alpha. The first factor leadership, information and services, had a high alpha (α=.937). The second component contained four items about healthy relationships and one item about family violence had a marginal alpha (α=.694). The third component containing three items related to attitudes to healthy relationships had a low alpha (α=.600).

Table 8: Eigenvalues, Cronbach's alpha and means of factor of ACMQ

Factor	Items in scale	Eigenvalue	Cronbach's α	M (SD)
Leadership, information and services	15	9.598	.937	35.55(14.89)
Healthy relationships and family violence	5	2.133	.694	13.62(3.96)
Attitudes to healthy relationships	3	1.649	.600	10.32(1.79)

The possibility of a two-factor solution was explored. A constrained two-factor solution with varimax rotation was completed. This solution provided two clear factors, with no items loading on more than one factor. Three items did not load on any factor above 0.4 and two of these items had not loaded on any factor in the three-component solution. The first factor represented items related to leadership, information and services. The second represented items related to personal relevance. The Pearson's correlation showed no correlation between the two factors. Internal consistency was again high for the first factor leadership, information and services (α= 0.940). However, the second factor personal relevance had low alpha of 0.612 (see Table 9). Cronbach's alpha is related to the number of items in a scale as well as the internal consistency of those items. Scales with fewer items are expected to have lower alpha scores.

Table 9: Eigenvalues, Cronbach's alpha and means of factors of ACMQ

Factor	Items in scale	Eigenvalue	Cronbach's α	M (SD)
Leadership, information and services	17	9.598	.940	40.85(16.43)
Personal relevance	5	2.133	.612	16.05(3.00)

At this point, the solution was between two and three components. The components were not stable between the preliminary pilot study and community pilot study.

The Community Mobilization Measure

When the development of the ACMQ began there were no published tools available to measure CM, apart from tools designed to measure a specific initiative. In May 2016 ,the first known CM measurement tool that could be used to assess any CM initiative, the CMM, was published by Lippman et al. (2016). This section introduces the CMM, and the following sections compare the CMM and ACMQ and describe how the CMM was used to improve the ACMQ.

Process of developing the Community Mobilization Measure

Lippman et al. (2016) observed that CM was increasingly being used to address complex health and social issues, but that the effectiveness of these efforts was limited by the lack of available and appropriate measurement and evaluation tools. Lippman et al. (2016) sought to address this by developing a measurement tool. They believed that developing measures of CM would help to improve the definition, implementation and measurement of CM work.

To develop a tool to measure CM, Lippman et al. (2013) reviewed academic and applied literature from the fields of social movements, community capacity, empowerment and development to identify the key domains of CM. Through this analysis, they identified six domains of CM: shared concern; critical consciousness; organisational structure/networks; leadership; collective action; and, social cohesion.

Table 10: CMM domain definitions (Lippman et al., 2016, p. 128)

Domain name	Definition
Shared concern	A shared concern or community issue that may address power imbalances, improve access to resources and services, or promote social inclusion (Buechler, 1995; Edelman, 2001; Minkler & Wallerstein, 2002; Tilly, 2004).
Critical consciousness	Critical consciousness addresses the requirement that the shared concern be built from collective sensitization processes (Freire, 1970) which lies at the heart of the community empowerment literature (Laverack & Wallerstein, 2001; Minkler & Wallerstein, 2002) and the concept of the learning culture (Norton et al., 2002) from community capacity. The critical consciousness domain is also akin to social movement theory's cognitive liberation and collective framing process (McAdam, 1999).
Organizational structures and networks	Organizational structures and networks or vehicles "through which people mobilize and engage in collective action" (McAdam, 1999) serve as basic structures to promote dialogue, disseminate messages, and build collective actions (Norton et al., 2002). Organizations build bridging social capital and inter-organizational linkages that connect communities and groups to more diverse networks and resources (Goodman et al., 1998; Putnam, 2000).
Leadership	Leadership, whether it be individual, institutional, or a coalition of activists, is at the centre of community change programs across disciplines (Laverack & Wallerstein, 2001; Norton et al., 2002).
Collective actions	Collective actions (Tilly, 2004) is a critical component to all reviewed literature and is primarily the domain associated with public participation in mobilization (Fawcett et al., 1995).
Social cohesion	Social cohesion represents the idea that there is a glue that holds people together, which is akin to the need for collective identity (Diani & Bison, 2004) and shared trust (Sampson, 2003; Sampson, Raudenbush, & Earls, 1997) or as a sense of community (McMillan & Chavis, 1986; Norton et al., 2002).

While the literature was an important resource used to identify the domains of CM, Lippman et al. (2013) acknowledged that the literature and therefore the domains were informed by European thinking, and that for their purposes, the measurement tool would be used to assess

CM in an African context. To understand if the domains were appropriate to the South African rural village context, Lippman et al. (2013) conducted qualitative research consisting of in-depth key informant interviews with a gender and age diverse range of community leaders and organisational representatives, and focus group discussions with village residents. They found that the six domains were a useful tool to conceptualise CM (Lippman et al., 2013), and that the domains were applicable to the study context. Only the domain of organisational structure and networks needed to be adapted significantly following the qualitative research, as the mobilising function that often carried out by formal organisations and organisational networks in a European context, was fulfilled by informal family networks in the rural South African context.

The measure

The CMM assessed seven domains of CM. Six domains were identified in the literature by Lippman et al. (2013), and a seventh domain of social control was added to explore its relatedness to CM. The CMM is a 65-item questionnaire completed by individuals, administered using computer-assisted personal interviews and supported by a researcher. Individual responses are aggregated to produce a community mean score across the seven domains. The CMM scales are: shared concern; critical consciousness; leadership; collective action; social cohesion; organisations and networks; and, social control. The CMM measures how mobilised a community or village is generally, and includes one issue specific scale, shared concern, which asks about perceptions of HIV amongst village members.

Psychometric properties of the Community Mobilization Measure

Lippman et al. (2016) completed comprehensive statistical analysis of the CMM tool. They used item response modelling, exploratory factor analysis, and confirmatory factor analysis to analyse the domains of the CMM. Goodness of fit was assessed using Hu and Bentler's (1999) criteria, where two out of the three criteria must be met:

- Comparative fit index (CFI) ≥ to 0.95
- Root mean square error of approximation (RMSEA) ≤ to 0.06
- Weighted root mean square residual (WRMR) ≤ to 1.00

Lippman et al. (2016) reported mild to moderate factor intercorrelations. The strongest correlation was between the factors of leadership and critical consciousness (CFA r=0.67, IRM r=0.70). The correlations between the six domains identified in the literature showed linked concepts related to CM. The domain of social control was the least correlated scale. This was predicted by Lippman et al. (2016), as social control was not identified in the literature review as a domain of CM but was included to investigate its relatedness.

The analysis showed that a seven-dimensional model was the best fit for the data. Analysis rejected exact fit, but showed that the proposed seven-dimensional model did fit the data well on an approximate basis (CFI=0.97, RMSEA=0.01, WRMR=1.46) (Lippman et al., 2016). Internal consistency of the factors was assessed using Raykov's p. Lippman et al. (2016) reported high internal consistency with p values between 0.81 and 0.93 (see Table 11).

Table 11: Internal consistency reliability of the CMM

CMM scale	Raykov's p
Leadership	0.92
Collective action	0.84
Critical consciousness	0.93
Organisation and networks	0.81
Shared concerns	0.85
Social cohesion	0.81
Social control	0.89

The analysis showed evidence of construct validity, although Lippman et al. (2016) stated that further evidence from larger and heterogeneous samples was required to establish validity and reliability.

Comparing the Aotearoa Community Mobilisation Questionnaire and the Community Mobilization Measure

The ACMQ and the CMM (Lippman et al., 2016) tools were developed for different purposes contexts. This section compares the two tools across context, domains and scales, scope, statistical analysis, and theoretical underpinnings.

The ACMQ and CMM were both developed using modern European literature, but for use in very different contexts. The CMM was developed by Lippman et al. (2013; 2016) for use in rural South Africa. The study setting was Agincourt, a sub-district of Bushbuckridge, 500km north-west of Johannesburg near the border of Mozambique, with a population of

approximately 90,000. Within Agincourt, 27 neighbouring villages defined by post-apartheid settlements, were part of a health and sociodemographic surveillance site. The area had a high prevalence of HIV infection (over 45% for 35–39 year olds), and a CM intervention was operating to reduce rates of HIV in young women. The villages were homogeneous and had centralised decision making structures. Lippman et al. (2013) completed qualitative research with people from the villages to ensure that the domains identified in the literature were relevant to the context the CMM was developed for.

The ACMQ was developed for the Aotearoa New Zealand context and for use in urban geographic communities. In the New Zealand urban context, geographic communities are heterogeneous and comprise of many sub-communities. Within each community, people use different approaches, structures and systems to address different community issues. These efforts may be connected, but may also run in parallel with little or no interaction between the people and strategies used to address different issues, and sometimes even the same issue. Non-government organisations, local government and government organisations are often active within local community settings, particularly in communities with low socioeconomic status.

The ACMQ and CMM both used literature to inform the development of domains of CM. The CMM drew from academic and practice literature, and tested these concepts within the study community, whereas the ACMQ used academic literature and a practice example to inform domain development. However, from these different approaches to development, there are a number of similarities between the domains identified and the scales developed to measure the domains (see Table 12).

Table 12: The domains of the ACMQ and CMM

Measurement tool	Domains of CM									
	Leadership	Participation	Collective action	Critical thinking/ Critical consciousness	Organisation and networks	Organisation	Attitudes and beliefs	Shared concern	Social cohesion	Social control
CM questionnaire	✓	✓	✗	✓	✗	✓	✓	✗	✗	✗
CMM	✓	✗	✓	✓	✓	✗	✗	✓	✓	✓

Both measurement tools include the leadership domain. The critical thinking (ACMQ) and critical consciousness (CMM) domains have a similar focus on critical thinking and reflection. While the domain names for attitudes and beliefs (ACMQ) and shared concern (CMM) differ, they also share a similar focus on the importance of the issue to the community. There were differences in the way that some seemingly similar domain scales were conceptualised. The participation (ACMQ) domain and the collective action (CMM) domain of has a different focus. Participation (ACMQ) is focussed on community awareness of activity and information available in the community and personal action. Collective action (CMM) is focussed on participation in community meetings and also working to address community problems. The organisation (ACMQ) and organisational structure and networks (CMM) domains also have a different focus. For the ACMQ, the focus of the organisation domain is on perceptions of services in the community, whereas the CMM organisation and networks domain is on the perceived importance of various type of organisations in the village. The CMM also included the social cohesion and social control domains which do not have equivalent domains in the ACMQ.

The different purposes and contexts of the ACMQ and CMM determined the focus of tools on either measurement of CM generally or CM on a specific issue. The CMM measures CM generally, with one issue specific scale on HIV prevention. In the rural South African village context, it may be that CM is transferable across village issues because of centralised decision making structures, in which case, this focus seems appropriate. In contrast, the ACMQ is an issue specific measure of CM on family violence and healthy relationships. This was the focus of this study and was seen to be appropriate for measurement of issues in heterogenous communities with multiple decision making structures. Also, Lippman et al. (2016) noted that

communities are likely to mobilise in response to a specific issue, which supports the focus on the ACMQ on a specific issue.

A comparison of the statistical analysis of the two tools showed that the CMM was more stable and had higher internal consistency than the ACMQ. The CMM reported a seven-factor model that was stable between the pilot and main study, whereas the components of the ACMQ were not stable between the preliminary pilot and the community pilot. The CMM also reported high internal consistency across all scales. The ACMQ had high internal consistency on three scales, but low scores for two scales (critical thinking α = 0.608; attitudes and beliefs α = 0.474). The CMM scales also included more items than the ACMQ scales which generally improves internal consistency scores (see Table 13). Cronbach's alpha was used to assess internal consistency reliability of the ACMQ, whereas the CMM used Raykov's p. Cronbach's alpha can give a high estimate of reliability (Trochim, 2001) and is the most widely used measure (Trizano-Hermosilla & Alvarado, 2016). The authors of the CMM stated that they used Raykov's p to assess reliability because it "relaxes alpha's often-unrealistic assumption of equal factor loadings" (Lippman et al., 2016, p. 130).

Table 13: Comparison of internal consistency of ACMQ and CMM scales

ACMQ scale (number of items)	Cronbach's α	CMM scales (number of items)	Raykov's p
Leadership (5)	0.829	Leadership (14)	0.92
Participation (12)	0.894	Collective action (6)	0.84
Critical thinking (4)	0.608	Critical consciousness (11)	0.93
Organisation (5)	0.824	Organisation and networks (10)	0.81
Attitudes and beliefs (3)	0.474	Shared concerns (10)	0.85
		Social cohesion (6)	0.81
		Social control (8)	0.89

Finally, the ACMQ and CMM tools had different but related theoretical underpinnings. Lippman et al. (2013) used social movement theory, community empowerment, CD and capacity building literatures (academic and grey literature) to conceptualise six domains of CM. The ACMQ was developed using academic literature from the fields of CM; community participation; community engagement; community empowerment; community organising; CR; community involvement; and, community capacity. The ACMQ also included theoretical underpinnings of change and readiness through integration of the HEART Movement theory of change.

Improving the Aotearoa Community Mobilisation Questionnaire

The analysis of the ACMQ preliminary pilot and community pilot showed that the components of the tool were not stable over assessments, and that two components had low internal consistency scores. The publication of the CMM (Lippman et al., 2016) presented the opportunity to compare the two measurement tools. This comparison led to a decision to use the CMM to improve the ACMQ by replacing two scales with low internal consistency and to include the social cohesion scale (see Table 13). In this section, the changes that were made to improve the ACMQ are described.

Analysis of the CMM scales showed that the scales and items could be adapted and used to replace the weak ACMQ scales. The ACMQ critical thinking scale (α= 0.608) was replaced with the CMM critical consciousness scale (p=0.93). The items in the CMM critical consciousness scale were included as they were, apart from two items which were adapted to be specific to the issue of family violence. The ACMQ attitudes and beliefs scale (α=0.474) was replaced with the CMM shared concern scale (p=0.85). Shared concern is an issue specific scale, so the CMM focus on HIV prevention was replaced with family violence prevention and healthy relationship promotion in the ACMQ. The shared concern scale was included twice to ask respondents about both topics. The CMM scales that were adapted for use in the ACMQ did not require much change to make them appropriate for the context. The CMM use of the words “your village” were replaced with “your community” for the Aotearoa New Zealand context. Inclusion of the CMM scales was intended to improve assessment of the ACMQ domains, without compromising the theoretical underpinnings of the ACMQ. The CMM social cohesion scale was included as a new domain and scale within the ACMQ, as it was seen to add to understanding and assessment of CM as conceptualised by Lippman et al. (2016), who stated that social cohesion may be a vital element in communities mobilising to address an issue. The ACMQ leadership, participation and organisation scales all had high internal consistency and were retained unchanged. The CMM leadership, collective action, organizations and networks, and social control scales were not seen to contribute to improved assessment of the CM domains identified for the ACMQ as they were not relevant to the context, or to assessment of a specific issue. The social control scale was not identified by Lippman et al. (2013) as a domain of CM; however, they included it to investigate the link with social cohesion but found none. For this reason, social control was not included in the revised ACMQ.

The format of the ACMQ was changed for the final questionnaire with the intention of making it more user friendly. In the first version of the ACMQ, scale items were separated and mixed throughout the questionnaire. In the revised version, whole scales were presented together with a short description of what was being asked in the scale. The response scale was also changed in the revised ACMQ. The Likert type scale (Strongly agree; Agree; Disagree; Strongly disagree; Don't know) was replaced with the response scale used by Lippman et al. (2016) (Agree a lot; Somewhat agree; Do not agree at all) to simplify the response categories.

The revised ACMQ was piloted with 15 doctoral students. The mean time to complete the questionnaire was 10 minutes. No wording changes were made to the items following the pilot. However, feedback from the pilot was used to improve formatting and the clarity of instructions. Ten participants said that they wanted a "Don't know" response option as they were not able to answer the questions in the organisation and participation scales as they did not know about services, information or activity in their local communities. A "Don't know" response can be problematic for scoring, because the researcher cannot know if this means that participants do not have the information to answer the question or if they are unsure about how much they agree or disagree with the item. To resolve this issue, a gating question was added before these two scales. The gating question asked participants if they were aware of services (organisation scale) or activity (participation scale) in their local communities with a Yes/No response option. If participants responded with "Yes", they were asked to complete the associated scale. If the responded "No", they were asked to move on to the next section.

The final Aotearoa Community Mobilisation Questionnaire

The final ACMQ measured six domains of CM, namely, leadership; participation; organisation; critical consciousness; shared concern; and, social cohesion. The ACMQ comprises of seven scales, as the shared concern scale was included twice to measure concern about both family violence and healthy relationships. The ACMQ had 63 items in total including three demographic questions and two gating questions (see Appendix 4 for the full questionnaire). The domain scales, purpose of the scale, and source of the scale and items is presented in Table 14. The purpose of the scales included from Lippman et al. are summarised from the original (Lippman et al., 2016, p. 129). For the final scale items see Appendix 5.

Table 14: Final ACMQ scales, purpose and scale/item source

Domain scale (number of items)	Purpose	Scale/item source
Leadership (5)	To assess perceptions of community leadership and leadership around family violence and healthy relationships.	Developed for this study and includes two items from Chilenski (2007) originally from Feinberg et al. (2004)
Participation (12)	To assess community awareness of activity and information available in the community to address family violence and promote healthy relationships, visibility of healthy relationships and personal action to prevent family violence.	Developed for this study
Organisation (5)	To assess perceptions of services in the community working to address family violence and promote healthy relationships.	Developed for this study
Critical consciousness (11)	To assess consciousness and critical thinking and whether critical reflection and dialogue processes are used to understand the problem and solutions.	Adapted from Lippman et al. (2016)
Shared concern (2 scales – 19 in total)	To assess whether community members define family violence and healthy relationships as important issues, whether they discuss these issues and if they believe they can do something to change these issues. NB: Scale included twice.	Adapted from Lippman et al. (2016)
Social cohesion (6 items)	To assess community connectedness and working trust.	Lippman et al. (2016) adapted from Sampson, Raudenbush, & Earls (1997)

Analysis of the final Aotearoa Community Mobilisation Questionnaire

The ACMQ was used to assess CM in the two case study communities from October to December 2016. One hundred and ninety participants completed the questionnaire. Due to changes made to the ACMQ, further analysis of the tool was completed which is reported in the following sections.

The final analysis was performed using the R packages psych and polcor (R Core Team, 2017) which provide a more robust PCA than SPSS as they can use a polychoric correlation to inform the PCA, rather than Pearson's r. Polychoric correlation is a maximum likelihood estimate (Kolenikov & Angeles, 2004) that is well suited to analysis of ordinal data generated by Likert scales as it is used to understand the continuum underlying ordinal variables. This addresses the criticisms of the use of PCA with ordinal data, as it does not assume that the variables are continuous (Kolenikov & Angeles, 2004).

A PCA of 58 scale items was completed. Demographic and gating questions were excluded from the analysis. The same criteria as earlier analyses were used to identify components, including eigenvalues over one and factor loadings of over 0.4 on only one component. Cronbach's alpha was used to assess internal consistency of the scales. The scree plot of eigenvalues showed an elbow at eight components (see Figure 4).

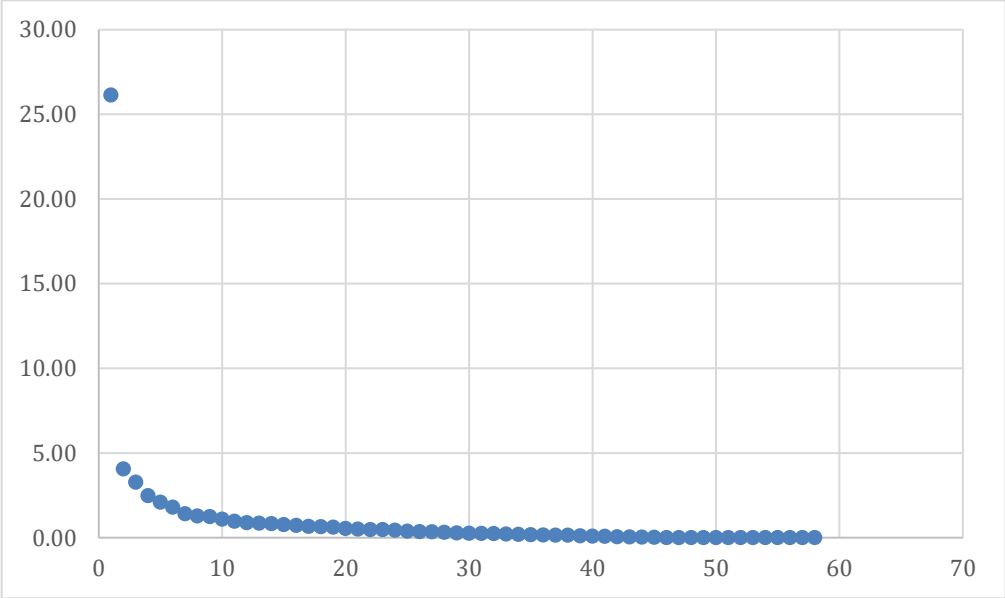

Figure 4: Scree plot of eigenvalues

The results of the PCA showed an eight-component solution. The first component contained 12 items on participation. The second component contained 11 items on critical consciousness, and one item on participation ("Information e.g. booklets, training about family violence is available in [community]"). The third component contained eight items on shared concern about family violence. The fourth component contained nine items on shared concern about healthy relationships, one item on shared concern about family violence ("People in [community] exchange information about family violence"), and one item on social cohesion ("People in [community] can be trusted"). The fifth component contained six items on social cohesion, and one item on shared concern about healthy relationships ("People in [community] are concerned about healthy relationships"). The sixth component contained five items on leadership and one item on organisation ("When people need help to make their relationships healthier the services in [community] work together well"). The seventh component included three items on shared concern about family violence and one item on shared concern about healthy relationships. Two of the three items on shared concern about family violence were not included in any other component. Items in the seventh component

related to the importance of the issue of family violence to the community, and the impact of family violence and healthy relationships on the community. Items about family violence in the third component related to talking about family violence, doing something to address it, or belief in change. The eighth component contained five items on organisation.

Following further analysis of the PCA plots (see Figure 5) and factor loadings, items that loaded on more than one variable over 0.4 were removed. Three items remained that loaded on two components over 0.4 that required further analysis. The first item, “People in [community] believe that family violence impacts the community” loaded on the components shared concern about family violence (0.436) and importance of family violence (0.639). As this item had a higher factor loading on the component importance of family violence and was a good fit with the two other items in this component, it was retained with this component. The second item, “People in [community] are concerned about healthy relationships” loaded on the components shared concern about healthy relationships (0.452) and social cohesion (0.482). The factor loading of this item on the social cohesion component was much lower than the loadings of other items, and the meaning of the item was a better fit with the component shared concern about healthy relationships. The third item, “When people need help to make their relationships healthier the services in [community] work together well” loaded on the components leadership (0.44) and organisation (0.416). While the factor loading was higher on the leadership component than the organisation component, it was considerably lower than the factor loadings of other items in the component. As this item was from the organisation scale, it was decided the item was best included in the organisation component.

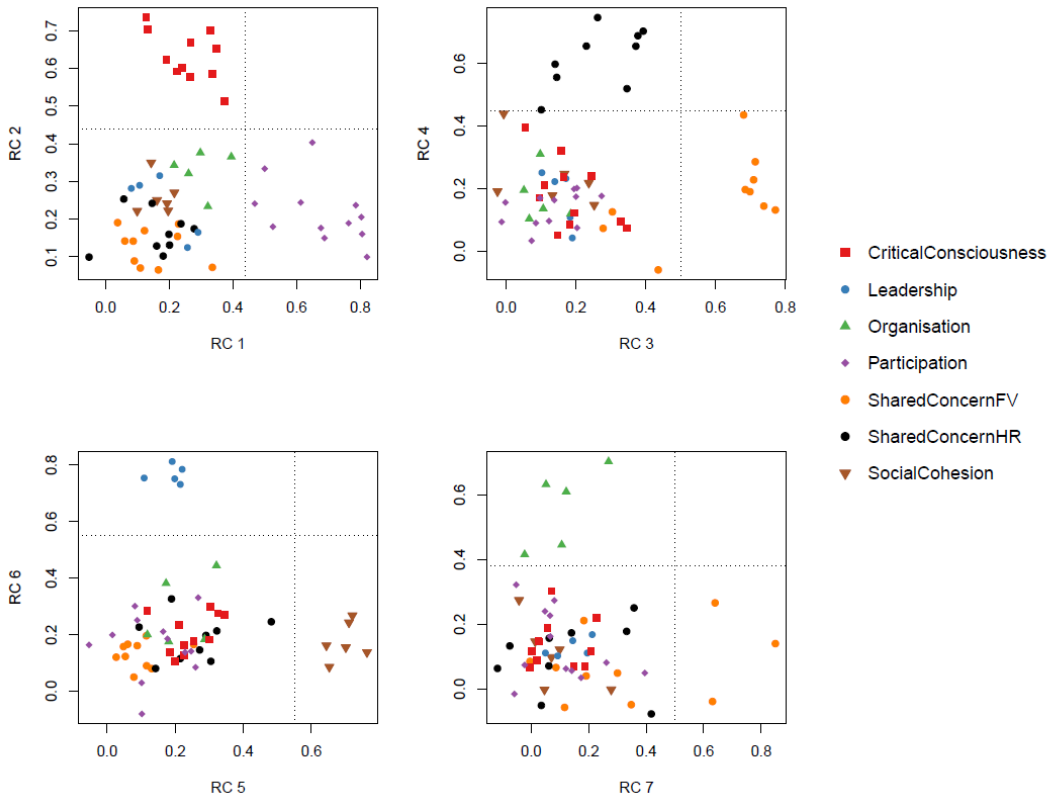

Figure 5: PCA plots

The final eight-component solution including eigenvalues and Cronbach's alphas is presented in Table 15. As can be seen, all eigenvalues were above 1.0 and high internal consistency was demonstrated by Cronbach's alpha ranging from .76 to .92. The lowest alpha was associated with the importance of family violence component which was moderate (0.759) and was likely due to the small number of items in this component (see Table 15).

Table 15: Component, number of items, eigenvalues and Cronbach's alphas for ACMQ

Component	Items in component	Eigenvalues	Cronbach's α
Participation	12	26.13	.922
Critical consciousness	11	4.05	.924
Shared concern – family violence	7	3.27	.882
Shared concern – healthy relationships	9	2.48	.896
Social cohesion	6	2.09	.886
Leadership	5	1.80	.904
Shared concern – family violence, importance	3	1.41	.759
Organisation	5	1.28	.859

The components mapped the domains scales of the ACMQ with one exception. The shared concern – family violence scale was split between two components signalling two distinct aspects of shared concern around family violence in communities. One aspect was the

importance of the issue to the community, and the other was what people in the community talked about and did about the issue of family violence.

The internal consistency of the ACMQ scales was high. The internal consistency scores were the same as that of the components, apart from the shared concern – family violence scale which had a higher internal consistency when all shared concern – family violence items were included (see Table 16).

Table 16: Internal consistency of ACMQ scales

ACMQ 2016 scale (number of items)	Cronbach's α
Critical consciousness (11)	.924
Participation (12)	.922
Leadership (5)	.904
Shared concern – family violence (9)	.896
Shared concern – healthy relationships (10)	.886
Social cohesion (6)	.886
Organisation (5)	.859

Summary

In this chapter the process of developing the ACMQ was documented. The ACMQ is a community-level measure that assesses six domains of CM to measure change in mobilisation on a specific issue over time. The six domains are leadership; organisation; participation; shared concern; social cohesion; and, critical consciousness. An analysis of the psychometric properties of the final version of the ACMQ proposed an internally consistent eight-component solution.

CHAPTER 5: METHODS

This study is guided by postpositive methodology as described in Chapter 3. The research used a case study to pilot the ACMQ and to assess CM and CR in two diverse urban communities in Auckland, Aotearoa New Zealand. In this chapter, the research methods used to complete this two-case case study are detailed. First, the recruitment of the case study communities is described, and then the specific recruitment strategies for the ACMQ and the CR assessments are described. Following this, the study participants, measures, procedure and data analysis are outlined. Finally, ethical considerations relevant to this research are described.

Recruitment

To test the ability of the ACMQ to assess community mobilisation and to investigate the relationship between measurement of CM and CR, a two-case case study design was chosen. The first step in recruitment was selecting the study communities. Glen Innes was selected as a case study community because a working group had previously formed to develop a CM initiative to prevent family violence in that community. The working group had adopted my recommendations to develop a CM approach and had verbally agreed to participate in my doctoral research to investigate CM and CR (see Chapter 6). I had been a member of the working group that was developing the CM family violence prevention initiative and I was later employed to develop and implement this initiative. The working group had also been involved in the development of the study. Once the specific details of the CM and CR studies were finalised, I presented the proposed study to the working group for discussion and formal consent was sought from the working group to proceed with the study. The working group supported the research and signed consent forms to allow the CM and CR studies to proceed in the community (see Appendices 6 and 7).

The Glen Innes community was defined for the purpose of this study by the Census Area Units (CAUs) of Glen Innes East, Glen Innes West and Point England. It was decided that the second case study community would be a community with similar demographic characteristics, but one that was not implementing a planned approach to prevent family violence, beyond ad hoc or one-off activities. This was performed to ensure it was possible to investigate if the ACMQ tool was sensitive to differences in levels of activity in the study communities. Data from the New Zealand Census (Statistics New Zealand, 2006) were used to identify a second geographic

community that had similar demographic characteristics to Glen Innes in terms of population size, ethnic diversity, income, and deprivation level. The 2006 Census data were the most recent data available when the comparison communities were selected. From using these criteria, Ranui was identified as an appropriate comparison. For the purpose of this study, Ranui was defined by the CAUs of Ranui Domain, Ranui South, Starling Park and Urlich. The communities were located approximately 30 kilometres apart with Glen Innes in Tāmaki, East Auckland and Ranui in Waitakere, West Auckland. This was done to minimise the likelihood of any elements of the planned initiative being implemented in Glen Innes from spilling over into Ranui.

The population characteristics of the communities were similar. In 2006, the population of Glen Innes was 11,724 and 10,095 in Ranui. When compared to the wider Auckland population, both communities had higher proportions of Māori and Pacific Peoples, and lower proportions of European, Asian and Other ethnicities. Pacific peoples were the largest group in Glen Innes and European was the largest group in Ranui (see Figure 6).

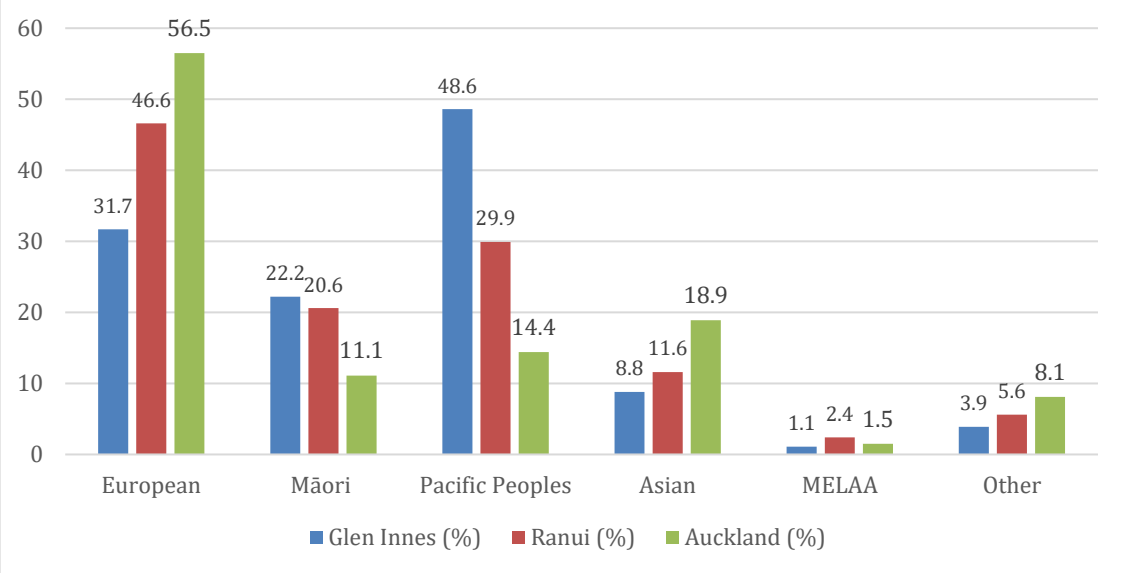

Figure 6: Census 2006 ethnicity data for Glen Innes, Ranui and Auckland regions

Glen Innes was somewhat a more economically deprived community than Ranui. The median income in Glen Innes for people aged over 15 years was $17,433, compared to $23,125 in Ranui. The Deprivation Index calculated on Census 2006 data (White, Gunston, Salmond, Atkinson, & Crampton, 2008) where Decile 10 represented the most deprived 10% of New Zealand and 1 represented the least deprived, shows the Glen Innes CAUs of Glen Innes East, Glen Innes West and Point England were all Decile 10. These data showed Ranui was also very

deprived (Ranui Domain – Decile 10; Urlich – Decile 9; Starling Park – Decile 9; Ranui South – Decile 7).

Once Ranui was identified as a possible comparison community, I approached the Ranui community broker based at the Ranui Action Project (RAP) (a long-term CD project detailed in Chapter 7) to discuss the research and we arranged a meeting. I shared with her the details of the proposed research and what participation from Ranui would involve. The community broker informed me that a local leadership group, the Ranui Accord, had formed and that it would be appropriate to present my request to this group. The Ranui Accord was established in 2011 and had become a key group for people external to the community to meet with to discuss proposed activity in Ranui and share information.

A meeting with the Ranui Accord was arranged. At this meeting I shared my background in working on the issue of family violence and my interest in CM. The aim of my doctoral project was discussed, and what it would mean for Ranui to participate in the research. The Ranui Accord members expressed their support for the research, and the process used to engage with them, and agreed to participate in the study. Formal consent was sought from the group and consent forms were signed to allow for the research to proceed in Ranui (see Appendix 6 & 7).

Aotearoa Community Mobilisation Questionnaire assessment

The Glen Innes Working Group and Ranui Accord also agreed to engage their staff and networks to distribute the anonymous questionnaire to potential participants and to host a sealed collection box in the reception areas of their organisations for completed questionnaires to be returned to (see Appendix 6). In addition, the public library in each community also displayed a poster promoting the study, had the ACMQ questionnaires available, and hosted a sealed collection box. The participant information sheet (PIS) was attached to the ACMQ survey (see Appendix 8), and participants were invited to remove the PIS and to keep it for future reference. The questionnaire was anonymous and completion was deemed to mean consent was given.

Community readiness assessment

To recruit participants for the CR assessment, members of the Ranui Accord and Glen Innes Working Group made the initial approach to participants from the list they had developed of potential participants. This involved contacting the person, sharing information about the study, giving them the PIS and consent form (see Appendix 9) to read in their own time and answering any questions they had about the study. The CR assessment interviewers then received a list of potential participants who had agreed to be contacted and made contact by phone with each person requesting their participation in the study. If they agreed to participate a time was arranged for an interview. Prior to commencing the interview, the interviewer checked if they had any questions and ensured the consent form was signed.

Participants

Aotearoa Community Mobilisation Questionnaire assessment

The ACMQ research participants were residents of the case study communities aged over 16 years. As the ACMQ is a self-completion questionnaire, it relied on participants to comply with the criteria for participation stated on posters advertising the study, the PIS and the questionnaire itself. There were 101 participants in Glen Innes and 89 participants in Ranui.

Community readiness assessment

In the CR assessment, participants are defined as key community informants. Key community informants are people who are knowledgeable about the community, are involved in community affairs and know what is going on, but do not have to be leaders or decision makers (Plested et al., 2006). Purposive sampling was used to identify key informants who were likely to be willing to share their knowledge of the community (Kumar, 2014). In the two study communities, a list of potential participants who represented priority community groups was developed. Priority community groups were defined within each community either because of the large size (for example, Māori, youth), or special character of the group (for example, refugees). The Glen Innes Working Group and the Ranui Accord each developed a list of potential participants. Participants had to be over the age of 16 years and live or work in the study communities.

The authors of the CR assessment state that four to six participants are sufficient to accurately score community readiness (Plested et al., 2006). In each community, 12 participants were recruited for each assessment. Six participants were recruited to complete a CR assessment on preventing family violence, and an additional six participants to complete an assessment on promoting healthy relationships. Prior to this study, an earlier CR assessment was completed in Glen Innes in 2011 with 24 participants. In that study, 12 participants responded to interviews on family violence and 12 on promoting healthy relationships. For the 2014 CR assessment, the interviewer contacted every second participant on the list of 2011 participants to recruit 12 participants, six for each topic.

Between the 2014 and 2016 CR assessments, a number of participants had to be substituted in both communities. The most common reasons that participants were no longer available were that they had left their working role or were no longer living in the community. In the 2016 CR assessment, seven participants were new in the Glen Innes study and five participants were new in the Ranui study. Replacement participants were representative of the same community group, for example, a young parent was replaced by another young parent. The authors of the CR assessment state that while it is ideal to use the same participants, changing participants within the community should not affect the results (Plested et al., 2006).

Measures

This study employed Yin's (2014) Type 4 case study design, and was a two-case case study with two embedded units of analysis (see Chapter 3). The embedded units of analysis were:

1. The ACMQ
2. The CR assessment (Plested et al., 2006)

This section describes the measures used.

Aotearoa Community Mobilisation Questionnaire

The ACMQ was developed as at the time there was no published measure available to assess CM. The ACMQ comprises six domains, namely, leadership; organisation; participation; shared concern; social cohesion; and, critical consciousness. The ACMQ is a 63-item self-completion questionnaire that assesses CM by measuring community members' perceptions of their community for the six domains of CM. For this study, the ACMQ was used to measure CM in

the context of preventing family violence and promoting healthy relationships. For a full description of the ACMQ and the process of developing and testing the tool see Chapter 4.

Community readiness assessment

CR is defined as the degree to which a community is prepared to take action on an issue (Plested et al., 2006, p. 3). In this study, two separate CR assessments were completed—one on family violence prevention and one on healthy relationship promotion. The methods for completing a CR assessment are outlined in the *Community Readiness Handbook* (Plested et al., 2006). The assessment involved completing semi-structured interviews with key community informants. The interview schedule (see Appendix 10) was used to assess the six dimensions of CR (see Table 17). Interviews were scored using the anchored rating scales provided in the CR tool to produce a numeric score (Plested et al., 2006).

Table 17: Dimensions of CR (from Plested et al., 2006, p. 7)

Dimension	Description
Community efforts	The extent that there are efforts, programmes and policies to address the issue.
Community knowledge of efforts	The extent that community members know about local efforts and the effectiveness of these efforts, and that these efforts are accessible to all aspects of the community.
Leadership	The extent that community leaders and influential community members are supportive of the issue.
Community climate	The prevailing attitude of the community towards the issue.
Community knowledge about the issue	The extent that community members know about the causes of the problem, consequences, and how it impacts the community.
Resources related to the issue	The extent that local resources are available to support local efforts.

As outlined in the CR assessment guide, interviews scores were then used to calculate a mean score for each dimension of CR. The mean dimension scores were then used to calculate an overall mean score that translates to a stage of readiness. For the nine stages of CR see Table 18.

Table 18: Stages of CR (from Plested et al., 2006, p. 9)

Stage	Description
1. No awareness	Issue not generally recognised by the community or leaders as a problem (or it may truly not be an issue).
2. Denial/Resistance	At least some community members recognise that it is a concern, but there might be little recognition that it is a concern locally.
3. Vague awareness	Most feel that there is a local concern, but there is no immediate motivation to do anything about it.
4. Preplanning	There is clear recognition that something must be done, and there may be local efforts addressing it. Efforts are not focussed or detailed.
5. Preparation	Active leaders begin planning in earnest. Community offers modest support.
6. Initiation	Enough information is available to justify efforts. Activities are underway.
7. Stabilisation	Activities are supported by administrators or community decision makers. Staff are trained and experienced.
8. Confirmation/ Expansion	Efforts are in place. Community members feel comfortable using existing services, and they support expansions. Local data are regularly obtained.
9. High level of community ownership	Detailed and sophisticated knowledge exists about prevalence, causes and consequences. Effective evaluation guides new directions. Model is applied to other issues.

CR assessments were completed in the study communities in 2014 and 2016. The 2014 assessment was also used to assess the appropriateness of the communities to be used for comparison in this research. Plested et al. (2006) claim that communities with similar levels of readiness are appropriate to use for research comparisons, whereas communities with very different levels of readiness are not.

While the CR assessment (Plested et al., 2006) is a useful measure of CM, it is not a specific measure of CM. In this study, both CR and CM assessments were completed. The rationale for this was that CM measurement is in its infancy. Only one author has published studies using a specific CM tool (Lippman et al., 2016). Using CR and CM measures allowed for a more comprehensive assessment of community efforts to address an issue. This enabled comparison of the results from the two tools to learn what elements of CM each tool assessed most effectively and if there were any gaps in assessment.

Procedure

I met with the Glen Innes Working Group and the Ranui Accord before each phase of research to organise data collection and after data collection to share the preliminary results.

Aotearoa Community Mobilisation Questionnaire assessment

The ACMQ assessment was conducted between October and December 2016 in both communities. Participants were invited to complete the questionnaire in community organisations, libraries and at community events and meetings. To complete the ACMQ, participants took a questionnaire, read the questions, and responded by circling their response choice on the questionnaire. Participants were able to take the questionnaire away and return it to a sealed collection box in one of the community organisations, or to complete and return the questionnaire to the person who invited them to participate. Participants were able to take as long as they wished to complete the questionnaire. When finished, they placed the questionnaire in a sealed collection box.

Community readiness assessment

Two CR assessments were completed in each community. The first assessment was conducted from April–May 2014 in Glen Innes, and from May–June 2014 in Ranui. The second CR assessment was conducted in Glen Innes and Ranui September–December 2016. Due to difficulties arranging interviews over the holiday period, the two final interviews for Glen Innes were completed in February and March 2017, and the final interview for Ranui was completed in February 2017.

To manage the potential for response bias due to my role coordinating the Glen Innes initiative (until October 2014), I did not complete any of the CR interviews. Two interviewers were employed to complete the CR assessments including conducting interviews and scoring the data. Three interviewers were employed in total. The interviewer who completed the Glen Innes interviews in 2014 had become involved in implementing the CM initiative by 2016 so was no longer eligible to be an interviewer; therefore, a new interviewer was employed. All three interviewers were women and were qualified social workers with experience working with family violence. It was important that the interviewers had experience with family violence so they were comfortable discussing the issue, and were able to manage requests for help from participants should these arise. Interviewers signed a confidentiality agreement before beginning interviewing (see Appendix 11).

Face-to-face interviews were completed at a time and place that was convenient to the participants including in homes, workplaces, community facilities, and cafés. The interviewers

allocated participants sequentially to complete the assessment alternating between assigning a family violence or healthy relationships interview.

Interviews were audio recorded using a Livescribe™ smartpen recording device that produced audio files in M4A format. The interviewers also recorded responses in writing in Livescribe™ notebooks which produced PDF files of the written notes and linked audio recordings. The M4a and PDF files were transferred from the devices to the researcher's computer.

Data analysis

In this section, the processes used to analyse the data collected from the ACMQ and the CR assessments are detailed.

Aotearoa Community Mobilisation Questionnaire analysis

The data from the ACMQ assessments was analysed separately for each community using SPSS (IBM Corporation, 2010). Descriptive statistics were generated for demographic variables. For each domain scale, the mean item score and standard deviation were calculated. In addition, a descriptive analysis of item response patterns was undertaken, and chi square analysis was used to determine any significant difference in these between the two communities.

Community readiness assessment

The process for scoring the CR interviews is provided in the *Community Readiness Handbook* (Plested et al., 2006, pp. 15-24). Anchored rating scales are used to convert participant responses into numerical scores. Each of the six dimensions of CR has a specific anchored rating scale. The CR assessment process requires two people to score the interviews. In the first step, the interviewers independently scored the interviews they had completed themselves using the anchored rating scales provided in the CR assessment and recorded their scores. Next, the interviewers exchanged interview notes and recordings, and scored the interviews from the other community, and recorded their scores. The interviewers then met to discuss the scores. If there were differences between the scored items they followed the guidance as outlined in the CR assessment to reach consensus on a final score (Plested et al., 2006).

Once all interviews were scored, the data was entered by the interviewers into a Microsoft Excel™ spreadsheet and a mean score was calculated for each dimension of CR for the family violence and healthy relationship interviews separately. The mean scores for each dimension of CR were then used to calculate an overall mean score for stage of readiness for both family violence prevention and healthy relationship promotion.

The interviews were not transcribed, as Plested et al. (2006) did not specify the need for this, and because the interviews were not going to be used for in-depth analysis. However, using the Livescribe™ PDFs made it possible to identify each question, the response and to listen to specific sections of the interview. Quotes were used from the CR interviews to provide an understanding of some of the views that contributed to the scores and describe the community context. After the CR scoring process was completed by the interviewers, I listened to all interviews to identify relevant quotes or "text segments that contain meaning units" (D. Thomas, 2000, p. 4). I then transcribed quotes that were relevant to the CR scores or described the community context. In doing so, I used a general inductive approach described by D. Thomas (2000) that used raw qualitative material to meet the specific objectives of this study, and was not constrained by structured methodologies of qualitative analysis. This method allows raw data to be used to show a clear link to summarised quantitative results (D. Thomas, 2000). I transcribed numerous quotes for each of the six dimensions of readiness for both the family violence and healthy relationship assessments. The quotes included in the case studies were selected because they illustrate either a common sentiment shared by a number of participants or a unique perspective, and this is indicated in the text. For each dimension of readiness, a summary of participant responses is provided. These are drawn from the interviewer's notes and from the body of quotes that were transcribed.

Case comparison analysis

In a two-case case study each case is presented individually followed by a case comparison analysis. This analysis included a synthesis of the research results for each community, information about activity in the community, and all contextual information gathered from existing documentation. This synthesis was used to interpret and discuss the study results. The case comparison is presented in Chapter 8.

Ethical considerations

Conducting research in community settings presents a number of ethical challenges. In this section, the ethical considerations for research in community settings in general and the relevant considerations for this study in particular are presented.

Research completed in community settings and with community groups is intended to help community groups understand and address the problems they face. The worth of the research must be seen by the community, and not only by the researcher (Miles & Huberman, 1994). Completing research in community settings means that researchers must engage in some level of partnership with people who live and work within the study community. In this partnership there are a wide range of possible ethical issues that may arise through differences in working and communication style; understanding of the aim of the research; levels of access to information, resources and power; competing timeframes; and, interpretation and dissemination of findings (E. E. Anderson et al., 2012). These challenges must be managed respectfully by the researcher throughout the entire research process.

A fundamental principle of community-based research is respect for community members (Buchanan et al., 2007). Some community partners may be very familiar with research processes and can advocate well for their communities. Others may have had little or no involvement with research, and learn about the research and research process as the study is implemented. Researchers are largely responsible for managing these challenges to ensure they do not benefit from research at the detriment of the communities they intend to serve (Minkler & Wallerstein, 2008).

Ethical considerations are amplified when study communities are perceived as having high needs, or are stigmatised because of high rates of crime, health, social or other disadvantages (Minkler & Wallerstein, 2008). Communities who experience disadvantage are often the subject of research projects generated outside the community to fulfil research goals defined by government or other external organisations, rather than by the community itself. Both of the communities in this study had been and were participating in research driven by external organisations. In Glen Innes, experiences of externally driven research had contributed to the impetus to develop a locally owned family violence prevention initiative, and to contribute to the development of the research used to measure the impact of that initiative. However, in Ranui, the community had not requested this research. I was very aware that participation in

the research took time and energy away from the prioritised issues Ranui organisations were already addressing, and that any benefits from participating in this study may take time to emerge. As family violence is a widely recognised issue in Aotearoa New Zealand, community partners may have had heightened interest in the research and wanted to be a part of it. However, it may also have been possible that for some it was hard to say no to participation, because of a perception that they should be doing something to address the issue.

A conflict of interest is inherent in this study as I was part of the working group that developed the Glen Innes initiative and was employed to coordinate the initiative for three years. To manage this conflict of interest the study was designed so I would not interact with research participants. This was achieved by employing interviewers to complete and score the CR interviews, and by involving the staff and networks of the community organisations in each community to distribute the ACMQ and to act as key community contacts. Not being involved in any data collection reduced my potential to influence responses and participation rates due to my role and relationships in the Glen Innes community.

Another ethical consideration for this study is that family violence is a sensitive topic. Research can direct community attention to an issue that may not have been a priority to address. While this was not the case in Glen Innes since the community wanted to address family violence, it was the case in Ranui where my research brought added attention to the issue. This presented an ethical question about asking to research in Ranui and because the community had not asked for the research, this issue was stated up front in initial discussions about participation. While this study did not ask participants about their personal experiences of family violence, discussing family violence in any way can be unsettling for people, particularly if they have experienced violence or are close to someone who has. For this reason, all research participants were offered contact details of services they could access to get help for family violence issues that may arise through participation. Local, regional and national services were offered as well as ethnic specific services where possible. Participants were also given details for anonymous national helplines and emergency service details.

Questions about who owns the data and the conclusions of a study are also important ethical issues to address (Miles & Huberman, 1994). In this study I had the responsibility to keep the data and ensure confidentiality and anonymity of participants. I owned the conclusions I drew from the data. However, the results of each assessment were fed back to the two communities

as they were completed. Results were shared with the communities on the understanding that they were confidential and not able to be used without my permission until after my doctorate was completed. Upon completion of my doctorate, the full thesis would be made available to the communities, and I made myself available to each community to make sense of the results in ways that were appropriate to them.

Ethics approval for this study was gained through the University of Auckland Human Participants Ethics Committee. The CR study was approved on the 17th of October, 2013 for three years (Reference: 2013/010436). The CM study was approved on the 6th of October, 2014 for three years (Reference: 2014/013083). See Appendix 12 for ethics documentation.

In the next two chapters, case studies are presented on the Glen Innes and Ranui communities.

PREAMBLE TO THE CASE STUDIES

Case study was used to confirm the psychometric properties and utility of the ACMQ and to measure CM and CR in two communities. One community, Glen Innes, was implementing a long-term CM strategy to prevent family violence and promote healthy relationships. The other community, Ranui, was similar in terms of size and demographic characteristics, but did not have a strategy in place to address these issues.

In the case studies, existing documentation was used to describe the two communities and the activities undertaken to prevent family violence and promote healthy relationships between 2014 and 2016. The sources of documentation included administrative reports from the community organisations, publicly available project reports, research and evaluation reports, books and media articles. Documentation was collected retrospectively from local organisations in October and November 2016. No new reports were written for the purpose of this research, as local organisations did not have the capacity to do this, nor was it deemed necessary. In Ranui, there were no administrative reports available on activity to prevent family violence or promote healthy relationships. This was because family violence prevention and healthy relationship promotion were not specifically targeted or funded projects in Ranui during the study period.

Criteria were developed to bound the case study documentation as recommended by Yin (2014). The following criteria were used to decide whether information and activities were included in the case study:

- Historical and statistical information about the communities
- Research and reports on CD activity in the communities
- Activity to prevent family violence or to promote healthy relationships
- The activity was targeted at residents of the case study communities
- The activity occurred within the defined geographic boundaries of the case study communities, or where it occurred outside the community boundaries, the activity was targeted at residents of the case study communities.

Activity that did not fit these criteria was excluded to ensure the case studies had a clear focus. The documentation was not used as a data source and did not constitute a documentation analysis.

In addition to the documentation specified above, statistical data from two New Zealand Government agencies was included in the case studies. Data from the New Zealand Census (Statistics New Zealand, 2006) was used to provide demographic information about the two communities. Data was also collected through an Official Information Act request which was made for this study. The Official Information Act request was made to the Ministry of Justice. This request sought the number of family violence homicides in the two communities during the study period. This request was completed for the relevant CAUs in each community. The *Official Information Act* request for data from the Ministry of Justice was completed in May 2018. A third *Official Information Act* request was made to the New Zealand Police regarding the incidence of family violence within the study communities during the study period. This request was completed; however, the limitations of this information meant that it was not included in the case studies.

Ethics approval was gained to access reports from the local organisations by the University of Auckland Human Participants Ethics Committee on the 6th of October, 2014 for three years reference number 013083 (see Appendix 13).

CHAPTER 6: GLEN INNES CASE STUDY

> *We're just at the beginning of admitting that there is a problem. The beginning of deciding to do something about it. We should be held responsible, if we see family violence and don't do anything about it. We're just at the brink of starting, and I think we've got a long way to go. With the HEART Movement that's the aim to create conversations about what healthy relationships should look like in our area in Tāmaki. What healthy relationships look like and what unhealthy relationships are, because they've become normal.*
>
> CR assessment participant (2016)

In this chapter a case study is presented on the Glen Innes community as defined in Chapter 5. The case study investigated CM and CR in the context of preventing family violence and promoting healthy relationships. The purpose of the case study was to present the real-world community context that the ACMQ and CR assessments were completed in, to use this contextual information to interpret the results and to investigate how community context impacts on CM.

The Glen Innes community

History

Historically, the Māori name for the Tāmaki area was Ukutoia, meaning hauling waka (canoe) over clay (Hancock, Chilcott, & Ka Mau Te Wero, 2005). Ukutoia was an important site for food gathering and trade due to its position on the Tāmaki River which connects the Manukau and Waitematā harbours (E. T. Jackson, 1978; Scott, 2013). The mana whenua of the area included the iwi Ngai Tai, Ngāti Paoa and from the mid-18th century, Ngāti Whātua (Hancock et al., 2005; Scott, 2013). Descendants of Tainui, Aotea, Te Arawa, and Mātaatua waka also settled in the area (Hancock et al., 2005). The area was once the site of a large and strongly fortified pā named Taurere[1] (E. T. Jackson, 1978).

The area of Tāmaki was part of the land gifted by Ngāti Whātua to the Crown, and by the mid-19th century native bush was largely cleared for farmland (Scott, 2013). The area was given the Pākehā (English) name Glen Innes by one of the early colonial farmers in the area, William Innes Taylor (E. T. Jackson, 1978). In the 1950s, the Taylor farm was developed into a suburban and predominantly government owned state housing area to house people on low incomes

[1] The meaning of Taurere is "the loved one flown away", which refers to the legend of Parehuia (E. T. Jackson, 1978).

working in the meat freezing works in nearby Panmure and Mt Wellington (Scott, Shaw, & Bava, 2010). Glen Innes was the first planned town centre in Auckland (Auckland City Council, 2004), and it flourished in the 1950s and 1960s. However, by the 1980s it had started to decline due to changes in the economy and reductions in local retail and industry (Auckland City Council, 2002).

Glen Innes was an affordable area to live in because of predominance of state housing (Scott, Shaw, et al., 2010). This made it attractive to Māori moving to Auckland from rural areas, and Pacific peoples migrating to New Zealand for work and from other parts of Auckland because of gentrification (Scott, Shaw, et al., 2010). Two-thirds of Māori and Pacific men in Glen Innes were blue collar workers in the 1980s (Department of Planning and Community Development, 1986), which meant that the community was seriously affected by the structural economic reforms of the 1980s, resulting in significant job losses and unemployment (Scott, 2013).

Demographic profile

Glen Innes was a young and multicultural community with a population of 11,472 in 2013 (Scott, Shaw, et al., 2010; Statistics New Zealand, 2013). The largest ethnic group in Glen Innes was Pacific peoples (47%), followed by New Zealand European (36%), Māori (22%), Asian (11%), MELAA (2%) and Other (>1%). A large proportion (39%) of the Glen Innes community were born overseas. Glen Innes is a low socioeconomic community and was classified as being in the most deprived 10% of New Zealand in 2013 (Atkinson, Salmond, & Crampton, 2014) (see Chapter 5 for more detail). The average personal income for people aged over 15 years was considerably lower in Glen Innes (NZD$17,900) than the Auckland region (NZD$29,600) (Statistics New Zealand, 2013). Over 60% of the homes in Glen Innes were state-owned, and in some streets, state housing accounted for up to 90% of houses (Scott, Shaw, et al., 2010).

Community strengths and challenges

A number of strengths and challenges have been documented through local research and reports on Glen Innes. In 2005, a household survey was undertaken using a participatory approach involving community members as volunteer researchers who were engaged in all aspects of developing, implementing the study and analysing the data (Liew, 2011). The survey questionnaire assessed needs and priorities of the community and involved random selection of houses and door knocking by the volunteer researchers. Over 200 residents responded

(Liew, 2011). Residents said the positive aspects of living in Glen Innes were the location, friendly atmosphere and people, familiarity, shops, and the environment. The results also showed that residents believed that people were the community's greatest asset (Hancock et al., 2005). At that time, people described a strong sense of community spirit and said that people pulled together to help each other when things needed to be done. Residents said they valued the strong connections that came from families living in the area across several generations, and the cultural diversity in the community.

A second household survey was conducted in Glen Innes in 2011 by local organisation Ka Mau Te Wero (KMTW) (Liew, Andajani-Sutahjo, Esekielu, & Mason, 2012). This survey of 465 residents asked participants about their aspirations and priorities for the community. Residents said their priorities were good health and wellbeing, a better future for their children, increasing family connectedness and increasing income. When asked if they felt a sense of belonging, 87% of respondents said yes. Ninety-three percent of those surveyed agreed that there were people in the community who could help and support them when they were in need (Liew et al., 2012).

However, Glen Innes has experienced a number of challenges. The community has been a focus of many central and local government interventions to address community problems, but these interventions have often been unsuccessful, or failed to address local concerns and priorities (Scott & Liew, 2012). Community challenges that were documented in the 1980s have continued to be issues for Glen Innes. These issues include unemployment, low incomes, economic activity, and social cohesion, poor housing, concerns about young people, and high crime rates (Department of Planning and Community Development, 1986). The community has developed a negative media image and some stigma because of this (Dialogue Consultants, 2003; Scott, Shaw, et al., 2010). Along with these long known issues, a 2003 evaluation of the CD initiative KMTW (Dialogue Consultants, 2003) documented some new issues, namely, family and sexual violence, addictions, educational achievement, poor health, Māori identity issues, lack of resources to support refugees and new migrants, women's personal and professional development, inadequate recreational activities, and the number of single parent whānau.

In the 2005 household survey residents reported similar issues. Residents said the negative aspects of living in Glen Innes were feeling unsafe, the environment, youth behaviours and attitudes, anti-social interactions, poor housing, low quality shops, low income and

employment, poor health, and abuse of alcohol and other drugs (Liew, 2011). In research completed by Scott et al. (2010), lack of social connection was also identified as an issue. They found that while ethnic and church groups had strong ties in the community, wider social networks were not connected, and this resulted in low levels of community belonging, connectedness and engagement in Glen Innes. The issue of family violence was again documented in a 2011 household survey, which showed that 88% of respondents agreed that family violence was an issue that needed to be addressed in the community. When asked what would help people to help others who were experiencing family violence, residents said that more support was needed from police, family, social services schools and churches, more information, people needed to take responsibility to respond to family violence, and more local leadership on the issue (Liew et al., 2012).

Community development

Glen Innes has a long history of CD efforts driven by local people and local community organisations; however, many of the funded initiatives have been externally driven by government agencies. In 1998, staff from local community organisations and Auckland City Council worked together to run an event known as the Glen Innes Charrette, a community consultation process that asked residents about issues and needs in their community. In 2000, Glen Innes was identified as an area for growth and was re-zoned for intensification by Auckland City Council. This meant Glen Innes was to be the focus of many future government interventions on housing, health and education. These processes led to the establishment of a local CD project called KMTW. While there have been many CD initiatives in Glen Innes, only few have been documented. The two CD initiatives described here, KMTW and Tāmaki Inclusive Engagement Strategy (TIES), were documented and have relevance to the activity that occurred in the study period.

Ka Mau Te Wero

Ka Mau Te Wero means rising to the challenge. It was a CD initiative established to prepare the community for planned changes and developments. KMTW was initially funded and co-managed by Auckland City Council and was later one of seven sites funded through the Strengthening Communities Action Fund, a Department of Child, Youth and Family initiative that aimed to devolve decision making to communities about social services and build capacity of communities to identify their own needs. The initial direction of KMTW was built on the

findings of the Glen Innes Charrette (Dialogue Consultants, 2003), and initiatives were developed to meet community needs such as refurbishing Ruapotaka Marae, developing ethnic community networks, and community pride and employment initiatives (Hancock et al., 2005).

An evaluation of KMTW that used key informant interviews stated that early initiatives had supported collaboration between local organisations, and increased social cohesion and social capital (Dialogue Consultants, 2003). The evaluation also noted increased trust in relationships between local organisations and community members, and an increase in children's access to health services, sports and cultural activities. KMTW completed further consultation and research to inform its direction, including a visioning project and the household survey in 2005 (see above). The visioning project was established to ensure the local community had a voice in future changes, and especially to give voice to Pacific people and youth. The visioning project was community-owned and engaged over 600 people who lived and worked in Glen Innes. The result of this project and the second household survey (Liew, 2011) informed the development of a five year action plan. The key priorities of the plan were community leadership; community pride and wellbeing; and, collaboration (Hancock et al., 2005). In 2006, KMTW became its own legal entity funded by the Department of Internal Affairs Community Development Worker Scheme. By 2009, KMTW had established or was contributing to a range of community activities on the identified priority areas and a strong focus on youth emerged (Liew, 2011). There was no formal evaluation of the efforts from 2006 to 2013. KMTW was disestablished in 2013 due to lack of funds.

Tāmaki Inclusive Engagement Strategy

TIES built on the earlier work of the Glen Innes Visioning Project (Hancock et al., 2005) to establish a vision for working in Glen Innes that actively engaged community members in decision making (TIES Team, 2010). The impetus for TIES was the establishment of the Tāmaki Transformation Project (TTP). TTP started in 2008 and was led by central government and Auckland Council. TTP aimed to address housing, education, health, environment, employment, crime and safety, and culture and identity issues (Scott, Perese, & Laing, 2010). In the first years of TTP, several initiatives were resourced including community leadership development to facilitate engagement between TTP and the community.

TTP had a 20 year vision to transform Tāmaki by improving housing, employment, health, social services and education. As TTP was a large, externally driven initiative, the developers of TIES, local organisations and residents, wanted to ensure that the local community was in partnership with TTP, and that local voices and preferred ways of working were respected. TIES developed a resource and toolkit that shared local history and "positioned community members as agents of change and decision makers" (TIES Team, 2010, p. 37). The toolkit outlined a community engagement process which the community continues to use to work together and with external groups, and to develop and improve local initiatives. However, there is no evidence to show how effective TIES has been in creating a partnership between the community and the external parties implementing TTP. TTP was shut down in 2011 due to perceived implementation challenges, and restarted in 2012 as the Tāmaki Regeneration Company (TRC) with a new governance and management structure (Scott, 2013).

Housing development

Glen Innes had an unusually high proportion of state housing (Scott, Shaw, et al., 2010). In New Zealand, state housing is government owned housing which is available to people on low incomes to rent at low-cost. The high proportion of state housing in Glen Innes has made it possible for the government to make changes to housing on a scale that would not be possible in other communities. While housing is not the focus of this case study, it is important to briefly describe the housing development in Glen Innes as it was by far the largest intervention underway during the study period, and has had major impacts on the community (Cole, 2015; Gordon, 2015; Scott, 2013).

Plans for the redevelopment of the Glen Innes Town Centre began in 2000 following re-zoning of the area for intensive housing development. This included revitalisation of the town centre, public facilities and spaces, and transport hubs (Auckland City Council, 2002). This was followed by a large state investment in urban renewal to improve housing and living conditions in Glen Innes in 2004, and later led to implementation of TTP and later TRC (Scott, 2013). The work of TRC included the transfer of ownership and management of 2,800 state houses from the New Zealand Government to TRC, and responsibility for replacing 2,500 existing homes with 7,500 new homes within 15 years (New Zealand Government, 2015). The TRC programme has led to a high level of uncertainty in Glen Innes, and increased mobility for Housing New Zealand tenants who were relocated, within and outside the community, to make way for the

new development (Gordon, 2015; Scott, 2013). TRC has created large divides in the community, and strong opposition and protest from some residents (Cole, 2015; Gordon, 2015; Scott, 2013). Some community members felt displaced, and say that the development seriously affected their health and wellbeing and damaged the once strong social networks in Glen Innes (Cole, 2015). The uncertainty created by TRC and increased mobility in the community has been ongoing for many years including throughout the study period. Perhaps the most negative impacts of this transformation project may have already been felt by the community as the building phase has now begun. The building phase brings positive outcomes of better housing and new community programmes and facilities, but the existing community will likely feel the negative impacts of gentrification for many years to come.

The HEART Movement

The issue of family violence in Glen Innes was documented in 2003 (Dialogue Consultants, 2003) and 2011 (Liew et al., 2012). In 2008, a commitment was made by local organisations and residents to address the problem. Four years of discussion followed, and in 2012 a long-term family violence prevention initiative called the HEART Movement was launched. This section describes the background and development of the HEART Movement.

Background

The Glen Innes Health Project Working Group was an initiative led by Auckland City Council to support community organisations to address local health needs. In June 2008, the Glen Innes Health Project Working Group held a meeting to discuss family violence and what could be done to address the issue locally (Glen Innes Health Project Working Group, 2008). While services were available to respond to violence after it had occurred, meeting attendees discussed the need for better service responses, especially services that were culturally appropriate and designed for men, and to break the intergenerational cycle of family violence by focusing on prevention.

In 2007, KMTW (see above) gained funding from the government funded national family violence prevention campaign *It's not OK* to run a short-term family violence prevention project in Glen Innes. The Health Project Working Group meeting attendees discussed this project and stated a preference for a stronger CD approach that involved community members

and focussed on strengths, including building community members skills and knowledge to change current responses to family violence and to prevent violence.

Attendees made a commitment to address the issue and decided to learn what more could be done to prevent family violence, and what support there was from community members to take a stand against violence. A working group comprised of managers and practitioners from local organisations, external practitioners and researchers with expertise in family violence prevention was formed to progress development of a local initiative. The local practitioners had strong connections to the community and some were also local residents. This group met regularly between 2008 and 2009. At that time, although there was an unprecedented level of family violence prevention work being implemented nationally, locally residents and practitioners asserted that these external efforts had very little impact on the Glen Innes community.

The working group recognised that while organisations working in Glen Innes had skills to respond to family violence, expertise in family violence prevention was not present locally. In 2009, a meeting was held between Puamiria Maaka, the Manukura (Chief Executive) of local organisation Te Waipuna Puawai[2], Dr Janet Fanslow of the University of Auckland, and myself to discuss a shared interest in CM to prevent family violence. I was soon to start my master's dissertation on this topic, and it was agreed that once completed, the recommendations from my dissertation would be presented to the working group and used to inform the development of an initiative in Glen Innes.

I completed my master's dissertation in 2010. The dissertation involved a structured literature review on effective CM to prevent family violence. The recommendations of my dissertation were to use:

- A CM approach: informed by public health, developmental evaluation and complexity theories;
- The theory of change model (A. Anderson, 2005) to plan the initiative; and,
- The CR model (Plested et al., 2006) to establish a baseline of readiness in the community to address the issue and measure the impact of the initiative over time.

[2] Te Waipuna Puawai Mercy Oasis is a community development initiative of the Ngā Whaea Atawhai o Aotearoa – Sisters of Mercy New Zealand. Te Waipuna Puawai Mercy Oasis was established in 1999 and built on the work of the Sisters of Mercy in Glen Innes for over a decade.

The community and working group agreed to adopt the recommendations from my dissertation to develop a local initiative which became the HEART Movement.

Development of the HEART Movement

By 2010, a working group and a network of 26 agencies had formed to support a local family violence prevention initiative. In 2011, the initiative was named The HEART Movement (HEART). HEART stands for Healthy Relationship in Tāmaki. A positive name was chosen to acknowledge the desire of community members to focus on achieving positive outcomes. The aim of the HEART Movement was to both prevent family violence and promote healthy relationships. The focus on promoting healthy relationships was understood by the working group to be a new approach to family violence prevention in New Zealand at that time. The approach was adopted with the recognition that to stop violence, it was necessary to build knowledge of how to have healthy relationships. HEART was set up as an inclusive, bottom-up way of working that community members were a central part of. The development of HEART was heavily influenced by the TIES approach to community engagement developed by Glen Innes community members and organisations (TIES Team, 2010). TIES demonstrated a determination in Glen Innes to build community capacity to lead local CD initiatives.

In 2011, three years of dedicated funding was secured from the Department of Internal Affairs Community Development Worker Scheme to support the initiative and employ a coordinator. At that time, I was involved in the HEART working group in my role as a project manager on the It's not OK campaign at the Ministry of Social Development. I had worked in Glen Innes in two previous roles in education and public health. I applied for the HEART Community Development Coordinator role and was successful in gaining the appointment. The purpose of this role was to work with the local community to develop an initiative that built the capacity of community members and practitioners to prevent family violence and promote healthy relationships. I was based at Te Waipuna Puawai and worked collaboratively with local community organisations and community members.

In 2011, the first CR assessment was completed in Glen Innes (see Chapter 5). This assessment was thought to be unique with its dual focus on assessing readiness to prevent family violence and to promote healthy relationships, as only examples of assessing readiness to address a problem (e.g. family violence) were available in the literature (Trewartha, 2010). This assessment was used to inform development of HEART and specifically the theory of change.

The theory of change tool (A. Anderson, 2005) was recommended in previous research (Trewartha, 2010) to guide development and implementation of complex community initiatives. For HEART, the theory of change was informed by the 2011 CR assessment, local knowledge of the community and CD initiatives, community initiatives to address family violence around New Zealand (Campaign for Action on Family Violence, 2011) and internationally, especially the Raising Voices community mobilisation initiative SASA! in Uganda (Michau, 2007, 2012; Michau & Naker, 2003). SASA! was identified as a well-developed and long running example of CM (Trewartha, 2010). The theory of change was completed in a series of workshop meetings in 2012 and involved the advisory group, HEART Network and community members. The ultimate goal of HEART stated in the theory of change was:

> "Glen Innes and Point England homes actively grow loving, safe and supportive relationships".

Given the ambitious nature of the goal and the frustrations of local practitioners with short-term approaches, a 20-year time frame was proposed. The theory of change was presented back to the HEART Network in a workshop in 2012 attended by 22 network members. Those present endorsed the theory of change and agreed the HEART Movement would progress accordingly.

Activity during the study period

The HEART Movement implemented a range of activities during the study period to engage the community in preventing family violence and promoting healthy relationships. Street barbeques were held in neighbourhood parks. These events were held in areas that local practitioners believed had high prevalence of family violence according to local practitioners. The events encouraged positive engagement with HEART and included a free barbeque, art activities centred on healthy relationships, sharing information and resources, face painting, and sports. HEART ran numerous street barbeques during summer months between 2012 and 2016 and reached approximately 1,600 people.

HEART also used large community events as an engagement strategy. Between 2012 and 2016, HEART ran events including White Ribbon Day (an international day to speak out on violence against women), Matariki (the Māori New Year), an art exhibition on healthy relationships, children's day events, events at Tāmaki College (a local secondary school), and at family days and parenting events. HEART also supported two plays on family and sexual violence to be

performed in Glen Innes in 2015 and 2016. In 2016, HEART began to hold a weekly community meal open to all residents at Ruapotaka Marae with the purpose of connecting people trying to build healthy relationships.

While these activities were important aspects of the CM initiative, building community leadership was the key CM strategy. A voluntary role called 'change agents' was developed to foster grass roots leadership. Change agents were well-connected local residents who supported the HEART kaupapa (purpose) and wanted to get more involved. They were asked to commit to ongoing involvement and development including training, engaging with people in their social networks, planning and running events and activities, and sharing their ideas about developing HEART. The group started with seven women in 2014, and they defined the role for themselves and started to lead their own actions. Although the intended focus of the role was prevention of family violence and promotion of healthy relationships, community facilitators were also helping in family violence situations, and had been since before HEART began, so received further training to respond to family and sexual violence and were able to access social work support. By 2016, there were 32 change agents, including eight men. The change agents had begun to led action and were supported to do so by the HEART programme lead.

Youth were identified by the HEART Network as a priority group in changing social norms about violence. A needs assessment process with local youth in 2013 led to the development of a music initiative to mobilise young people, called East HEART Unplugged. Eighteen young Māori and Pacific musicians participated in a noho marae (marae stay) over three days where they learnt about healthy relationships from Māori and Pacific perspectives; were mentored by established musicians and producers; created bands and wrote four original songs on the theme of healthy relationships; spent time at an audio and music institute; and, recorded their original songs. They also performed at a concert in Glen Innes to an audience of 350 people. The group continued to meet regularly in 2014 and 2015.

HEART developed a community campaign to stimulate community conversation. The campaign included posters featuring local leaders sharing positive messages about change, brochures with contact details for local services, public murals and social media. From 2016, the focus of the campaign was to encourage people to become part of the HEART Movement and to commit to building healthy relationships. This included making short films about the HEART

Movement, and change agents sharing their stories of change on social media. HEART provided a wide range of information and resource materials on family violence to practitioners and community members.

Another activity was employing a parenting community development coordinator based at the Glen Innes Family Centre. A key project from this work was Whānau Āwhina (Family Support), a year-long project led by local parents. These parents aimed to inspire other parents to become part of positive parenting activity in the community through implementation of new parenting initiatives. An evaluation of this initiative showed reduced isolation for the parents involved, better connections between parents and services, personal and skill development, and more valuing of informal parent networks, and opportunities to be part of activity beyond parenting programmes (Woodley, Metzger, & Myers, 2016). One initiative developed in this process, Breathing Spaces, became a weekly gathering place for local parents to support each other and share parenting challenges.

In 2016, HEART established Koru, a weekly peer support group focussed on developing health and wellbeing to support community change. All members took part in facilitating the group, and a social worker was present to support the group. This was a conversation space that allowed for deep conversations about individual and community change. Up to 25 people participated in this group weekly.

Finally, HEART also implemented a range of activities to develop organisational capacity and collaboration. The key focus of this work was increasing the skills of local practitioners. To do this, HEART ran annual surveys to assess local training needs, Ako (teaching and learning) sessions in the bi-monthly network meetings, and ongoing workshops and trainings for practitioners and community groups. HEART delivered training to 573 practitioners and community members between 2013 and 2016 on topics including basic and advanced family and sexual violence training; Māori and Pacific specific approaches; child and adolescent brain development; communication and conflict resolution; mental health and suicide prevention; and, addictions. HEART also aimed to strengthen the collaboration between services. By 2016, the HEART Network included 21 signed up member organisations. The membership agreement included a commitment to developing knowledge and skills to prevent family violence and promote healthy relationships through participation in HEART training. HEART is still running in Glen Innes in 2019.

Results

In the previous sections the community context was described. In the next sections, the results of the CM and CR assessments are reported.

Community mobilisation results

In this section the results of the CM assessment using the ACMQ are reported. See Chapter 4 for development of the ACMQ and Chapter 5 for methods.

There were 101 participants in the ACMQ assessment. Of these, 54.5% of participants reported their gender as female, 44.6% as male and 1% as other. The age range of participants was 16–62 years and the mean age was 33.75 years. Participants reported their ethnicity as Māori (58.6%), Pacific peoples (31.3%), Pākehā (8.1%), Asian (1%) and Other (1%).

The mean item scores were calculated for each of the ACMQ domain scales (see Table 19). The scores ranged from 1=lowest agreement to 3=highest agreement. As can be seen in Table 19, there was little variation in the mean item scores across the scales, with scores reflecting a generally positive response to items in each scale.

Table 19: Mean item scores and standard deviations for each of the ACMQ scales

Domain scales (number of items)	Mean scale score	SD
Leadership (5)	2.15	0.601
Participation (12)	2.27	0.553
Organisation (5)	2.24	0.506
Critical consciousness (11)	2.13	0.572
Shared concern family violence (10)	2.31	0.600
Shared concern healthy relationships (9)	2.20	0.596
Social cohesion (6)	2.04	0.595

In the following sections, analysis of the item responses is reported.

Participant responses to the leadership scale (see Table 20) showed the highest agreement to the item that leaders were role models of healthy relationships. While 29% of respondents agreed a lot to the item leaders spoke out against family violence, this item also showed the highest do not agree at all response (13%). The lowest agreement on this scale was on leaders' abilities to manage inter-group conflict (22.2%).

Table 20: Distribution of responses to ACMQ leadership scale items

Leadership (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
Leaders in Glen Innes speak out against family violence	29.0	58.0	13.0
Leaders in Glen Innes promote healthy relationships	27.7	60.4	11.9
Leaders in Glen Innes are role models of healthy relationships	29.4	60.8	9.8
Community leaders are able to represent all sectors of the community	24.2	63.6	12.1
Community leaders are able to manage inter-group conflict within the community	22.2	66.7	11.1

The highest agreement on the participation scale was for the item information about family violence in the community and 35.5% of participants agreed a lot that this information was useful (see Table 21). Fewer participants agreed a lot that information on healthy relationships was available (28.9%). Nearly one-third of participants agreed a lot that there had been activity in the community about family violence and healthy relationships. The highest do not agree at all was on the item 'I see people in healthy relationships' (9.8%). Before answering the participation scale, participants were asked if they knew of any activity to prevent family violence or promote healthy relationships; 71% said "Yes" and 29% said "No".

Table 21: Distribution of responses to ACMQ participation scale items

Participation (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in Glen Innes	31.7	64.6	3.7
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in Glen Innes	30.5	65.9	3.7
I have done something to help to prevent family violence in Glen Innes	32.5	61.4	6.0
Information (e.g. booklets, training) about family violence is available in Glen Innes	41.5	52.4	6.1
The available information about family violence is useful	35.8	61.7	2.5
Information (e.g. booklets, training) about where to get help for family violence is available in Glen Innes	30.5	63.4	6.1
Information (e.g. booklets, training) about healthy relationships is available in Glen Innes	28.9	62.7	8.4
The available information about healthy relationships is useful	27.8	68.4	3.8
Information (e.g. booklets, training) about where to get help for healthy relationships is available in Glen Innes	31.7	61.0	7.3
The available information about where to get help for healthy relationships is useful	29.6	66.7	3.7
In Glen Innes I know people in healthy relationships	32.5	62.7	4.8
In Glen Innes I see people in healthy relationships	32.5	57.8	9.6

Responses to items on the organisation scale items were very similar without high agreement or disagreement (see Table 22). The item with the highest agreement was that Glen Innes had people with the skills to help to prevent family violence (29.9%). Before answering the organisation scale, participants were asked if they knew of any services in the community that helped to prevent family violence or promote healthy relationships; 70% said "Yes" and 30% said "No".

Table 22: Distribution of responses to ACMQ organisation scale items

Organisation (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
In Glen Innes we have the services we need to help to prevent family violence	23.9	72.7	3.4
In Glen Innes we have the people with the skills to help to prevent family violence	29.9	69.0	1.1
The support that people get from services for family violence helps to keep them safe	29.1	65.1	5.8
When people need help to make their relationships healthier the services in Glen Innes work together well	27.6	67.8	4.6
The support that people get from services helps them to make healthy relationships	26.4	70.1	3.4

On the critical consciousness scale, highest agreement was on items about volunteering to help solve community problems (29.3%) and thinking about the causes of family violence to address the cause of the problem (29%). The strongest disagreement was on items about the community cooperating to solve problems and trying again if attempts to solve a problem failed. The items about people talking about how to solve problems (12.9%) and enjoying discussing different solutions (17%) showed a low number of agree a lot responses (see Table 23).

Table 23: Distribution of responses to ACMQ critical consciousness scale items

Critical consciousness (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Glen Innes talk to each other about how to solve community problems	12.9	77.2	9.9
People in Glen Innes enjoy discussing different ways to solve community problems	17.0	76.0	7.0
People in Glen Innes are open to hearing different views about community problems and solutions	26.7	61.4	11.9
People in Glen Innes volunteer to help solve community problems	29.3	57.6	13.1
People in Glen Innes think about why family violence happens so they can address the cause of the problem	29.0	63.0	8.0
People in Glen Innes not only talk about family violence but they also try to prevent it	25.7	68.3	5.9
People work together to solve problems in Glen Innes	24.5	62.7	12.7
There is a lot of cooperation between groups in Glen Innes	28.0	59.0	13.0
If your community fails to resolve a community problem, they will try another different approach to solving the problem	20.0	69.0	11.0
If your community fails to resolve a community problem, they will learn from that experience and do a better job when they try to solve the problem in the future	24.0	63.0	13.0
If leaders in Glen Innes fail to resolve a community problem, people will work together to find a solution	24.5	62.2	13.3

On the shared concern – family violence scale, the highest agreement was for the items about the impact of family violence on the community (50%), followed by the importance of the issue of family violence (48.5%). There was lower agreement on items about talking openly about family violence, exchanging information and belief the community could prevent family violence. Of note, 15.2% of respondents did not agree at all that people talked openly about family violence (see Table 24).

Table 24: Distribution of responses to ACMQ shared concern – family violence scale items

Shared concern – family violence (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Glen Innes are concerned about family violence	40.0	54.0	6.0
People in Glen Innes consider family violence an important issue	48.5	47.5	4.0
People in Glen Innes talk openly about family violence	30.3	54.5	15.2
People in Glen Innes believe that family violence impacts the community	50.0	46.9	3.1
People in Glen Innes talk about family violence at community meetings	41.0	49.0	10.0
People in Glen Innes work together to prevent family violence	39.4	52.5	8.1
People in Glen Innes take family violence seriously	39.8	57.1	3.1
People in Glen Innes believe they can prevent family violence	31.3	62.6	6.1
People in Glen Innes exchange information about family violence	30.6	59.2	10.2
People in Glen Innes work together to reduce the effects of family violence	34.3	54.5	11.1

Responses to the shared concern – healthy relationships scale showed lower agreement than the shared concern – family violence scale. The highest number of agree a lot response was for the item 'People take healthy relationships seriously' (36%). Of note, 18% of respondents did not agree at all that people talk openly about healthy relationships (see Table 25).

Table 25: Distribution of responses to ACMQ shared concern – healthy relationship scale items

Shared concern healthy relationships (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Glen Innes are concerned about healthy relationships	26.3	64.6	9.1
People in Glen Innes consider healthy relationships an important issue	30.7	61.4	7.9
People in Glen Innes talk openly about healthy relationships	23.0	59.0	18.0
People in Glen Innes believe that healthy relationships impact the community	36.3	57.8	5.9
People in Glen Innes talk about healthy relationships at community meetings	29.9	62.9	7.2
People in Glen Innes work together to promote healthy relationships	29.3	57.6	13.1
People in Glen Innes believe they can promote healthy relationships	30.7	62.4	6.9
People in Glen Innes exchange information about healthy relationships	28.0	65.0	7.0
People in Glen Innes take healthy relationships seriously	36.0	51.0	13.0

The social cohesion scale had the lowest agreement of all seven scales. The highest score was for the item 'People generally get along well' (29.3%). Responses to this scale indicated that participants had concerns about the willingness to help neighbours, trust people, share values, look out for each other, and of Glen Innes being a close-knit community.

Table 26: Distribution of responses to ACMQ social cohesion scale items

Social cohesion (n=101)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Glen Innes are willing to help their neighbours	17.8	64.4	17.8
People in Glen Innes can be trusted	12.9	70.3	16.8
People in Glen Innes generally get along well with each other	29.3	62.6	8.1
People in Glen Innes share the same values	19.2	62.6	18.2
People in Glen Innes look out for each other	21.8	60.4	17.8
This is a close-knit community	17.9	64.2	17.9

The ACMQ results indicate that while shared concern about family violence was high in Glen Innes, agreement for the other domains of CM was considerably lower. Of particular interest is the low agreement on the social cohesion scale. This result will be explored further in later chapters.

Community readiness

In this section, the results of the CR assessments that measured the readiness of the Glen Innes community to prevent family violence and promote healthy relationships are reported. CR assessments were completed in 2014 and 2016 as part of this study. The results from the CR assessment completed prior to this study in 2011 are also included for comparison. The family violence assessment results are presented first followed by the healthy relationships assessment results. Each dimension of CR is reported and quotes from CR assessment participants in 2014 and 2016 are used to provide context to the CR scores and insight into the participant's understanding of these issues. For a description of the CR assessments, the stages of community readiness and definitions of the dimensions of community readiness see Chapter 5.

In the CR assessment, participants were asked to describe the community of Glen Innes. Some described the strengths of the community, especially vibrancy, diversity and resilience. Others described the challenges for the community, including housing, unemployment, crime and

inequalities in health and income. However, most participants described strengths of the community in relation to challenges, or the contradictions they saw in the community,

> *Everyone knows each other. There's a lot of working together. I feel like there's a lot of support there. I know there is also a lot of brokenness in the community. A lot of whānau are just trying to stay afloat. It's safe and dangerous at the same time if that makes sense.* (HR2 2016)

> *I'd describe it as a connected, unconnected community.* (FV5 2016)

These contradictions of the community being safe and unsafe, connected and unconnected, also reflected the resilience in the community that participants named. Participants said the resilience had grown in response to challenges the community faced. The major challenge noted by participants was the rapid change in the community due to the Tāmaki Regeneration Programme and the impact this had had on social connections:

> *It's a unique community that historically has had a sense of strong connections, but those connections have come through third or fourth generation families that have grown up together. With the circumstances of our families being sent out of the community or communities coming in, there is a slight decrease in that whole community feel.* (HR5 2016)

Due to the scale of the Tāmaki housing redevelopment, this was a major focus for the community during the study period.

Family violence

In this section the results of the CR assessments on community readiness to prevent family violence in 2011, 2014 and 2016 are reported (see Table 27 and Figure 7). The results showed the stage of readiness increased at each assessment and in 2016 reached stage 5 – preparation, which is defined as "Active leaders begin planning in earnest. Community offers modest support" (Plested et al., 2006, p. 9).

The scores for the community efforts, leadership and resources dimensions decreased between the 2011 and 2014 assessments, and then increased again in the 2016 assessment.

Table 27: Glen Innes CR results 2011, 2014 and 2016 – family violence

Dimension	Scores and stage of readiness		
	2011	2014	2016
Community efforts	6.25 – Initiation	5.50 – Preparation	6.67 – Initiation
Knowledge on efforts	3.25 – Vague awareness	3.67 – Vague awareness	4.67 – Preplanning
Leadership	5.33 – Preparation	4.83 – Preplanning	5.33 – Preparation
Community climate	3.08 – Vague awareness	4.17 – Preplanning	4.17 – Preplanning
Knowledge on issue	3.42 – Vague awareness	4.33 – Preplanning	4.33 – Preplanning
Resources	5.25 – Preparation	4.67 – Preplanning	5.17 – Preparation
Overall stage of readiness	4.43 – Preplanning	4.53 – Preplanning	5.06 – Preparation

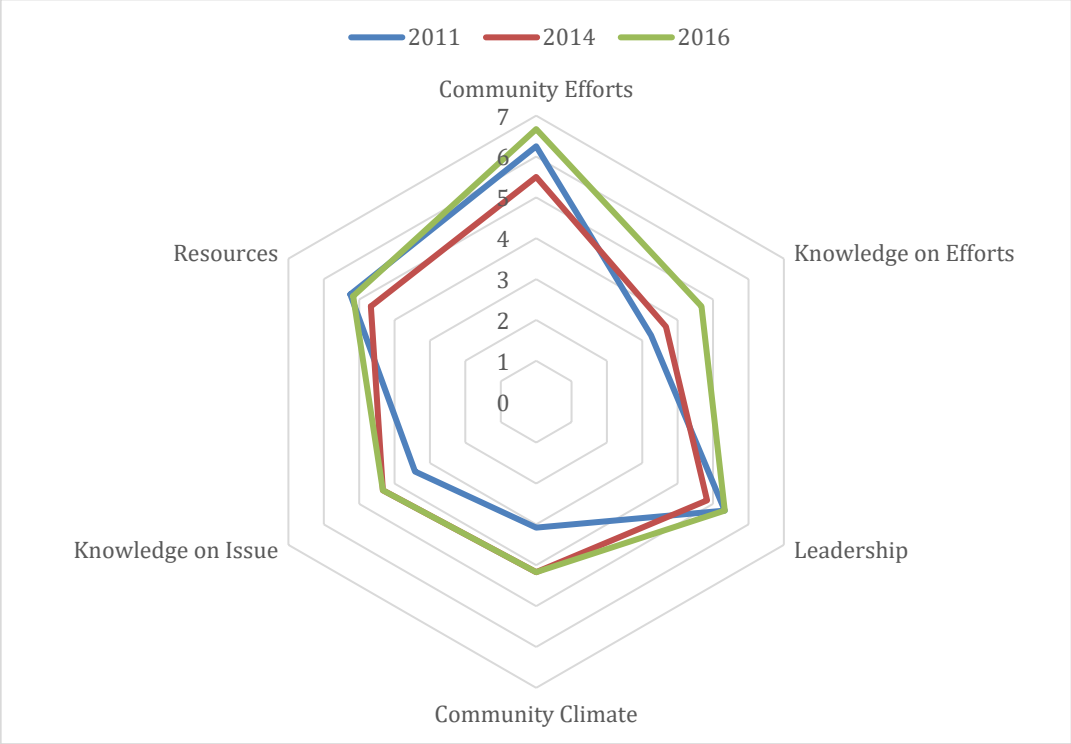

Figure 7: Glen Innes CR results 2011, 2014 and 2016 – family violence

The highest scoring dimension across the three assessments was community efforts. Leadership was the second highest scoring dimension. The lowest scoring dimension was community climate which assessed attitudes in the community to family violence. The community knowledge of efforts domain showed the largest increase between 2011 and 2016. The results for each of the six dimensions of CR are reported below in more detail, and quotes from interview participants are used to provide context to the dimension scores.

Community efforts

Community efforts was the highest scoring dimension across all three CR assessments on family violence. Participants described local efforts to involve community members in

preventing family violence in detail. They also described the efforts focussed on practitioners and organisations, especially the increased information and training available through the HEART Movement and the increase in collaboration between organisations. Participants also described how the community was involved in these efforts:

> *HEART tries to encourage them to be very proactive where they live, so to make friends with the neighbours, even form little groups. Some of the older women have caught on to what this means to actually help, to have an understanding around domestic violence and around child abuse.* (FV1 2016)

Many participants were involved in the efforts to prevent family violence and were optimistic about the potential of these efforts; however, they were also realistic that stopping family violence would take a long time.

Community knowledge of efforts

The community knowledge of efforts score was lower (stage 4) than the community efforts score (stage 6) in all three CR assessments. This signals that while organisations were very aware and involved in family violence prevention efforts, the wider community was not as aware or involved. A number of participants said that people often did not want to know about family violence because it was a challenging issue:

> *If you were to ask the average person in the streets what's available for them, they wouldn't know, and in some cases, they wouldn't really care. So, it's not due to lack of advertising, it's a hard sell family violence.* (FV2 2014)

Participants also described barriers to seeking help including perceived apathy, stigma and a tolerance of family violence:

> *Although there's an awareness of what services are available, we're not very open about some of the issues surrounding family violence in our community. Some of the communities are still very disconnected or it's not an issue, or it's an issue that's generational so it's been normalised or socially accepted.* (FV4 2016)

When asked about the strengths of the current efforts, participants named the coordination of efforts across the community and the positive approach of promoting healthy relationships. People also described capacity building as a strength, working bottom-up and the local focus:

> *They're building capacity in the local people and community. That's creating a sense of worth.* [Local people] *are actually finding or using their knowledge that they didn't know they had. That gives them a sense of pride, and then they become a role model.* (FV3 2016)

> [It is a] *grass roots movement, so people that are not connected to the sector in any way or have no prior experience of community development and are just people who are really passionate about having healthy relationships.* (FV6 2016)

Again, these quotes describe the ability of local efforts to involve community members in a voluntary capacity and to work beyond organisations. However, efforts to build capacity within organisations was also noted as a strength:

> *The professional development that HEART is able to provide is really important so we can keep building the capacity, the practice and the terminology with practitioners, and organisations, so that it becomes a culture.* (FV6 2016)

Participants also described weaknesses of current effort to prevent family violence. They said it was challenging and long-term work:

> *It is so hard to work in the community, to get people involved. Once people are on board they get it, then it takes a lot of work for people to really understand.* (FV1 2014)

Other specific weaknesses of current efforts named by participants were the lack of ethnic and language specific services and the lack of funding and capacity in local services to respond to family violence. While the majority of participants said that the positive approach of promoting healthy relationships was a strength of the family violence prevention efforts, one participant said that there needed to be a stronger focus on family violence:

> *There's the HEART stuff, but they* [the community] *see that as HEART, not as family violence. It should have been named family violence instead of HEART.* (FV5 2016)

Participants were very knowledgeable about local efforts, mainly due to their involvement in these efforts. However, they were aware that the general community was far less aware of efforts to prevent family violence.

Leadership

Leadership was the second highest scoring dimension of readiness across the three CR assessments. Participants named numerous people and organisations who they described as leaders addressing family violence:

> *The HEART Movement, TWP, Glen Innes Family Centre, Tāmaki Community Development Trust, Ruapotaka Marae, Tongan Social Services in Glen Innes, I have to say CYFs, schools, our local churches. I'd like to say Tāmaki Housing* [new state housing landlord]*, if there is something that they see they will refer them to us.* (FV3 2016)

Participants said that family violence was a serious concern and that this concern was visible because leaders continued to be involved in efforts to address the issue:

> *They* [leaders] *are attending the workshops and courses and passing the information on to the organisations. And supporting groups to participate and encouraging* [people] *to become leaders within it, from the grass roots.* (FV1 2014)

Participants said that leaders understood the intergenerational nature of family violence and how much there was to be gained by stopping it:

> *A great concern* [to leaders]. *It all comes back to the family and how they live, and for their future as well, because if that's what's happening in their family the children think that that's right and normal, and that's what will happen in the future.* (FV3 2016)

Leaders were said to be involved in local efforts in many ways, by attending events and training, encouraging others to get involved, and sharing information.

Community climate

Community climate was the lowest scoring dimension in the 2011 and 2016 CR assessments. A number of participants described a tolerance to family violence that existed within the community, and said that violence was often excused or ignored. Others said that they felt family violence was a private matter and that they felt they could not intrude:

> *It's a personal, it's a private matter. It's none of my business. There's a conflict I believe about knowing it's not right and doing something about it. Well that's how I feel about it, and I've talked to some of my friends and that's how they feel about it. Actually, they have to ask for the help if it's a problem.* (FV6 2014)

This quote describes the discomfort that is caused by knowing about violence but not feeling able to act. One participant shared a different view that people must do something when they know about family violence:

> *There's no tolerance, if you see it you've got to seek help as to what actions you should be doing.* (FV3 2016)

However, this view was less common and most participants talked about people ignoring violence or not knowing what to do. Participants also shared mixed views about how community members supported current efforts to address family violence. Some said that there was a small but committed group involved. Others suggested that people were most comfortable getting involved in groups rather than as individuals:

> *More in the group things, once people get to know that this group is supporting healthy relationships, they can come on board there. I think it's really having conversations in groups, school groups or church groups or whatever, and they can support one another in taking this stand. Individually I think they are still a bit hesitant.* (FV1 2016)

When asked what the obstacles were to addressing family violence, participants said that while there was a lot of information and services available to help, this information was not reaching those who needed it most. Participants also described how difficult it was to make change on family violence when people were living in poverty and violence was intergenerational. Participants said that those experiencing family violence usually did not ask for help until after police or child protection services had become involved. One participant named the challenge of working with perpetrators who did not want to change:

> *As practitioners, we all want to address this. But if you were to ask a service user they would say their only crime was that they got caught*. (FV2 2014)

This quote appears to illustrate that entrenched norms about family violence are difficult to address. One participant said that despite the high level of prevention activity, it was likely that only a family violence homicide would make people respond or make change:

> *I think more can be done, it's definitely a topical issue. You know the It's not OK campaign, through the media, you can't pick up a newspaper without seeing family violence. It's a practice that's not going to go away easily, and unfortunately all it takes is a death in this community of family violence that will bring this community together, which is how this community works.* (FV2 2014)

Despite this view, some participants said awareness was growing, and that people understood the seriousness of the problem, especially in Glen Innes:

> *They really want to promote and work at their own relationships, and to make sure that their children are safe. There's a general feeling that's it's not OK to have family violence and abuse. And more and more people are starting to wear white ribbons, and things like that.* (FV1 2016)

> *There's a degree of normal around some practices, that would be considered not OK in other communities*. (FV6 2016)

However, participants said there was a long way to go to make change:

> *We're just at the beginning of admitting that there is a problem. The beginning of deciding to do something about it. We should be held responsible, if we see family violence and don't do anything about it. We're just at the brink of starting, and I think we've got a long way to go. With the HEART Movement that's the aim to create conversations about what healthy relationships should look like in our area in Tāmaki.*

> *What healthy relationships look like and what unhealthy relationships are, because they've become normal.* (FV3 2016)

This quote conveys an understanding of the complex and long-term nature of the process of making change in a community.

Knowledge about the issue

The score for the knowledge about the issue of family violence dimension increased between 2011 and 2014, but remained stable in 2016. Participants said that there was a lot of information available in the community, such as brochures and training, and that people were talking about family violence. They said that there were posters, radio, social media and television coverage about family violence and that if people wanted to learn about family violence, information was available. Some participants said that conversation was growing about the issue, but also questioned how this information was shared in the community:

> *There's always a significant amount of training and workshops available within the community, in terms of how that's then communicated to whānau and other communities in the area I'm not too sure. I think there was a lot of drive around the It's not OK campaign, that really really helped to open the issue, to be able to create some dialogue.* (FV4 2016)

One participant said that there was an accepted level of family violence amongst some community members:

> *They know a lot about family violence, but it's what level of family violence is not OK. There's that whole thing that it's OK to slap your partner, but to punch her is not OK.* (FV3 2014)

Another participant said that the community only understood serious physical violence, but not other forms of family violence:

> *Community members regard family violence as black eyes and full beatings, they don't regard it as benign stuff, and they don't see the verbal violence or the psychological violence as being family violence. So they only relate it to beatings.* (FV5 2016)

A number of participants said that knowledge was limited, and that people did not know what to do about family violence. They also said that information was getting to people too late:

> *Family violence information is only given to them once they've been caught. Once they're caught the support comes, but it's 10 steps too late.* (FV2 2014)

Participants shared differing views of community members' knowledge of family violence. However, responses showed that information was available for those who sought it out or wanted to know, but that the tolerance of family violence and not knowing what to do were barriers to engaging with information about the issue.

Resources

The score for the resources dimension was the third highest dimension score in 2011 and 2016. The score for this dimension was the highest in 2011; the 2014 score was lower, and although the score increased in 2016, it remained lower than the 2011 score.

Participants had differing views about the level of training and expertise in the local services to address family violence. Most said that the skills of local practitioners to address family violence was growing, and that the training provided locally was contributing to this development. Some participants said that there were already some very skilled people working in the local organisations. Most participants said that the first person most people turned to for help was a friend, family member or neighbour. However, one participant recognised that people experiencing family violence often did not get the help they needed from within their own networks.

One participant also said support from business and other community groups for efforts was growing, and that a diverse range of volunteers were involved:

> *They* [businesses] *are more aware and invited to workshops so they can be more aware. They are more helpful with projects and efforts to stop family violence*. (FV1 2014)

> *The volunteers range from married couples to single people, couples with children, without children, older mature couples whose children have grown up and not living at home, and all different ethnicities. And also working* [people] *as well as volunteers, and stay home mums, so it reflects our wider community.* (FV3 2016)

A number of participants described increasing resources and support in the community for local efforts, and it is unclear why the 2011 score for this dimension was higher than the 2014 and 2016 scores.

Healthy relationships

The results of the CR assessments on healthy relationships in 2011, 2014 and 2016 (see Table 28 and Figure 8) showed that the overall score decreased between the 2011 and 2014 assessment, and then increased again in 2016 to stage 5 – preparation, defined as "Active

leaders begin planning in earnest. Community offers modest support" (Plested et al., 2006, p. 9).

Table 28: Glen Innes 2011, 2014 and 2016 CR results – healthy relationships

Dimension	Scores and stage of readiness		
	2011	2014	2016
Community efforts	6.50 – Initiation	6.83 – Initiation	6.83 – Initiation
Knowledge on efforts	3.67 – Vague awareness	3.83 – Vague awareness	4.50 – Preplanning
Leadership	5.92 – Preparation	5.50 – Preparation	6.17 – Initiation
Community climate	4.33 – Preplanning	4.50 – Preplanning	4.67 – Preplanning
Knowledge on issue	4.25 – Preplanning	4.17 – Preplanning	4.67 – Preplanning
Resources	6.00 – Initiation	4.67 – Preplanning	5.17 – Preparation
Overall stage of readiness	5.11 – Preparation	4.92 – Preplanning	5.33 – Preparation

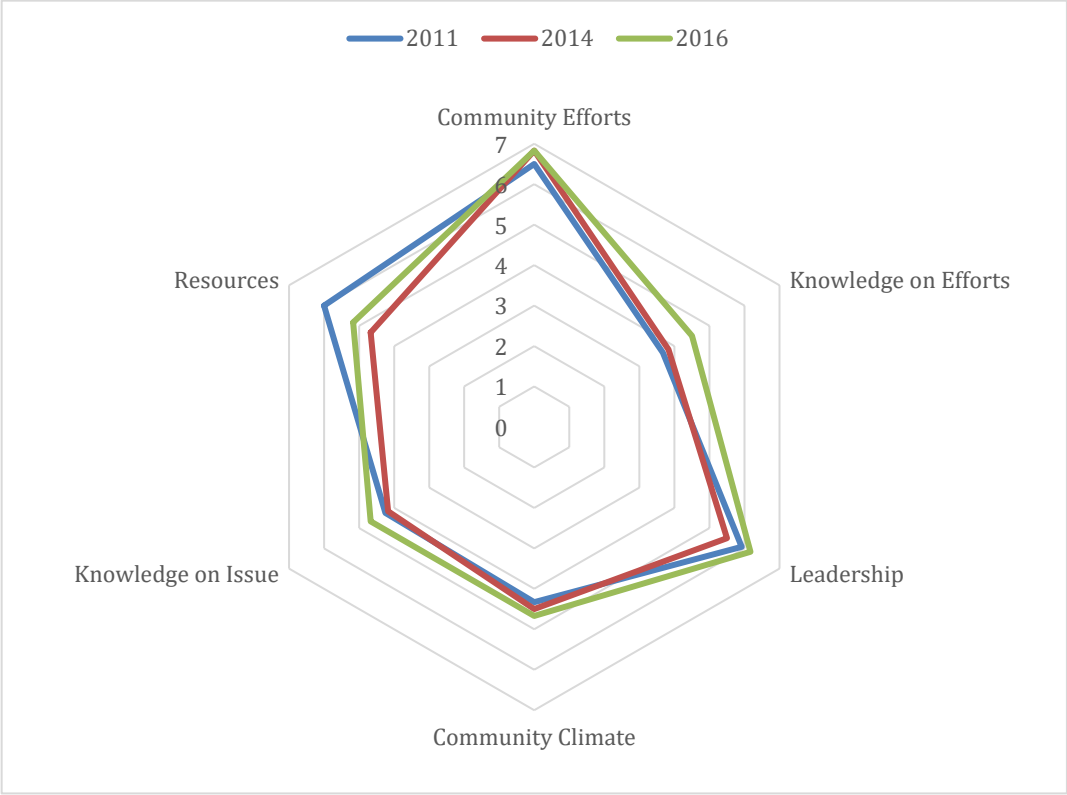

Figure 8: Glen Innes CR results 2011, 2014 and 2016 – healthy relationships

The highest scoring dimension was community efforts, followed by leadership. The lowest score was for the community knowledge of efforts dimension at all three assessments. The scores for the leadership and knowledge on the issue dimensions decreased between 2011 and 2014, and increased again in 2016. The score for resources was the highest in 2011 and scored lower in subsequent assessments. The following section reports the results of the CR assessments in 2014 and 2016 on the six dimensions of CR with quotes from interview participants.

Community efforts

The score for the community efforts dimension was the highest score of all dimensions at all three assessments. Participants described the efforts in the community to promote healthy relationships. One participant described the CM approach being implemented in the community:

> *There's definitely a visible coordinated effort through the HEART Movement, and so I think that's quite considerable. And I think they are going about it the right way as well, high visibility, grass roots, neighbourhood conversation by conversation, getting people as champions or change agents.* (HR3 2016)

Another participant said that local efforts had increased awareness about healthy relationships in the community:

> *It just seems in the last year this is the topic that is always coming up, through my work, through home, in the schools. So I definitely think our community they're aware of and wanting to know more about it*. (HR2 2014)

Despite the visible local efforts to promote healthy relationships, many participants said the biggest concern in the community was about the housing regeneration programme in Tāmaki:

> *The biggest issue for us in GI at the moment is obviously the* [housing] *transformation project and the impact of that on our vulnerable families and where the future lies for a lot of those vulnerable families. They* [TRC*] are putting supports in place, and they are genuinely concerned about the changes within the community.* (HR6 2016)

The thorough descriptions of local activity from participants supported the high score for this dimension.

Community knowledge of efforts

The score for the dimension knowledge of efforts increased at each assessment to stage 4 in 2016. However, the score was two stages of readiness lower than the score for the community efforts dimension, signalling that the knowledge of efforts was higher amongst the participants than the wider community. Some participants said that the focus on healthy relationships was a new focus:

> *It's* [healthy relationships] *not really a focus is it? Apart from the effort that the HEART Movement has pushed into the community, I think that's about the biggest effort we've had really.* (HR5 2014)

Some participants said that awareness was increasing as people learned about local efforts:

> *People who are actually coming out of the house to see what this is about and why HEART is running. When you explain it to them you can see them pause like 'oh ok'. So it's just getting the message out.* (HR1 2014)

Despite local efforts being in place, a number of participants noted that they did not reach everyone:

> *There's always lots of promotion around the people or services that can help, but there's still a lot of whānau who will say 'I didn't know', they stay in their own little worlds. It's that lack of knowledge. Or some people choose not to know.* (HR5 2016)

Participants were asked about the strengths of current efforts. One participant said that a key strength was that the community had developed its own approach to addressing the problem:

> *HEART was created from the community, it came out of a need from community.* (HR5 2016)

A number of participants said that the CM and positive approach were effective:

> *That they* [efforts] *are collaborative, that they're strengths-based, it's really well positioned because you're talking about the heart space or love compared to domestic violence and that it's very grass roots. It's very holistic, you've got a grass roots bottom-up behaviour change campaign going where individuals are starting to be the change that they want to see and encourage other people to change their behaviour, but at the same time there's efforts being done through policy and legislation that create the environment to help with that behaviour change. I feel like that's a really good way to go about addressing a social problem. Because if we just do one or the other, it's very hard to shift.* (HR3 2016)

This participant conveyed a thorough analysis of local efforts and the strengths of these efforts. They also described how the local bottom-up CM approach was supported by top-down nationwide efforts and identified this as a strength.

When asked about the weaknesses of current efforts rather than naming a weakness, a number of participants said they wanted more activity, more people involved, more youth focussed activity and more resources to increase local efforts. Some participants said that the collaborative approach was good, as often local organisations worked in isolation. However, participants did say collaboration was challenging:

> *Whilst it's collaborative and the intention is there, people are still working in their silos to a degree. The theory of change is really good, the implementation of it still isn't being done according to the game plan.* (HR3 2016)

This participant suggested more activity was needed to achieve the stated goals for stronger collaboration.

Leadership

The score for the leadership dimension was the second highest score in 2014 and 2016. Participants named a number of local people and organisations as leaders promoting healthy relationships. Participants said leaders were clearly concerned about healthy relationships and gave their support to local efforts:

> *They're real with their own life and relationships and sharing their stories and their journey so they're kind of agents of change in themselves, which is always a good thing. They're delivering activities or projects or events that focus on healthy relationships. A lot of them have supported the HEART kaupapa so you'll see a lot of these people on posters, or they've got the t-shirts they'll wear them at events.* (HR3 2016)

Participants highlighted the importance of leaders sharing their own stories of change and not hiding the challenges that they also faced. One participant said the leaders needed to be authentic if they were involved:

> *If those champions aren't congruent with what they say and do, they are not going to be respected and believed, and they're not going to have faith in the initiative.* (HR2 2016)

This participant said that authentic leadership was important not just for the individuals involved, but for the community efforts to promote healthy relationships as a whole.

Community climate

The score for the community climate dimension changed very little over the three assessments. Participants said that community members supported local efforts, but some said that making change was challenging. One participant articulated how difficult it was to have healthy relationships if people did not see people around them in healthy relationships:

> *So when there's a lack of role modelling in families and when that lack of role modelling is intergenerational, and when our youth are seeing that their parents are being disrespected and the same thing happened with their grandparents, they are going to treat the partners like that.* (HR2 2016)

Another recognised that when people are stressed with daily life it was challenging to get involved in local efforts to promote healthy relationships:

> *Sometimes it's just not a priority for some, other things are more important to them than that kind of stuff, feeding their kids is more important, trying to get a job is more important. And for some it's the mind set as well, especially if we are thinking intergenerational stuff*. (HR1 2014)

This participant acknowledged the importance of healthy relationships, but also the importance of enabling people to define what a healthy relationship was for them:

> *There's always huge support around promoting healthy relationships. But also there's a lot of education that has been done and still continues around accepting there's no one right way. There are different ways that people see healthy relationships.* (HR5 2016)

Participants identified many obstacles to having healthy relationships including abuse of alcohol and other drugs, family violence, poverty and mental illness. Some participants said that the negative impacts of the housing regeneration programme had affected engagement in other local efforts because of lack of trust:

> *Currently in this community there is mistrust because of what's happening here with the* [housing] *regeneration programme. Unemployment, self-esteem all that and generational behaviour is a big obstacle.* (HR5 2016)

> *We have a community now that is very sceptical of change, of what is happening, but we also have a sector of the community that really care.* (HR6 2016)

When asked about the overall feeling in the community about healthy relationships, participants said the feeling was mixed, but that there was some positive movement and questioning:

> *Personally, I think myself it's the best thing* [HEART] *that's ever happened in this community. I don't know how they* [the community] *think. And more community people are getting involved.* (HR1 2014)

> *I feel like there has been a shift so people are more aware of healthy relationships, and we're starting to get traction and movement towards the right direction, but I also know that people feel that there is a lot more to go, and we're not there yet. There is a bit of an attitude that we can do something about it.* (HR3 2016)

One participant acknowledged that for some, healthy relationships was not something they knew and raising awareness of healthy relationships was the starting point, but also that young people were keen to learn how to have healthy relationships:

> *The whānau that I work with* [in abusive relationships] *have very little faith in healthy relationships. The people that I work alongside, we're really trying to raise the awareness of the importance of healthy relationships. I know our youth are big on what healthy relationships look like.* (HR2 2016)

Knowledge about the issue

There was little change to the score for the knowledge about the issue dimension across the three assessments. Participants said that there was little knowledge around healthy relationships, and that people were questioning what healthy relationships really were:

> *Not knowledgeable enough. I think we've all got our own ideas about what a healthy relationship is, but sometimes what you thought was healthy actually isn't.* (HR2 2014)

> *Unhealthy relationships are very visible. There's not that much knowledge in the community around healthy relationships.* (HR2 2016)

Participants said that there was some information available on healthy relationships, but mostly on family violence. Some said that information about healthy relationships was available, but only people who were really interested were using it. Participants said the local efforts stimulated conversations about healthy relationships:

> *The HEART Movement, I know we are always pushing what a healthy relationship looks like. I certainly do. The community events, the t-shirts. Usually you get questions, what's HEART all about. So someone will usually bust out their version of what a healthy relationship looks like.* (HR5 2014)

However, most participants shared a view that the community had a long way to go to really understand what healthy relationships were.

Resources

The score for the resources dimension decreased between 2011 and 2014, then increased in 2016 to stage 5, but remained lower than the 2011 score. Participants said that people first turned to whānau/family and friends for help with healthy relationships if they thought they would be supportive, or elders and people they trusted. One participant said that while services are skilled, the community needed the skills too:

> *Need to train up your everyday Joe Blogs to have that knowledge and have that skill, so that when the person who is in a situation they turn to their friend or family that is skilled and doesn't need to refer.* (HR2 2014)

This quote articulates support for a CM approach that builds the capacity of community members to help each other. Participants said that local volunteers were running activities to promote healthy relationships, and that this had the potential to grow. Some participants said that the same group of volunteers were involved, whereas other said that there were different groups of volunteers that represented different parts of the community. When asked about

community and business support for efforts, participants said that support was growing but could be more consistent. One participant said that people in the community were supportive of local efforts:

> *Supportive and open minded and open to learning what this kaupapa is all about. I certainly haven't come across anyone when I've talked about HEART that they've been put off by it. I think it's a positive thing that people are open and willing to listen and just take it in, that's a good start.* (HR5 2014)

As with the score for resources for family violence, it is unclear why the 2011 score was higher than the 2014 or 2016 score for healthy relationship promotion.

Summary

The results of the ACMQ assessment in 2016 showed that the highest agreement was on the scale shared concern – family violence, followed by participation, organisation, shared concern – healthy relationships, leadership, critical consciousness, and the least agreement was on the social cohesion scale. The high agreement on the shared concern – family violence scale supports the documented concern about family violence in previous research (Dialogue Consultants, 2003; Liew et al., 2012), and suggests that family violence continues to be an important issue in Glen Innes.

The low agreement on items in the social cohesion scale is of interest. There are a number of possible reasons for the low score for social cohesion, and it is likely that a combination of factors contributed to this low agreement. For example, in the CR interviews, many participants spoke of concern about the TRC housing redevelopment programme. Where residents were forced to move homes or out of the community, this intervention was perceived to negatively impact on social connections. Participants said that this disrupted the intergenerational connections between families in the community. They also said that the TRC development had affected trust between people in the community. Other factors that may have contributed to the low social cohesion score include the long-term experience of social issues, crime, and inequalities in health, education and income.

The CR results showed an increase in readiness at each assessment for family violence prevention to stage 5 –preparation in 2016, defined as:

> Active leaders begin planning in earnest. Community offers modest support (Plested et al., 2006, p. 9).

The scores for the dimensions community efforts, leadership and resources decreased between the 2011 and 2014 assessments, and then increased again in the 2016 assessment. It is unclear what led to this result, but it is possible that participants overestimated the level of efforts, leadership and resources to support family violence prevention in 2011, and in later assessments had reflected more on this and reported less activity, or perhaps that their analysis of dedicated resources became more astute over time.

The results of the CR assessments on healthy relationships in 2011, 2014 and 2016 showed that the overall score decreased between the 2011 and 2014 assessment, and then increased again in 2016 also to stage 5 – preparation. The highest scoring dimension was community efforts, followed by leadership. The lowest score was for the community knowledge of efforts dimension at all three assessments. The scores for the leadership and knowledge on the issue dimensions decreased between 2011 and 2014, and increased again in 2016. The score for resources was the highest in 2011 and scored lower in the subsequent assessments. This result suggests that participants perceived there were more resources in the community to support healthy relationships in 2011, and that this perception changed in later assessments.

In both the family violence and healthy relationship CR assessments, the scores for dimensions knowledge of efforts, community climate and knowledge of the issue were lower than the scores for community efforts, leadership and resources. A distinction can be made between these two groups of dimensions. The 'active dimensions' include community efforts, leadership and resources which can be resourced and implemented, and the 'response dimensions' include knowledge of efforts, community climate and knowledge of the issue which assess how these efforts are received by the wider community. These results show that the response dimensions were lagging behind the active dimensions.

The ACMQ and CR assessments used different participant groups, and it is possible the results reflect the different knowledge and involvement of these two participant groups in local efforts. The ACMQ participants were community residents with no special knowledge of family violence prevention, whereas CR participants were key community informants involved in planning and implementing local activity. For example, the difference in ranking of the leadership domain in the ACMQ (4th) and CR family violence assessment (2nd) results suggest that the two tools assessed different levels of knowledge within the community. In both CR assessments, family violence prevention and healthy relationship promotion, the scores for the

community knowledge of efforts domain was two stages lower than the score for community efforts. This shows that the key informant participants were also aware that they had more knowledge about local efforts than residents.

Overall, ACMQ results showed that family violence was an issue the community was concerned about, and that low social cohesion may have affected the community's ability to mobilise to address this issue. CR results showed that readiness to prevent family violence and promote healthy relationships increased in Glen Innes. The case study also showed that there were bigger contextual factors at play, namely, a community history of deprivation and the current impact of a large-scale housing redevelopment intervention.

CHAPTER 7: RANUI CASE STUDY

> *"I think we'd love to live in a violence free community, but I think we know the reality, so I think there's a degree of sitting with that, being aware of it, and I think there is probably also a little bit of feeling that it's overwhelming."*
>
> *CR assessment participant 2016*

In this chapter a case study of the community of Ranui in Waitakere, West Auckland is presented. Ranui was chosen as an appropriate comparison community to study because it had a similar demographic profile to Glen Innes, and there was no planned family violence prevention initiative running in the community at the time the research began. The case study investigated CM and CR in the context of preventing family violence and promoting healthy relationships. As with the previous case study on Glen Innes, the purpose of the case study was to present the real-world community context that the ACMQ and the CR assessments were completed in, to use this contextual information to interpret the results and to investigate how community context impacts CM.

The Ranui community

History

Historically, Ranui was not settled by Māori or Europeans; it was a portage area for Te Kawerau a Maki and Ngāti Whātua iwi (Conway, Huckle, Jennings, & Witten, 2003). For many years, the area was seen as part of the wider Swanson and Henderson area, but had no name and was not a distinct community (Chow:Hill & Waitakere City Council, 2008). It was not until 1925 that the name Ranui, meaning "much sun", was formally used for the area when a new railway station was built (R. Evans, 2016). There are many understandings of how Ranui was named, but the name was not given by Te Kawerau a Maki and Ngāti Whātua iwi (Conway, Huckle, et al., 2003). Local memory offers possible ways the name Ranui was adopted including that it was suggested by local Pākehā families, it was named after a land development company in the area (R. Evans, 2016), or a large local orchard, or as a result of a newspaper competition (Conway, Huckle, et al., 2003).

The area was settled by Māori, and later Croatian and Dutch migrants in the late 19th century (Conway, Huckle, et al., 2003; MacDonald & Kerr, 2009). Early industry centred on kauri milling and gum digging, and later agriculture, horticulture and viticulture became the dominant

industries (J. Adams, Witten, & Conway, 2009; Conway, Huckle, et al., 2003). After World War I, returning soldiers were given blocks of land to farm, and by the 1940s it was an established rural area (R. Evans, 2016). Due to the small size and isolation of the area, there was a history of local residents working together to address local issues (R. Evans, 2016). Suburban development began after World War II (R. Evans, 2016). It was a low-cost housing area, with a high proportion of state housing (Conway, Huckle, et al., 2003). The population grew significantly during the 1960s and 1970s, but the community was geographically isolated and lacked support services and recreational facilities (MacDonald & Kerr, 2009). By the early 2000s, Ranui was mainly suburban, with some rural areas remaining (Conway, Adams, & Witten, 2003).

Demographic profile

The population of Ranui was 11,253 in 2013 (Statistics New Zealand, 2013). It was a young community with 27%of the population aged less than 15 years old, compared to 21% for the Auckland region. The largest ethnic group was New Zealand European (44%) followed by Pacific peoples (28%), Māori (19%), Asian (15%), MELAA (2%), and Other (>1%). Ranui had larger Pacific and Māori populations, and smaller European and Asian populations than the Auckland region. Thirty-one percent of the community were born overseas (Statistics New Zealand, 2013). Ranui was a low socioeconomic community (Atkinson et al., 2014; Wellington School of Medicine, 2014). The average personal income for people aged over 15 years was NZD$22,950, which was lower than the average across the Auckland region (NZD$29,600) (Statistics New Zealand, 2013) (see Chapter 5 for further detail).

Community strengths and challenges

In this section, community strengths and challenges that have been identified through local research are presented to provide context and support the interpretation of the findings later in this chapter.

Ranui was the site of two connected government funded health and wellbeing initiatives in the early 2000s, which are presented in the next section. As part of the research and evaluation that supported these initiatives, Adams et al. completed two comprehensive surveys of social cohesion in Ranui, first in 2001 and again in 2004 (J. Adams, Witten, Woodson, Bala, & Huckle, 2005). The survey involved structured telephone interviews conducted with a representative

sample of the community (n=458 in 2001; n=423 in 2004). Adams et al. (2005) found that the majority of residents felt Ranui was a good and safe place to raise children, that the community was well-connected, that people were friendly and would help one another. At that time, the majority of residents also reported pride in their community, sense of belonging and social cohesion, particularly amongst Pacific peoples and long-term residents.

Some local challenges have also been identified through research in Ranui. In the early 2000s, a profile of the community was completed by Conway et al. (2003). The research used a literature review and semi-structured interviews with 25 key community informants to identify local issues. The most significant issues at that time were related to health inequalities and housing issues. Housing issues identified included low quality housing, issues with overcrowding and associated health problems, infestations and lack of insulation (Conway, Huckle, et al., 2003). The need for affordable housing for people on low incomes, and better quality short-term accommodation have also been documented (Thornley, 2008).

Other challenges that have been identified include high numbers of residents on benefits, concerns about community safety, transient students, financial stress and lack of recreational resources for young people. Concerns about family violence were documented in the early 2000s—at that time, police estimated family violence accounted for half of all reported violent assaults in Ranui (Conway, Huckle, et al., 2003; Waitakere City Council, 2002); however, no other documentation of this issue was available. In 2005, community safety was identified as a concern, particularly safety walking at night, the number of crimes in Ranui, and graffiti and vandalism (J. Adams et al., 2005).

Community development

This section describes collaborative multi-year CD initiatives that have been implemented in Ranui in recent years. The purpose of this section is to demonstrate the focus of the work of local community organisations, and the impact of this work where evidence was available. This contextual information is used to aid in interpretation of the findings later in this chapter, and to compare the two case study communities in Chapter 8.

Ranui Action Project

Ranui was identified by the Ministry of Health in 2000 as a site for the Intersectoral Health Initiative, which included funding for a public health and CD approach that addressed the

determinants of health and reduced health inequalities (Conway, Adams, et al., 2003). Later that year, the Department of Child, Youth and Family chose Ranui as a site for the Stronger Communities Action Fund (SCAF) initiative, and funded the community for six years devolving decisions about local social services to the community to strengthen community participation and capacity, and reduce social exclusion (Conway, Adams, et al., 2003).

These two funding initiatives led to the establishment of a CD initiative in Ranui in 2001 called the Ranui Action Project (RAP). The Ministry of Health and SCAF priorities were incorporated into the RAP action plan that focussed on health participation and CD (J. Adams et al., 2009). RAP involved local community members and organisations in planning (J. Adams et al., 2005), which started with the Futures Creation Festival in August 2001 and involved around 400 community members sharing their aspirations for their community (J. Adams et al., 2005). Along with this process, a community profile (Conway, Huckle, et al., 2003), and a social cohesion survey (J. Adams et al., 2005) contributed to the development of the Ranui Action Plan in 2002. The activity involved a wide range of projects and initiatives focussed on youth development; public safety; health and social services; educational opportunities; environment; employment and economic development; and, community pride, vitality and identity (Waitakere City Council, 2002).

In 2001, a violence prevention initiative began in Ranui called Violence Free Ranui, which was run by Violence Free Waitakere in partnership with RAP (Conway, Adams, et al., 2003). Violence Free Waitakere chose to work in Ranui as it had high rates of crime and violence, and a negative image because of this (Dyer, 2017). The initiative did not have a specific focus on family violence initially, rather on preventing violence generally and fostering positive perceptions of Ranui. The initiative began with a community awards project and community initiatives to promote a culture of non-violence, and later developed into running family violence specific programmes. These included the Alternatives to Violence programme for adults, and a school-based programme called Violence Free Begins with Me, which was run intensively in Ranui schools until 2005 (Dyer, 2017; Violence Free Communities, 2017).

Research shows that RAP built a reputation as a dynamic, connected community initiative that built community capacity and used an inclusive approach to involve community members from the beginning (J. Adams et al., 2005). An evaluation of RAP showed the initiative had successfully achieved the following: developed a strong identity for the project locally and

nationally; funded and supported a large number of community initiatives; engaged youth; worked towards sustainability; secured funding and other resources; and, engaged the community (Conway, Adams, et al., 2003). RAP continues to operate in Ranui; however, there are no recent research or evaluation reports on the activity.

Back2Back

Back2Back was a project run in Ranui and Massey (an adjacent suburb), to increase neighbourhood-led initiatives and development. It was developed by the local organisations of Massey Matters, RAP, Community Waitakere, Waitakere City Council, and the national organisation Inspiring Communities. Back2Back was funded for three years by the Department of Internal Affairs Community Development Worker Scheme in 2008 (Chilcott, 2012). The project aimed to improve housing conditions, foster active and vibrant streets, support skill development and local employment, improve food choices, connect people to care for the natural environment, and increase pride and community connection through neighbourhood-led initiatives and development (Chilcott, 2012). Back2Back ran for four years and became well known for fostering collaboration and the number of diverse initiatives it supported to address neighbourhood concerns (Inspiring Communities, 2013). An evaluation showed that Back2Back effectively encouraged neighbours to work together to address local concerns, and develop neighbourhood connections and activities (Chilcott, 2012).

Social sector trial

During the study period the main focus of collaborative work in Ranui was on young people. Ranui was selected by the government in 2013 as one of 11 sites around New Zealand for the Social Sector Trials intervention to trial new approaches to social service delivery (New Zealand Blue Light, 2013). In Ranui, the focus was youth aged 12–18 years and the outcomes sought were to reduce truancy, offending, drug and alcohol use, and to increase engagement in education, training and employment. Further documentation was not available on this initiative.

Activity during the study period

In this section, a description of the activity in Ranui to prevent family violence and promote healthy relationships during the study period is provided. There was no planned initiative to prevent family violence or promote healthy relationships, which is one of the reasons Ranui

was chosen as a comparison community. However, during the study period, there was some family violence prevention activity in the community which is documented in this section. While other activities ran during this time, such as a community network meeting focussed on family violence, these were not documented, and there was no specific initiative or funding to support these activities.

Response to local homicides

During the study period, there were three homicides in Ranui in one week. Two of these homicides were family violence[3], where a man killed his wife and daughter. In response to the homicides, the community held a candle lit vigil[4] in memory of the two women killed, and developed two youth focussed initiatives. One initiative was a community haka (ceremonial Māori dance) developed by local leaders to reinforce community pride and share the dreams and aspirations of the community. The haka was learnt and performed by local school children. The second initiative engaged youth in a film project and asked them what they liked and did not like about their community, and what they would change. It is not possible to document the many other responses to these deaths including media, and perhaps most important, conversations amongst community members.

Behind Closed Doors exhibition

In November 2015, the Waitakere family violence prevention network, WAVES (Waitakere Anti Violence Essential Services[5]), curated an exhibition in Ranui Library for White Ribbon Day, an international day that asks men to stand up against violence against women[6]. The exhibition was called *Behind Closed Doors*, and was designed to raise awareness of the hidden nature of domestic violence using a collection of doors each painted by a different artist to show the many aspects and impacts of domestic violence.

While there may have been other activity to prevent family violence or promote healthy relationships, the exhibition was the only documented activity during the study period.

[3] A 23-year-old man was killed in a double shooting on 21 May 2014. This death was not family violence related.

[4] http://www.stuff.co.nz/auckland/local-news/western-leader/10085584/A-vigil-for-unity-in-Ranui

[5] WAVES began in 1993 to support victims of family violence. Since the early 2000 the focus of WAVES work is on advocacy, training and professional development, prevention initiatives, and research (WAVES Trust, 2017).

[6] http://www.stuff.co.nz/auckland/local-news/western-leader/74206183/antiviolence-exhibition-opens-doors-on-hidden-issue

Results

In the previous sections, the community context was presented. In the following sections, the results of the CM and CR assessments are reported.

Community mobilisation results

In this section, the results of the CM assessment using the ACMQ in Ranui are reported. See Chapter 4 for methods and Chapter 5 for development of the ACMQ.

There were 89 participants in the ACMQ assessment. Of these, 56.2% of participants reported their gender as female, 42.7% as male and 1%as other. The age range of participants was 16–71 years and the mean age was 39.23 years. Participants reported their ethnicity as Māori (55.7%), Pākehā (25.0%), Pacific peoples (15.9%), Other (2.3%) and Asian (1.1%).

The mean item scores were calculated for each of the ACMQ domain scales (see Table 29). The scores ranged from 1=lowest agreement to 3=highest agreement. As can be seen in Table 29, there was little variation in the mean item scores across the scales, with scores reflecting a generally positive response to items in each scale.

Table 29: Mean item scores and standard deviations for each of the ACMQ scales

Domain scale (number of items)	M	SD
Leadership (5)	2.45	0.602
Participation (12)	2.38	0.718
Organisation (5)	2.41	0.624
Critical consciousness (11)	2.32	0.651
Shared concern – family violence (10)	2.40	0.633
Shared concern – healthy relationships (9)	2.29	0.653
Social cohesion (6)	2.38	0.592

In the following sections, analysis of the item responses is reported.

Participant responses to the leadership scale (see Table 30) showed high agreement, especially on items about leaders promoting healthy relationships and speaking out against family violence.

Table 30: Distribution of responses to ACMQ leadership scale items

Leadership (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
Leaders in Ranui speak out against family violence	54.0	40.2	5.7
Leaders in Ranui promote healthy relationships	54.5	39.8	5.7
Leaders in Ranui are role models of healthy relationships	52.3	44.3	3.4
Community leaders are able to represent all sectors of the community	52.9	40.2	6.9
Community leaders are able to manage inter-group conflict within the community	40.2	52.9	6.9

The responses to the participation scale (see Table 31) show that highest agreement was for the items 'I know people in healthy relationships' and 'I see people in healthy relationships'. Eleven percent did not agree at all that there had been activity about family violence in the community, and 13% did not agree at all that information about where to get help for family violence was available. Nineteen percent did not agree at all that they had done something to prevent family violence. Before answering the participation scale, respondents were asked if they knew about activity in the community to prevent family violence of promote healthy relationships; 48% said yes and 52% said no.

Table 31: Distribution of responses to ACMQ participation scale items

Participation (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in Ranui	46.3	42.6	11.1
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in Ranui	41.5	49.1	9.4
I have done something to help to prevent family violence in Ranui	38.9	42.6	18.5
Information (e.g. booklets, training) about family violence is available in Ranui	41.5	49.1	9.4
The available information about family violence is useful	53.7	40.7	5.6
Information (e.g. booklets, training) about where to get help for family violence is available in Ranui	45.3	41.5	13.2
Information (e.g. booklets, training) about healthy relationships is available in Ranui	43.4	47.2	9.4
The available information about healthy relationships is useful	51.0	43.1	5.9
Information (e.g. booklets, training) about where to get help for healthy relationships is available in Ranui	49.1	41.5	9.4
The available information about where to get help for healthy relationships is useful	51.0	41.2	7.8
In Ranui I know people in healthy relationships	59.3	31.5	9.3
In Ranui I see people in healthy relationships	57.4	33.3	9.3

The responses to the organisation scale (see Table 32) showed the highest agreement to the item 'The support people get from services helps them to make healthy relationships'; however, this item also had the highest disagreement on this scale. Before answering the organisation scale in 2016, participants were asked if they knew about services in Ranui that helped people to prevent family violence or make healthy relationships; 49% said "Yes" and 51% said "No".

Table 32: Distribution of responses to ACMQ organisation scale items

Organisation (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
In Ranui we have the services we need to help to prevent family violence	47.8	47.8	4.3
In Ranui we have the people with the skills to help to prevent family violence	46.7	46.7	6.7
The support that people get from services for family violence helps to keep them safe	43.5	50.0	6.5
When people need help to make their relationships healthier the services in Ranui work together well	45.7	47.8	6.5
The support that people get from services helps them to make healthy relationships	55.6	33.3	11.1

On the critical consciousness scale, the highest agreement was for the item 'People are open to hearing different views about community problems and solutions' (see Table 33). Participants showed high agreement that people volunteer to help solve problems and that leaders continued to find solutions when previous efforts had failed. Sixteen percent of respondents did not agree at all that people talk to each other about how to solve community problems. The agreement was lower on items that were specific to addressing family violence, than to items that were about critical consciousness generally.

Table 33: Distribution of responses to ACMQ critical consciousness scale items

Critical consciousness (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Ranui talk to each other about how to solve community problems	30.2	53.5	16.3
People in Ranui enjoy discussing different ways to solve community problems	38.6	53.0	8.4
People in Ranui are open to hearing different views about community problems and solutions	54.1	36.5	9.4
People in Ranui volunteer to help solve community problems	51.2	38.1	10.7
People in Ranui think about why family violence happens so they can address the cause of the problem	37.6	48.2	14.1
People in Ranui not only talk about family violence but they also try to prevent it	38.8	47.1	14.1
People work together to solve problems in Ranui	39.3	53.6	7.1
There is a lot of cooperation between groups in Ranui	40.5	48.8	10.7
If your community fails to resolve a community problem, they will try another different approach to solving the problem	40.5	50.0	9.5
If your community fails to resolve a community problem, they will learn from that experience and do a better job when they try to solve the problem in the future	46.5	46.5	7.0
If leaders in Ranui fail to resolve a community problem, people will work together to find a solution	51.2	40.7	8.1

Responses to the shared concern – family violence scale (see Table 34) showed that 72% of respondents agreed a lot to the statement 'People in Ranui consider family violence an important issue', and 67% of respondents agreed a lot that family violence impacts the community. However, 21% of respondents did not agree at all that people talked openly about the issue, and 17% did not agree at all that family violence was talked about in community meetings.

Table 34: Distribution of responses to ACMQ shared concern – family violence scale items

Shared concern – family violence (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Ranui are concerned about family violence	55.1	39.3	5.6
People in Ranui consider family violence an important issue	71.9	21.3	6.7
People in Ranui talk openly about family violence	34.1	44.3	21.6
People in Ranui believe that family violence impacts the community	66.7	31.0	2.3
People in Ranui talk about family violence at community meetings	33.7	48.8	17.4
People in Ranui work together to prevent family violence	48.9	43.2	8.0
People in Ranui take family violence seriously	61.6	34.9	3.5
People in Ranui believe they can prevent family violence	41.4	51.7	6.9

People in Ranui exchange information about family violence	36.4	48.9	14.8
People in Ranui work together to reduce the effects of family violence	44.3	45.5	10.2

On the shared concern – healthy relationships scale, 62% of respondents agreed a lot that healthy relationships impact the community (see Table 35). Eighteen percent did not agree at all that people talk openly about healthy relationships, and 20% of respondents did not agree at all that people exchanged information about healthy relationships. These results indicate that community concern about family violence was greater than concern about healthy relationships.

Table 35: Distribution of responses to ACMQ shared concern – healthy relationships scale items

Shared concern – healthy relationships (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Ranui are concerned about healthy relationships	42.7	51.7	5.6
People in Ranui consider healthy relationships an important issue	46.0	49.4	4.6
People in Ranui talk openly about healthy relationships	36.0	46.1	18.0
People in Ranui believe that healthy relationships impact the community	61.8	33.7	4.5
People in Ranui talk about healthy relationships at community meetings	36.0	47.7	16.3
People in Ranui work together to promote healthy relationships	36.4	48.9	14.8
People in Ranui believe they can promote healthy relationships	45.5	48.9	5.7
People in Ranui exchange information about healthy relationships	32.6	47.2	20.2
People in Ranui take healthy relationships seriously	51.7	36.0	12.4

Scores on the social cohesion scale showed that 58% agreed a lot that people were willing to help their neighbours, and 46% agreed a lot that people look out for each other (see Table 36). The highest disagreement was to the item 'People shared the same values', with 11% of participants responding that they did not agree at all. Disagreement on the willingness to help and get along well items was very low, with just 1% responding that they did not agree at all to these items.

Table 36: Distribution of responses to ACMQ social cohesion scale items

Social cohesion (n=89)	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)
People in Ranui are willing to help their neighbours	58.0	40.9	1.1
People in Ranui can be trusted	38.6	52.3	9.1
People in Ranui generally get along well with each other	43.8	55.1	1.1
People in Ranui share the same values	36.0	52.8	11.2
People in Ranui look out for each other	46.1	47.2	6.7
This is a close-knit community	42.9	49.4	7.8

The results of the ACMQ assessment show high agreement on the leadership scale despite no planned or formal efforts to address family violence. This suggests that the ACMQ is able to assess informal efforts of leaders and this result will be explored further in later chapters. Results show that while agreement on organisation, shared concern – family violence, social cohesion and participation scales was at a similar level, agreement on the critical consciousness and shared concern – healthy relationships scale was lower. This indicates discussion in the community about how to address complex issues and the focus on healthy relationship were less developed in Ranui than the other aspects of CM.

Community readiness

In this section, the results of the CR assessments that measured the readiness of the Ranui community to prevent family violence and promote healthy relationships are reported. CR assessments were completed in 2014 and 2016 (see Chapter 5). The family violence assessment results are presented first, followed by the healthy relationships assessment results. Each dimension of CR is reported and quotes from the CR assessment participants in 2014 and 2016 are used to provide context to the CR scores, and insight into the participant's understanding of these issues. For a description of the CR assessments, the stages of community readiness and definitions of the dimensions of community readiness, see Chapter 5.

In the CR assessments, participants were asked to describe the community of Ranui. A number of participants expressed pride in their community and said it was a vibrant place with talented people who were innovative and resourceful. One participant said:

> *Tight community, well-connected. Proud of their place. Multicultural. I would say that it's quite vibrant at the moment, we've got a new café. And I'd say that there is a creative core here. And I would say they're caring in the community as well.* (FV4 2016)

Some participants described the new facilities that had recently been built in a development of the town centre as a source of pride and positivity. Participants said that these developments had made a notable positive difference to the community:

> *Now we have the library, the medical centre, the new supermarket, and the renovated community house with lots of things going on, it's really come alive and very positive, and I think that does a lot for people feeling connected.* (HR6 2016)

> *Personally I think it's a cool place to live. There's a lot of change and a lot of growth, a lot of development that's occurring. I think that historically it's been one of the last places people want to land, and I think it's changing a little bit. People are becoming a little bit proud and a little bit hopeful you know about their community now with all the changes and all the opportunity that's emerging.* (HR3 2016)

These positive developments had made a difference to how local people thought about their community, and also how they felt about the negative perceptions that outsiders had of the community. One person said:

> *Outside Ranui people think it's quite a bad place, but it's just a name it got itself. It's really changed here because people have got something they can claim a belonging to, and can be proud of.* (HR2 2016)

Participants said that more recently, things had changed for the better, and that the past and current challenges the community faced had developed resilience and passion in the people to make the community better.

Family violence

In this section, the results of the CR assessments in 2014 and 2016 on family violence are reported (see Table 37and Figure 9))see Chapter 5 for the stages of readiness and definitions). The results show that overall readiness to address family violence increased between 2014 and 2016, from stage 3 – vague awareness to stage 4 – preplanning. Preplanning is defined as:

> There is clear recognition that something must be done, and there may be local efforts addressing it. Efforts are not focussed or detailed (Plested et al., 2006, p. 9).

Table 37: Ranui CR results comparison 2014 and 2016 – family violence

Dimension	Scores and stage of readiness	
	2014	2016
Community efforts	4.17 – Preplanning	5.67 – Preparation
Community knowledge on efforts	2.83 – Denial/Resistance	4.00 – Preplanning
Leadership	3.67 – Vague awareness	3.17 – Vague awareness
Community climate	3.00 – Vague awareness	4.17 – Preplanning
Knowledge on issue	3.00 – Vague awareness	4.00 – Preplanning
Resources	3.50 – Vague awareness	3.67 – Vague awareness
Overall stage of readiness	3.36 – Vague awareness	4.11 – Preplanning

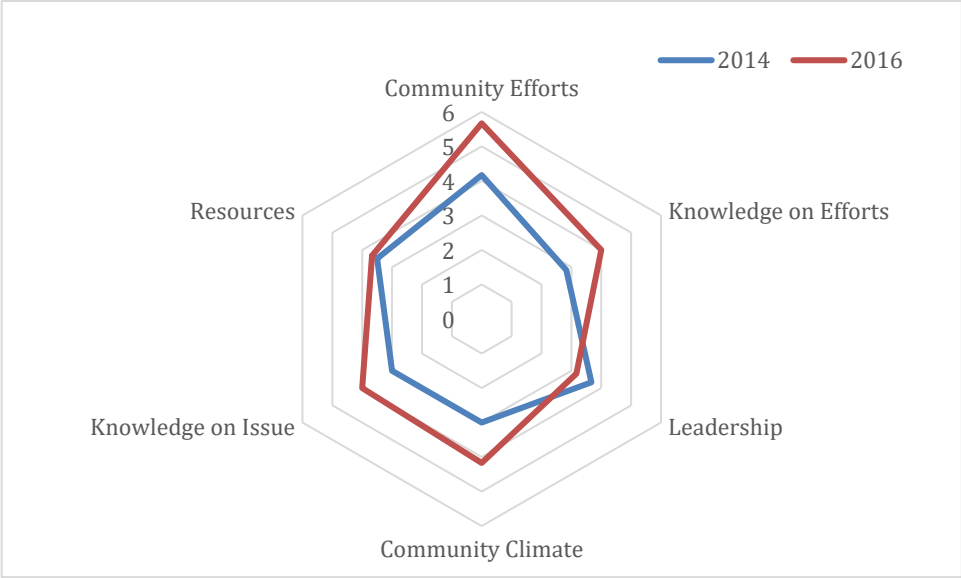

Figure 9: Ranui CR results 2014 and 2016 – family violence

There were increased scores for the dimensions of readiness of community efforts, knowledge of efforts, community climate, knowledge on the issue, and a slight increase on resources. The score for the leadership dimension decreased slightly between 2014 and 2016. The results on each of the six dimensions of CR are reported below in more detail, and quotes from interview participants are used to provide context to the dimension scores.

Community efforts

The community efforts dimension had the highest score of all dimensions in both CR assessments. The score for community efforts increased from stage 4 in 2014 to stage 5 in 2016. Interview participants said that family violence was a big concern in Ranui. During the 2014 CR assessment, three homicides occurred in the community and the local concern was evident in participants' comments:

> *We've had a shooting here, and a couple of days ago two people got killed. We hear the Police going past here every day.* (FV3 2014)

> *Increasingly people are shocked by what's going on around them in Ranui. Someone just said to me today 'The helicopter's out there and a few days ago there was that* [homicides]*, what's happening to Ranui?' So I think increasingly people are becoming concerned probably more than concerned, they're fearful, and I think really I think people are getting to the stage they welcome any actions that are going to increase their safety.* (FV3 2014)

The high level of concern about the homicides was evident in people's responses, as was the stress and fear that these deaths had caused across the community. The shock of these homicides was reported by many participants in 2014 and prompted a response from the community:

> *There was a community vigil to recognise and acknowledge about the violence* [homicides]*, it was about It's not OK for what happened, it was about anti-violence, it was also about relationships between families, children, neighbours. It was also about support, what kind of supports across the community as well as from other groups.* (FV5 2014)

However, participants reported that there were no family violence services within the community, and that services came in from outside the community when needed. Participants said there were no ongoing efforts to address the problem apart from White Ribbon Day:

> *Not specifically. I mean we have White Ribbon Day, which is something we do annually now and we work with the Police who come in and have a BBQ at the library. But no, nothing that is our kaupapa.* (FV4 2016)

Despite the lack of local efforts, the concern in the community was clearly high. In 2016, one participant said that there was greater awareness of the issue:

> *It's a real necessity now, everybody's taking a look at it. It's been a concern for us in the community and local bodies, and the local Police, it's a shame.* (FV2 2016)

Despite the limited ability of participants to name specific local efforts, the score for this dimension increased. It is possible that conversation in the community and media following the homicides in 2014 contributed to this.

Community knowledge of efforts

The score for the community knowledge of efforts dimension was the lowest score in 2014 assessment at stage 2; however, in 2016 the score increased to stage 4. In both assessments

participants said that they thought community members only found out about services when they needed them, and that there was a lack of awareness in the wider community:

> *I think they're very reactive, it's not until your back is up against the wall and you're absolutely desperate.* (FV5 2014)

> *It's mainly the recipients of social services that would be aware of them, mostly I think people are aware of what the Police are doing rather than what the social services are doing. If it doesn't affect them, then they don't know.* (FV1 2016)

Participants also said there was very little information about services and efforts visible in the community. One person said:

> *I don't know what the community knows about it, you might know that an organisation exists, but what you know about that organisation and how it works and what's available*. (FV4 2016)

Despite participants' perceptions of low awareness in the community, the higher score for this dimension in 2016 indicates that awareness of local efforts increased between assessments.

Leadership

Between 2014 and 2016 the score for the leadership dimension decreased slightly. Participants named a number of local people and organisations who were leaders in the community. They said that the concern of local leaders about the community was high, but their comments were broad rather than specific to leadership on family violence:

> *My impression of the leaders is that all of them have a great concern for the community, for the wellbeing of people, and they recognise that they are in a position of responsibility and a position where they can make a difference, and if they can make a difference, they will.* (FV3 2014)

Despite the praise for local leaders generally, and the clear recognition that family violence was a concern for leaders, participants were not able to describe organised efforts of leaders to address the problem.

Community climate

The stage of readiness on the community climate dimension increased between assessments from stage 3 in 2014 to stage 4 in 2016. In both CR assessments, participants shared the view that family violence was tolerated to some extent because it was a norm:

> *If you've grown up seeing it, you're more able to tolerate it. It's become a norm.* (FV5 2016)

This was a common view amongst participants. However, one participant said there was no tolerance for family violence for them and the people they knew:

> *No definitely not for people that I know or that I'm around. Violence shouldn't be tolerated at all*. (FV4 2014)

This was the only participant to share this view. Participants shared a number of obstacles they said contributed to not addressing family violence. Some said the obstacles were social norms against talking about family violence and that it was a normalised way of being. People also said that there was a lot of shame and fear about naming the issue as described by this participant:

> *Silence, fear, fear of retribution, fear of people losing each other. Fear is a big one. Fear of being hit again. Fear of cops. Fear of CYFs, and children being taken away. Drug addiction that's a bloody great obstacle at times. Financial is an obstacle. Lack of hope is an obstacle. Crap housing conditions, manifests as a huge precursor*. (FV3 2016)

Other participants said that the community lacked resources and services and this was an obstacle to change:

> *Lack of resources around family violence, lack of services being visible or accessible to our families. They* [services] *only appear when it does happen, they don't appear to try and prevent it.* (FV4 2014)

For some, the lack of response when violence was seen or known about was the biggest obstacle. People said:

> *The biggest problem for the people in Ranui is that they conform to the way people are, if they see no one reacting to family violence then they wouldn't do it. They'll just walk past.* (FV4 2014)

> *Bystanders, you know just watching and not doing anything about it. I reckon that's the biggest obstacle to face.* (FV5 2016)

One participant said that community members were less willing to act now than in the past, because of fear of what could happen to them if they intervened:

> *If there were arguments next door, you weren't frightened to step in, whereas today if someone is getting beaten up next door you pull the blind down and pretend it's not happening.* (FV1 2016)

One participant thought that there was less family violence in the community than in the past:

> *They say the violence in our community used to be diabolical, but now we're all trying to strive to make it a safe community.* (FV1 2014)

However, most participants said family violence was still a big issue that was not spoken about:

> *They do know that it's* [family violence] *big in our community, but no one wants to come forward because they believe that it could affect their family, and they don't know much information about family violence or the support that they have.* (FV4 2014)

In 2016, participants articulated an understanding of the challenge of addressing family violence and that understanding this challenge was a barrier in itself:

> *I think we'd love to live in a violence free community, but I think we know the reality, so I think there's a degree of sitting with that, being aware of it, and I think there is probably also a little bit of feeling that it's overwhelming.* (FV4 2016)

> *It's not acceptable, but it's a problem and there are not always easy solutions. Often is intergenerational.* (FV3 2016)

Participant responses to questions on community climate showed understanding of the issue and the obstacles to addressing it, including social norms, silence and fear, lack of resources and lack of response from community members and services to family violence.

Knowledge on the issue

The level of readiness for the knowledge on the issue dimension increased between assessments from stage 3 in 2014, to stage 4 in 2016. In 2014, participants shared a range of views on community awareness of the issue, from having no knowledge to being very knowledgeable. One person said there was limited understanding of the impact of domination and bullying in the home:

> *I think some people would be surprised. There are the outrageous acts of violence that attract media attention, but within a home, domination or bullying they may think that's a fact of life, I'm the boss of this house, there may not be such an awareness of that aspect.* (FV3 2014)

This participant referred to the normalisation of some forms of family violence that went largely unnoticed. However, in 2016 some participants thought that awareness was growing:

> *There have been some very effective ads on TV so I think there is increasing awareness. People have been reluctant to report anything until it gets to a serious stage, but now I think they are looking for help earlier, especially women, they were prepared to take the bashings and the abuse.* (FV1 2014)

Despite this, people said that information about family violence was not easy to obtain and had to be sought out. Television advertising and media were mentioned most as effective strategies as they reached people in their homes. One participant said that practitioners had received some training on family violence, but said that learning about risk could make people uncertain about how to act safely:

> *There's a lot of caution and there's a lot of risk that we get taught about, sometimes I think that that can be paralysing.* (FV4 2016)

Participants were unsure about where to get local data on family violence, and one had concerns about police not being able to share data:

> *The police tell us that the stats are going down, but I'm not sure. You can ask the Police, but they say we're not allowed to tell you.* (FV3 2014)

While there were mixed views about how and where people got information about family violence, many participants agreed that people knew about it from their own experience:

> *I think we are quite knowledgeable, but I think the knowledge comes from experience, it might be personal experience or experience within your own whānau. So, what I'm saying really is that there's no one who has not been touched by family violence in some way or form.* (FV4 2016)

Participant responses showed mixed perceptions about the level of knowledge in the community about family violence. While there was agreement that people knew about violence from their own experiences, the information and training that was available did not seem to be very accessible or helpful to community members or practitioners.

Resources

The score for the resources dimension increased slightly between assessments. Participants said that the first resources people accessed for help with family violence were friends, family and local organisations, including the RAP House or the Baptist Church, and police if it was serious. Participants said that people went to family and friends first because they could trust them. This one participant said that people were uncertain about going to services because they did not know much about how services could help:

> *Family members, because they have a close relationship with that person, and sometimes trusting services is the problem, because services aren't visible, they question how they will help the individual*. (FV4 2014)

Most participants said that the level of training and expertise in the community to address family violence was moderate to high. However, people noted that while Ranui was a community where people volunteered a lot generally, there was no specific volunteering for family violence because of perceived safety issues. Likewise, there were few local resources named that were dedicated to the family violence in Ranui. Participants said that community members sought help from family, friends and local organisations, and most had positive perceptions of the skills of local organisations. Participants could not name other aspects of the resources dimension such as planning for future efforts, funding, or evaluations of current efforts, which led to a low score for this dimension.

Healthy relationships

CR assessments measured the level of readiness in the Ranui community to promote healthy relationships in 2014 and 2016. The results of the assessments show that readiness increased between assessments to stage 4 – preplanning in 2016 (see Table 38 and Figure 10). Preplanning is defined as:

> "There is clear recognition that something must be done, and there may be local efforts addressing it. Efforts are not focussed or detailed." (Plested et al., 2006, p. 9)

Table 38: Ranui CR results comparison 2014 and 2016 – healthy relationships

Dimension	Scores and stage of readiness	
	2014	2016
Community efforts	4.17 – Preplanning	5.83 – Preparation
Community knowledge on efforts	2.67 – Denial/Resistance	3.67 – Vague awareness
Leadership	4.17 – Preplanning	3.83 – Vague awareness
Community climate	4.00 – Preplanning	4.33 – Preplanning
Knowledge on issue	3.00 – Vague awareness	3.83 – Vague awareness
Resources	3.67 – Vague awareness	4.17 – Preplanning
Overall stage of readiness	3.61 – Vague awareness	4.28 – Preplanning

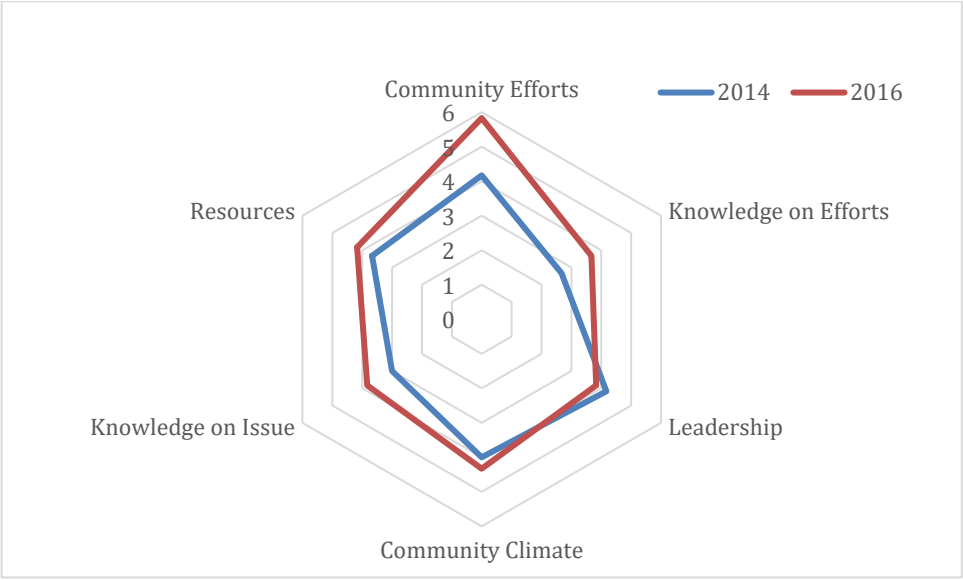

Figure 10: Ranui CR results 2014 and 2016 – healthy relationships

Scores increased on all of the dimension of readiness between the assessments, apart from leadership which decreased slightly (see Table 38). The results on each of the six dimensions of CR are reported below in more detail, and quotes from interview participants are used to provide context to the dimension scores.

Community efforts

The score for the community efforts dimension increased between assessments from stage 4 in 2014, to stage 5 in 2016. Participants said the local approach was subtle, small-scale and about bringing the community together:

> *I think it's more subtle to be honest, the way that we do things. I don't think it's like out on a billboard kind of thing. Social media that goes on in and around the things we do like events, geared more towards coming together, our community has recognised the importance of being together.* (HR3 2016)

> *I think a lot of the work is on quite a small-scale, like underground. There's a lot of small little things that are working towards strengthening people and giving them a sense of purpose*. (HR4 2016)

When asked about local efforts to promote healthy relationships, participants named general efforts that they said contributed to healthy relationships in the community; however, there were very few specific efforts. Many participants said that having healthy relationships was important to community members, but acknowledged that healthy relationships were not a reality for a lot of people.

Community knowledge of efforts

The score for the community knowledge of efforts dimension increased between assessments from stage 2 in 2014 to stage 3 in 2016. When asked about community knowledge about efforts to promote healthy relationships, participants in both assessments noted a lack of awareness and stated reasons for this including isolation, addressing more urgent priorities such as housing and youth issues, and cultural barriers to accessing support. Participants said that healthy relationships were not a specific focus in the community, noted the challenges of having different understandings of healthy and unhealthy relationships, and not knowing how to promote healthy relationships.

Leadership

The score for the leadership dimension decreased between assessments from stage 4 in 2014 to stage 3 in 2016. Participants said that healthy relationships were a big concern to community leaders. One participant said family violence was an ongoing topic of conversation:

> *You can judge these things pretty much by how often the topic comes around, and it's always discussed.* (HR5 2016)

However, despite this concern, participants acknowledged that leaders needed help to address the issue:

> *There is an honesty around, I think people have managed to overcome those barriers of getting an honest conversation started about it, and an acknowledgement of the scale of the problem. But they need help to make it one of those priorities for the community to fix.* (HR5 2016)

Although participants named the concern of leaders, the concern was mostly about family violence, rather than healthy relationships. Participants were not able to name ways that leaders were involved in specific efforts to promote healthy relationships.

Community climate

The score for the community climate dimension increased slightly between assessments. Participants said the community supported efforts to promote healthy relationships such as parenting events and activity, but that these efforts often did not reach those in most need:

> *A lot of community members are really big on healthy relationships, but there are still those families that are hard to reach, and actually really need to be reached, because I think there's a lot of families in the community that experience unhealthy relationships.* (HR6 2014)

The obstacles to promoting healthy relationships that were named by participants included lack of understanding, isolation and seeing relationships as a private matter:

> *I think one of the obstacles is around the perception 'it's my business'. I think it's quite a touchy area when you are talking about people's relationships. I think there's still shame. And sometimes there's an attitude of who are you to tell me what to do?* (HR4 2016)

Along with thinking relationships were a private matter, participants said other obstacles to promoting healthy relationships were that it was not a priority for those trying to survive day to day, and that is was hard for people to understand what a healthy relationship was:

> *Most people don't give it* [healthy relationships] *a lot of thought really. There are a lot of people who are just surviving. I think there's a lot of people who their main thing is, how do I survive today?* (HR4 2016)

> *I'm sure everyone thinks that a healthy relationship is important. It's just what do they consider a healthy relationship? And where the power balance is and is their idea of a healthy relationship really a healthy relationship? I mean how do you measure a healthy relationship?* (HR4 2016)

Participant responses to the questions about community climate showed that healthy relationships were not much of a focus in the community, and that there were many obstacles to building healthy relationships.

Knowledge on the issue

The score of the knowledge on the issue dimension increased slightly between assessments. Participants noted the mixed levels of knowledge within the community, and that while information was available, that did not mean it was accessible:

> *There are a number of community members who are really knowledgeable around healthy relationships, and they could name it, and they also educate their children on healthy relationships. But there are community members who are really uneducated on what a healthy relationship is, and have probably never been modelled one, so don't know what one looks like.* (HR6 2014)

> *There is quite a lot of information, but I'm not sure how accessible it is to people really. We've still got a long way to go to recognise what's healthy and what isn't.* (HR3 2016)

One participant noted a positive shift in attitudes amongst young people about healthy relationships:

> *There's an attitude shift especially amongst our young people, they are so transparent. Almost like a self-monitoring culture in social media.* (HR1 2016)

Participants responses' showed that although some in the community were very knowledgeable about healthy relationships, and young people were becoming more aware, many community members were unaware. Participants said that information needed to be more accessible to support people to learn about healthy relationships.

Resources

The score for the resources dimension increased between the assessments from stage 3 to stage 4. Participants said that people turned to friends, family and local organisations including churches to build healthy relationships:

> *First and foremost, they'd go to someone that they knew and someone that they trusted. Whether that's a family member, a friend, and if they didn't feel that they could deal with it themselves they'd probably more than likely try to access some external support, usually RAP, or one of the churches.* (HR3 2016)

Participants were asked about the level of training and expertise in the community on healthy relationships. They described a range of skills and motivations:

> *We have some really really good ones* [support people] *and we have some that are just there because they've got funding.* (HR1 2014)

> *There's just good quality people here who are pretty much on the same page when it comes to the big picture, especially in regard to healthy relationships.* (HR1 2016)

Participants spoke of local resources, but these resources were not specific to promoting healthy relationships. Some questioned the approaches used by outside agencies to help people to develop healthy relationships and said that this was a reason people got support from friends, family and local organisations.

Summary

The results from the ACMQ assessment showed the highest agreement was on the leadership scale, followed by organisation, shared concern – family violence, social cohesion, participation, and the lowest agreement was on the critical consciousness and shared concern – healthy relationships scales. The agreement on the social cohesion scale, and particularly the very low number of do not agree at all responses on this scale, supports earlier research and participants' descriptions in the CR assessments that Ranui was a connected community.

The CR assessment results show that overall readiness to address family violence increased between 2014 and 2016 to stage 4 – preplanning, defined as:

> There is clear recognition that something must be done, and there may be local efforts addressing it. Efforts are not focussed or detailed (Plested et al., 2006, p. 9).

The highest scoring dimension in both assessments was community efforts, followed by community climate, knowledge on the issue and knowledge of efforts. In 2016, the lowest scoring dimension was leadership. CR interview participants' responses showed that the biggest obstacles to addressing family violence were the lack of response when people saw or knew about family violence, and that violence was treated as a norm. There was an understanding of the issue of family violence and how challenging it was to address. This challenge was also named as an obstacle to starting action.

The result for overall readiness to promote healthy relationships was also stage 4 – preplanning in 2016. Community efforts was the highest scoring dimension; however, the lowest scoring dimension was knowledge of community efforts. Knowledge of community efforts, knowledge of the issue and leadership were all at stage 3 – vague awareness in 2016. This score is perhaps unsurprising, as promotion of healthy relationships was a focus of the research but was not a specific focus in the community.

The increase in the stage of readiness on healthy relationships may have been in part due to the acknowledgement of the work that was already happening in Ranui, and how this work contributed to promoting healthy relationships or an actual increase in efforts to promote healthy relationships. However, participants noted that the healthy relationship focus was implicit rather than explicit. The increase in score for the resources dimension may have been due to attribution by participants of work related to building healthy relationships, such as the increase in resourcing for youth initiatives which were a key focus of collaborative action.

While there was no planned action on family violence or healthy relationships in Ranui during the study period, CR increased on both topics. This may have been due to increased awareness of family violence and healthy relationships in New Zealand generally, an impact of conducting this research, an impact of the family violence homicides that occurred in the community in 2014, or informal efforts to address family violence. It is likely that a combination of these factors led to the increase.

It is of interest that the ACMQ result showed that the leadership dimension had the highest agreement, but in the CR assessment in 2016, leadership was the lowest scoring dimension. ACMQ responses showed the highest agreement on the items about leaders promoting

healthy relationships and speaking out against family violence, despite no formal or planned efforts in place. This suggests that community members experienced leadership in other ways beyond formal efforts, and that the ACMQ assessment may capture this informal activity. In contrast, in the CR assessments for both family violence and healthy relationships, the leadership dimension score decreased. This divergent result may be explained by the focus of the CR assessment on formal or planned efforts and will be explored further in later chapters.

CHAPTER 8: CASE STUDY COMPARISON

In the previous two chapters, case studies were presented on the Glen Innes (Chapter 6) and Ranui (Chapter 7) communities. In this chapter a case study comparison is presented. This includes a comparison of the results of the CM and CR assessments, and a discussion of these results drawing on the contextual information provided in the case studies.

CM assessment results

In this section, the results of the ACMQ assessment are compared between the two study communities. Results show that Ranui had significantly higher levels of CM than Glen Innes on all domains of the ACMQ assessment.

There was a higher proportion of female participants than male in the both communities. The mean age of participants was approximately six years younger in Glen Innes than Ranui. A higher proportion of Pākehā completed the ACMQ in Ranui than Glen Innes, and a higher proportion of Pacific peoples completed the questionnaire in Glen Innes than Ranui. This difference reflected the ethnic composition of the communities.

Results showed that Ranui had higher scores than Glen Innes on all seven scales. The mean item scores for the ACMQ assessment are presented in Table 39. The scores ranged from 1=Lowest agreement to 3=Highest agreement.

Table 39: Comparison of mean item scores and stand deviations on ACMQ scales by community

Domain scale (number of items)	Glen Innes M (SD) (n=101)	Ranui M (SD) (n=89)
Leadership (5)	2.15 (.601)	2.45 (.602)
Participation (12)	2.27 (.553)	2.38 (.718)
Organisation (5)	2.24 (.506)	2.41 (.624)
Critical consciousness (11)	2.13 (.572)	2.32 (.651)
Shared concern – family violence (10)	2.31 (.600)	2.40 (.633)
Shared concern – healthy relationships (9)	2.20 (.596)	2.29 (.653)
Social cohesion (6)	2.04 (.595)	2.38 (.592)

The following sections report a comparison of the item response patterns on the ACMQ scales.

The results for the leadership scale showed higher agreement for Ranui than Glen Innes on all items and all differences were statistically significant (see Table 40).

Table 40: ACMQ leadership scale item analysis

Leadership item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	$\chi 2$	p
Leaders in [community] speak out against family violence	Ranui	54.0	40.2	5.7	12.664	.002
	GI	29.0	58.0	13.0		
Leaders in [community] promote healthy relationships	Ranui	54.5	39.8	5.7	14.361	.001
	GI	27.7	60.4	11.9		
Leaders in [community] are role models of healthy relationships	Ranui	52.3	44.3	3.4	11.406	.003
	GI	29.4	60.8	9.8		
Community leaders are able to represent all sectors of the community	Ranui	52.9	40.2	6.9	16.208	.000
	GI	24.2	63.6	12.1		
Community leaders are able to manage inter-group conflict within the community	Ranui	40.2	52.9	6.9	7.263	.026
	GI	22.2	66.7	11.1		

Results for the participation scale (see Table 41) showed that Ranui participants had significantly higher agreement than Glen Innes on the items 'In the last 12 months there has been activity about family violence in my community', 'The available information on healthy relationships is useful', 'The available information on where to get help for healthy relationships was useful', 'I know people in healthy relationships', and 'I see people in healthy relationships'. Glen Innes showed significantly higher agreement on the two items, 'I have done something to prevent family violence' and 'information about where to get help for family violence is available'.

Before answering the participation scale, participants were asked 'do you know of any activity to prevent family violence or promote healthy relationships in your community'. The agreement on this item was significantly higher for Glen Innes (71%) than Ranui (48%) (p= 0.002).

Table 41: ACMQ Participation scale item analysis

Participation item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	χ^2	p
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in [community]	Ranui	46.3	42.6	11.1	7.411	.025
	GI	31.7	64.6	3.7		
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in [community]	Ranui	41.5	49.1	9.4	4.468	.107
	GI	30.5	65.9	3.7		
I have done something to help to prevent family violence in [community]	Ranui	38.9	42.6	18.5	7.195	.027
	GI	32.5	61.4	6.0		
Information (e.g. booklets, training) about family violence is available in [community]	Ranui	41.5	49.1	9.4	.556	.757
	GI	41.5	52.4	6.1		
The available information about family violence is useful	Ranui	53.7	40.7	5.6	5.926	.052
	GI	35.8	61.7	2.5		
Information (e.g. booklets, training) about where to get help for family violence is available in [community]	Ranui	45.3	41.5	13.2	6.590	.037
	GI	30.5	63.4	6.1		
Information (e.g. booklets, training) about healthy relationships is available in [community]	Ranui	43.4	47.2	9.4	3.368	.186
	GI	28.9	62.7	8.4		
The available information about healthy relationships is useful	Ranui	51.0	43.1	5.9	8.155	.017
	GI	27.8	68.4	3.8		
Information (e.g. booklets, training) about where to get help for healthy relationships is available in [community]	Ranui	49.1	41.5	9.4	4.980	.083
	GI	31.7	61.0	7.3		
The available information about where to get help for healthy relationships is useful	Ranui	51.0	41.2	7.8	8.356	.015
	GI	29.6	66.7	3.7		
In [community] I know people in healthy relationships	Ranui	59.3	31.5	9.3	12.720	.002
	GI	32.5	62.7	4.8		
In [community] I see people in healthy relationships	Ranui	57.4	33.3	9.3	8.863	.012
	GI	32.5	57.8	9.6		

Results on the organisation scale (see Table 42), showed that Ranui had significantly higher agreement than Glen Innes for the three items, ‘we have the services we need to prevent family violence’, ‘we have the people with the skills to help to prevent family violence’, and ‘the support people get from services helps them to make healthy relationships’.

Before answering the organisation scale, participants were asked if they knew of any services in the community that helped to prevent family violence or promote healthy relationships. In Glen Innes, 70% of participants said yes, compared to only 49% of participants in Ranui. This was a significant result (p= 0.004).

Table 42: ACMQ organisation scale item analysis

Organisation item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	$\chi 2$	p
In [community] we have the services we need to help to prevent family violence	Ranui	47.8	47.8	4.3	8.395	.015
	GI	23.9	72.7	3.4		
In [community] we have the people with the skills to help to prevent family violence	Ranui	46.7	46.7	6.7	7.728	.021
	GI	29.9	69.0	1.1		
The support that people get from services for family violence helps to keep them safe	Ranui	43.5	50.0	6.5	2.994	.224
	GI	29.1	65.1	5.8		
When people need help to make their relationships healthier the services in [community] work together well	Ranui	45.7	47.8	6.5	5.089	.079
	GI	27.6	67.8	4.6		
The support that people get from services helps them to make healthy relationships	Ranui	55.6	33.3	11.1	16.758	.000
	GI	26.4	70.1	3.4		

On the critical consciousness scale, results showed that Ranui had significantly higher agreement on eight of the eleven items (see Table 43).

Table 43: ACMQ critical consciousness scale item analysis

Critical consciousness item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	$\chi 2$	p
People in [community] talk to each other about how to solve community problems	Ranui	30.2	53.5	16.3	12.133	.002
	GI	12.9	77.2	9.9		
People in [community] enjoy discussing different ways to solve community problems	Ranui	38.6	53.0	8.4	11.646	.003
	GI	17.0	76.0	7.0		
People in [community] are open to hearing different views about community problems and solutions	Ranui	54.1	36.5	9.4	14.812	.001
	GI	26.7	61.4	11.9		
People in [community] volunteer to help solve community problems	Ranui	51.2	38.1	10.7	9.305	.010
	GI	29.3	57.6	13.1		
People in [community] think about why family violence happens so they can address the cause of the problem	Ranui	37.6	48.2	14.1	4.414	.110
	GI	29.0	63.0	8.0		
People in [community] not only talk about family violence but they also try to prevent it	Ranui	38.8	47.1	14.1	9.238	.010
	GI	25.7	68.3	5.9		
People work together to solve problems in [community]	Ranui	39.3	53.6	7.1	5.302	.071
	GI	24.5	62.7	12.7		
There is a lot of cooperation between groups in [community]	Ranui	40.5	48.8	10.7	3.181	.204
	GI	28.0	59.0	13.0		
If your community fails to resolve a community problem, they will try another different approach to solving the problem	Ranui	40.5	50.0	9.5	9.350	.009
	GI	20.0	69.0	11.0		
If your community fails to resolve a community problem, they will learn from that experience and do a better job when they try to solve the problem in the future	Ranui	46.5	46.5	7.0	10.722	.005
	GI	24.0	63.0	13.0		
If leaders in [community] fail to resolve a community problem, people will work together to find a solution	Ranui	51.2	40.7	8.1	14.001	.001
	GI	24.5	62.2	13.3		

Results showed that Ranui had significantly higher agreement on two items on the shared concern – family violence scale, namely, 'people consider family violence an important issue' and 'people take family violence seriously' (see Table 44).

Table 44: ACMQ shared concern – family violence scale item analysis

Shared concern – family violence item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	$\chi 2$	p
People in [community] are concerned about family violence	Ranui	55.1	39.3	5.6	4.432	.109
	GI	40.0	54.0	6.0		
People in [community] consider family violence an important issue	Ranui	71.9	21.3	6.7	14.072	.001
	GI	48.5	47.5	4.0		
People in [community] talk openly about family violence	Ranui	34.1	44.3	21.6	2.251	.325
	GI	30.3	54.5	15.2		
People in [community] believe that family violence impacts the community	Ranui	66.7	31.0	2.3	5.213	.074
	GI	50.0	46.9	3.1		
People in [community] talk about family violence at community meetings	Ranui	33.7	48.8	17.4	2.556	.279
	GI	41.0	49.0	10.0		
People in [community] work together to prevent family violence	Ranui	48.9	43.2	8.0	1.799	.407
	GI	39.4	52.5	8.1		
People in [community] take family violence seriously	Ranui	61.6	34.9	3.5	9.248	.010
	GI	39.8	57.1	3.1		
People in [community] believe they can prevent family violence	Ranui	41.4	51.7	6.9	2.309	.315
	GI	31.3	62.6	6.1		
People in [community] exchange information about family violence	Ranui	36.4	48.9	14.8	2.152	.341
	GI	30.6	59.2	10.2		
People in [community] work together to reduce the effects of family violence	Ranui	44.3	45.5	10.2	1.987	.370
	GI	34.3	54.5	11.1		

Results on the shared concern – healthy relationships scale showed that Ranui had significantly higher agreement for the item of 'People believe that healthy relationships impact the community'. Glen Innes had significantly higher agreement for the item of 'People exchange information about healthy relationships' (see Table 45).

Table 45: ACMQ shared concern – healthy relationships scale item analysis

Shared concern – healthy relationships item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	$\chi 2$	p
People in [community] are concerned about healthy relationships	Ranui	42.7	51.7	5.6	5.823	.054
	GI	26.3	64.6	9.1		
People in [community] consider healthy relationships an important issue	Ranui	46.0	49.4	4.6	4.897	.086
	GI	30.7	61.4	7.9		
People in [community] talk openly about healthy relationships	Ranui	36.0	46.1	18.0	4.204	.122
	GI	23.0	59.0	18.0		
People in [community] believe that healthy relationships impact the community	Ranui	61.8	33.7	4.5	12.544	.002
	GI	36.3	57.8	5.9		
People in [community] talk about healthy relationships at community meetings	Ranui	36.0	47.7	16.3	5.681	.058
	GI	29.9	62.9	7.2		
People in [community] work together to promote healthy relationships	Ranui	36.4	48.9	14.8	1.466	.481
	GI	29.3	57.6	13.1		
People in [community] believe they can promote healthy relationships	Ranui	45.5	48.9	5.7	4.374	.112
	GI	30.7	62.4	6.9		
People in [community] exchange information about healthy relationships	Ranui	32.6	47.2	20.2	9.192	.010
	GI	28.0	65.0	7.0		
People in [community] take healthy relationships seriously	Ranui	51.7	36.0	12.4	5.113	.078
	GI	36.0	51.0	13.0		

The results on the social cohesion scale showed the largest difference between the two communities, with significantly higher agreement for Ranui on all items, and the lowest agreement for Glen Innes of all the ACMQ scales (see Table 46).

Table 46: ACMQ social cohesion scale item analysis

Social cohesion item	Community	Agree a lot (%)	Somewhat agree (%)	Do not agree at all (%)	$\chi 2$	p
People in [community] are willing to help their neighbours	Ranui	58.0	40.9	1.1	38.608	.000
	GI	17.8	64.4	17.8		
People in [community] can be trusted	Ranui	38.6	52.3	9.1	17.152	.000
	GI	12.9	70.3	16.8		
People in [community] generally get along well with each other	Ranui	43.8	55.1	1.1	7.928	.019
	GI	29.3	62.6	8.1		
People in [community] share the same values	Ranui	36.0	52.8	11.2	7.152	.028
	GI	19.2	62.6	18.2		
People in [community] look out for each other	Ranui	46.1	47.2	6.7	14.535	.001
	GI	21.8	60.4	17.8		
This is a close-knit community	Ranui	42.9	49.4	7.8	13.994	.001
	GI	17.9	64.2	17.9		

Scores on the social cohesion scale were of particular interest. The results may be indicative of the impact of the housing redevelopment on social cohesion in Glen Innes (Cole, 2015; Gordon, 2015; Scott, 2013), or that social cohesion was already a concern in Glen Innes (Scott, Shaw, et al., 2010). The housing redevelopment in Glen Innes was a large intervention with many activities taking place within the study period. The negative impacts of this intervention may have affected the ACMQ results. In contrast, social cohesion was identified as a strength by Adams et al. (2005) in Ranui. The focus in Ranui on social cohesion through the RAP research and Back2Back project may have contributed to higher levels of social cohesion or awareness of social cohesion. Participants in the CR assessments also named social cohesion as a strength in Ranui.

Overall, the results show that Ranui had higher agreement than Glen Innes on the ACMQ, despite no planned or ongoing activity to prevent family violence or promote healthy relationships. This result is surprising due to the formal efforts that were implemented in Glen Innes. However, it is also perhaps not surprising when taking into account contextual differences between the two communities. An important contextual factor was that the Ranui community experienced two family violence homicides during the study period. It is not possible to know how the homicides in Ranui in 2014 impacted the ACMQ scores, but it is likely to have increased awareness of the problem of family violence and community conversation about the issue. This may have led to actual higher levels of CM, or higher levels of reported mobilisation, but it is not possible to make conclusions about this. Another possible explanation is that CM was not higher in Ranui, but without a local initiative on the issue, it was difficult for Ranui participants to make informed responses to the ACMQ as there was little to base their responses on. In contrast, the Glen Innes community had discussed the issue for some years and participants may have responded from a more informed position, with more ability to critique the activity they had seen going on and perhaps because they had participated in activity in their community. Results for the two gating questions (prior to the participation and organisation scales), showed Glen Innes participants were significantly more aware of activity to prevent family violence and promote healthy relationships and the services available in their community than Ranui participants. However, the results for the participation and organisation scales showed lower agreement in Glen Innes than Ranui, which indicates that while Glen Innes residents were more aware, they were less mobilised.

Community readiness assessment results

In this section, the results of the CR assessments in 2014 and 2016 are compared between the two communities. The findings show that readiness to prevent family violence and promote healthy relationships was higher in Glen Innes than in Ranui, in both the 2014 and 2016 CR assessments.

Family violence

The scores for CR to prevent family violence (Table 47 and Figure 11) show that Glen Innes had higher readiness to address family violence than Ranui on all dimensions of readiness at both assessments, apart from the scores for the community climate dimension in 2016, which were equal. The largest difference in scores was seen in the 2016 assessment, where the Glen Innes scores for leadership and resources were two stages of readiness higher than Ranui.

Table 47: CR comparison, family violence

	2014		2016	
	Glen Innes	Ranui	Glen Innes	Ranui
Community efforts	5.50	4.17	6.67	5.67
Community Knowledge of efforts	3.67	2.83	4.67	4.00
Leadership	4.83	3.67	5.33	3.17
Community climate	4.17	3.00	4.17	4.17
Knowledge on issue	4.33	3.00	4.33	4.00
Resources	4.67	3.50	5.17	3.67
Overall stage of readiness	4.53 – Preplanning	3.36 – Vague awareness	5.06 – Preparation	4.11 – Preplanning

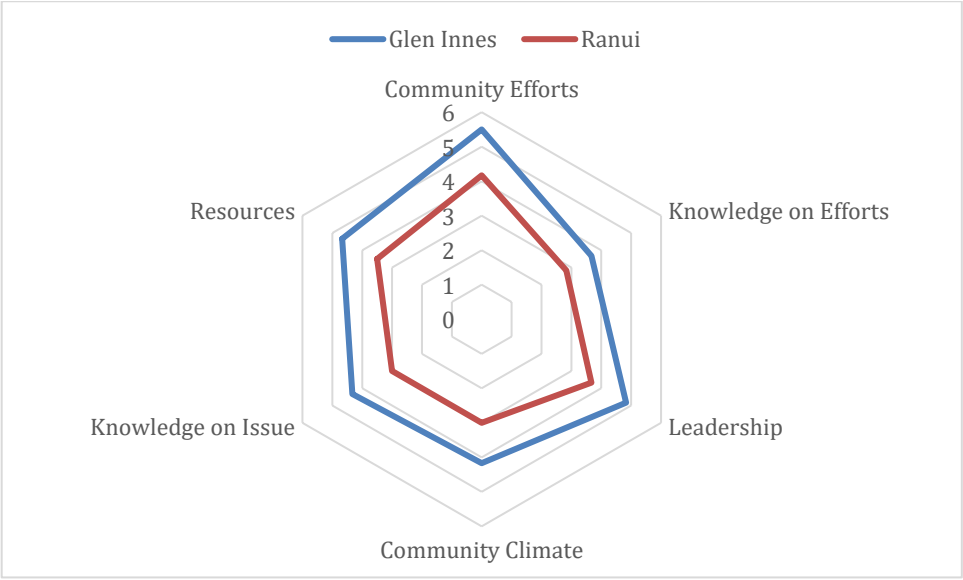

Figure 11: CR comparison 2014 – family violence

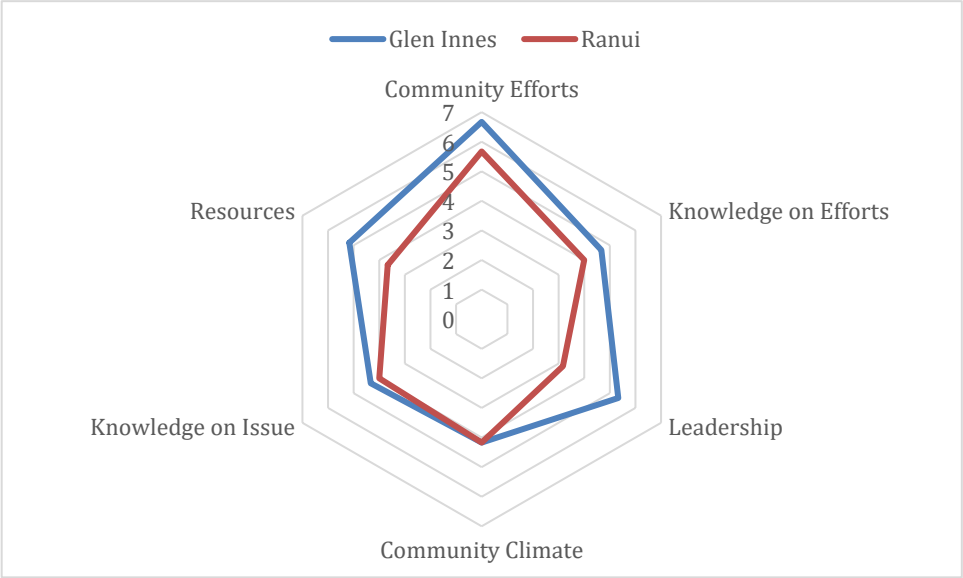

Figure 12: CR comparison 2016 – family violence

Healthy relationships

The scores for CR to promote healthy relationships (Table 48 and Figure 13) showed that Glen Innes had higher readiness to promote healthy relationships on all dimensions of readiness at both assessments. The largest difference in scores was for the leadership dimension in 2016, where the Glen Innes score was three stages of readiness higher than Ranui. The difference in scores between the two communities on the community efforts dimension in 2014 of two stages of readiness, reduced to one stage at the 2016 assessment. The score for community climate in 2016 was the most similar score between the two communities.

Table 48: CR comparison, healthy relationships

	2014		2016	
	Glen Innes	Ranui	Glen Innes	Ranui
Community efforts	6.83	4.17	6.83	5.83
Community knowledge on efforts	3.83	2.67	4.5	3.67
Leadership	5.50	4.17	6.17	3.83
Community climate	4.50	4.00	4.67	4.33
Knowledge on issue	4.17	3.0	4.67	3.83
Resources	4.67	3.67	5.17	4.17
Overall stage of readiness	4.92 – Preplanning	3.61 – Vague awareness	5.33 – Preparation	4.28 – Preplanning

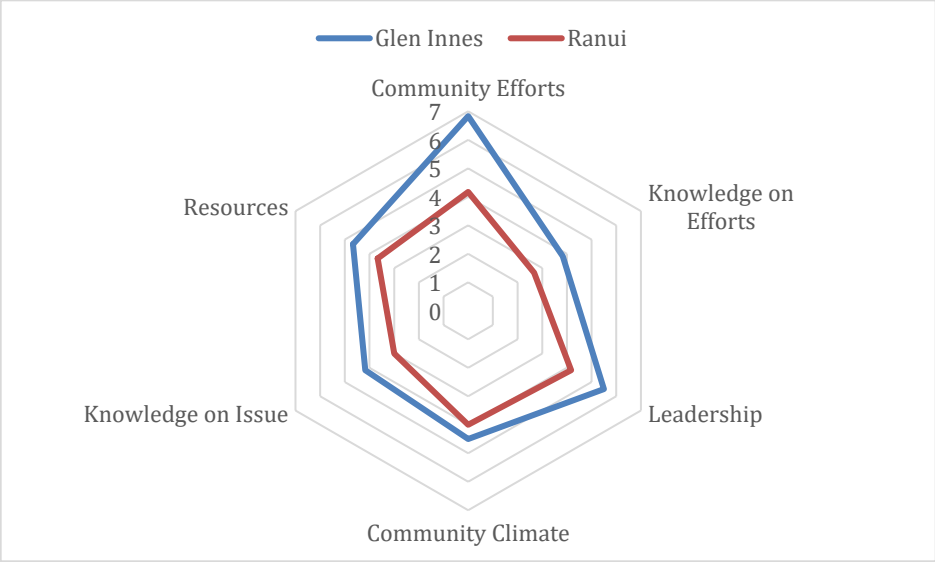

Figure 13: CR comparison 2014 – healthy relationships

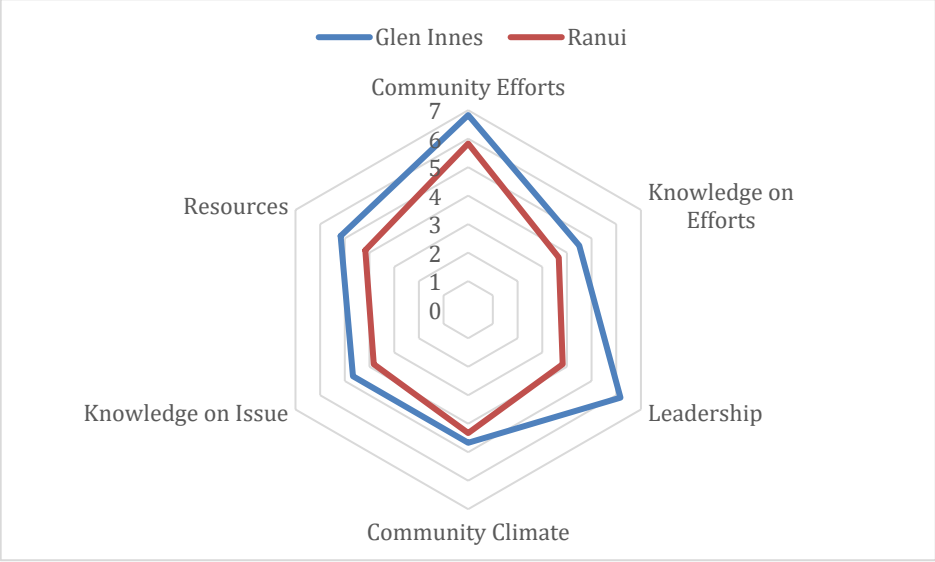

Figure 14: CR comparison 2016 – healthy relationships

The results show that CR to prevent family violence and promote healthy relationships was higher in Glen Innes than Ranui in 2014 and 2016. Glen Innes had higher readiness to address family violence than Ranui on all dimensions of readiness at both assessments, apart from the scores for the community climate dimension in 2016, which were equal. The largest difference in scores was seen in the 2016 assessment, where the Glen Innes scores for leadership and resources were two stages of readiness higher than Ranui. The most similar scores were on the community knowledge of efforts, community climate, and knowledge of issue dimensions in 2016.

The scores for CR to promote healthy relationships indicated that Glen Innes had higher readiness to promote healthy relationships on all dimensions of readiness at both assessments. The largest difference in scores was on the leadership dimension in 2016, where the Glen Innes score was three stages of readiness higher than Ranui. The second largest difference was on the community efforts dimension at the 2014 assessment, with Glen Innes scoring two stages of readiness higher than Ranui. However, by the 2016 assessment, the difference in scores was reduced, as the score for Ranui increased and the score in Glen Innes remained stable. The score for community climate in 2016 was the most similar score between the two communities.

In both communities, respondents described a high level of concern about the issues of family violence and healthy relationships. A key difference between the communities was that in Glen Innes, this concern had led to specific and ongoing action, whereas in Ranui, no ongoing action had been initiated. The long-term effort that was required to make change was recognised as a challenge in both communities. In Ranui, this was described as a barrier to starting action, whereas in Glen Innes, this was given as a reason that action began, and why it was being sustained. The scores for the resources dimension indicated that Glen Innes had higher levels of resources to prevent family violence and promote healthy relationships than Ranui. This reflected the reality that Glen Innes had secured resources to address these issues, and that Ranui had no specific resourcing for these issues.

In Glen Innes, the leadership scores for both family violence prevention and healthy relationship promotion increased between 2014 and 2016, whereas in Ranui, the scores for leadership decreased slightly between assessments on both topics. The clear difference in scores for the leadership dimension may not be surprising, as in Glen Innes, community

members, practitioners and leaders decided to address the problem with a locally developed approach. Participants in Glen Innes named many more community members, leaders and groups showing leadership on family violence and healthy relationships than Ranui participants, and could articulate how these leaders were specifically involved in local efforts. The decrease in the leadership scores in Ranui may be explained by heightened awareness in the community of family violence due to the homicides in 2014, but limited visible action from leaders.

The scores for the community climate dimension were the most similar between the two communities of all the dimensions for both family violence and healthy relationships, and showed little change between the 2014 and 2016 assessments. This may suggest that people's attitudes are more resistant to change than other dimensions of CR. It also may suggest that that attitudes on family violence and healthy relationships are largely informed by wider society, rather than being specific to communities, and the scores may then reflect a lack of change in attitudes in Aotearoa New Zealand on these issues. The key obstacles to preventing family violence and promoting healthy relationships named in both communities, were social norms that people do not intervene when they see or know about family violence and that family violence is tolerated.

Community context

In this section, the key aspects of community context are highlighted and compared and associations are made between these contextual aspects and results from the ACMQ and CR assessments.

In the CR assessments, Ranui participants reported more positive perceptions of their community than Glen Innes participants. In Ranui, the town centre development and increase in community facilities were described as having a positive impact on community pride and social connectedness. While Glen Innes participants named many positive aspects of their community, they often named these in contrast to a negative aspect, such as the community being safe, but also unsafe. Social connections were named as strong in both communities; however, in Glen Innes, the connections between families who had lived in the community over several generations were perceived to be affected by the housing redevelopment programme.

Housing was an important aspect in understanding the community context during the study period, especially in Glen Innes. Housing issues were a long-term concern in both communities, and were also named by participants in the CR assessments as a key community concern in both communities. In Glen Innes, the high proportion of state housing and the housing redevelopment intervention meant that the community was in a time of extraordinary change during the study period. During the study period the rebuilding phase had only just begun, and the potential positive benefits of the redevelopment were not evident to community members. The housing redevelopment caused uncertainty in Glen Innes, increased mobility within the community to new houses, and caused some residents to leave the community (Cole, 2015; Gordon, 2015; Scott, 2013). There was concern about immediate evictions and also long-term gentrification of Glen Innes. While the focus of the housing development was on state housing tenants (2,800 households), evidence suggests that this intervention affected the social connections and atmosphere of the community more broadly (Cole, 2015; Gordon, 2015; Scott, 2013). Evidence shows that increased residential mobility negatively impacts on social connections and community violence (Krug et al., 2002; Sampson et al., 1997). The impacts of the housing redevelopment on social connections were noted by participants in the CR interviews. Participants in Glen Innes said there had been a lot of change in a short period of time, particularly because many families had moved out of the community. This may have contributed to the low agreement on the social cohesion scale for Glen Innes in the ACMQ assessment.

Both communities had implemented many CD initiatives over time, including the multi-year CD initiatives of RAP and KMTW. Both initiatives had broad goals, and only early evaluation evidence was available to assess progress towards these goals. In Ranui, RAP was still running in 2016, whereas the organisation hosting the Glen Innes initiative, KMTW, closed in 2013. This may have contributed to greater consistency in CD efforts in Ranui. The Back2Back CD initiative in Ranui also had a focus on building connections between neighbours and supporting community members to lead their own activities to address their own issues. An evaluation report suggests that the Back2Back project contributed to activity to connect the community to address neighbourhood issues (Chilcott, 2012). This is aligned with a CM approach, and may have contributed to higher scores on the ACMQ assessment particularly on the social cohesion scale. The social cohesion surveys completed by Adams et al. (2005) in the early 2000s to

assess the impact of the RAP may also have increased awareness of social cohesion and activity to promote it in Ranui.

From available reports, family violence was documented as an issue once in Ranui (Conway, Huckle, et al., 2003), and three times in Glen Innes between 2003 and 2012 (Dialogue Consultants, 2003; Glen Innes Health Project Working Group, 2008; Liew et al., 2012). There were important differences between the communities in respect to the activity during the study period to prevent family violence and promote healthy relationships. The main difference was that in Glen Innes a collective decision was made by community members and organisations to address family violence, which resulted in implementation of a long-term family violence prevention initiative. CR participants also said there were a number of local organisations that had expertise to respond to family violence. Results from the CR assessments showed that the activity in Glen Innes contributed to higher levels of CR than in Ranui. This was because specific and formal efforts were in place in Glen Innes, which are necessary to achieve higher levels of readiness as assessed by the CR assessment tool. In Ranui, there were no planned efforts to prevent family violence implemented during the study period. However, the two family violence homicides in 2014 resulted in community responses and activity. It is likely that the homicides increased awareness of the issue of family violence as well as informal efforts including discussion in the community and may have increased help and information seeking also. The distinction between formal and informal community efforts will be discussed in the next chapter.

CHAPTER 9: DISCUSSION AND CONCLUSION

This research engaged with the complexity of measuring CM by developing a measure of CM and assessing CM and CR in two communities. In this chapter, the aims of the research are revisited. The emphasis of the discussion is on the development of the ACMQ, the relationship between the measurement of CM and CR, and the impact of social context on CM. Then the key findings and emergent concepts from the results about CM and CM measurement are presented. The strengths and limitations of the research are outlined. Key areas for future research are identified and final conclusions are presented.

Definition and domains of CM

The initial aims of this study were to define CM and to identify the domains of CM. The literature was reviewed extensively to identify available definitions of CM and the domains of CM, as reported in detail in chapter 4. Analysis of definitions in the literature led to the development of the following definition of CM for this study,

> Community mobilisation (CM) is a transformative approach used to create social change on complex issues. It is a long-term multifaceted strategy that uses capacity building to engage large numbers of community members in local action for change.

This definition is a contribution to the literature on CM to support discussion towards consensus building in the field.

The second related aim was the identification of the domains of CM. The domains of CM were identified as: leadership; participation; organisation; critical consciousness; shared concern; and, social cohesion. These domains were supported by the work of Lippman et al. (2013). This provides greater clarity for definition of CM and also has an important function in CM measurement as the domains were used to develop the ACMQ. In practice the definition and domains identified here support clarification of what implementation of CM is likely best focussed on which has been a key gap in the literature to date. Similarly, this study makes an important contribution to the gap in evidence about what to measure to assess CM. Though there is much room for further contributions to the evidence in the areas of definition and domains of CM, these are important progressions which can be used to foster further debate and discussion, and to guide implementation and measurement of CM.

The Aotearoa Community Mobilisation Questionnaire

The key aims of this study were to develop a quantitative tool to assess CM, and to test the validity and utility of the tool using case study design. The result was the development of the ACMQ. In this section, the development of the ACMQ is discussed.

Development of the Aotearoa Community Mobilisation Questionnaire

The development of the ACMQ is the key contribution of the thesis to the literature. The tool was rigorously developed and tested in two communities as is documented in chapter 4. This resulted in a quantitative tool with high internal consistency across the six domains of CM.

An important milestone for the CM field during the development of the ACMQ was that the first measure of CM was published that could be used to assess CM in any community rather than to assess one specific CM initiative—the CMM (Lippman et al., 2016). The CMM was published after the 2014 ACMQ community pilot and following the psychometric analysis of the data which showed low internal consistency on two ACMQ scales. The CMM presented an opportunity to improve the ACMQ. The key changes made to the ACMQ were replacement of the two scales with low internal consistency scores (attitudes and beliefs; critical thinking) with the equivalent scales from Lippman et al. (2016), shared concern and critical consciousness. A sixth scale measuring social cohesion was also adopted from Lippman et al. (2016). These changes further increased the internal consistency of the ACMQ and supported better measurement of the domains of CM. The already high internal consistency scores for the leadership, organisation and participation scales increased after these changes were made to the tool. The adoption of the social cohesion scale was an important improvement to the ACMQ, as the results of the case studies indicated that social cohesion plays a key role in CM, specifically, that low social cohesion may compromise a community's ability to mobilise and that high cohesion may support mobilisation. This finding would not have emerged without inclusion of the social cohesion scale in the ACMQ, and supports theory from Lippman et al. (2016) about the importance of social cohesion in CM. The role of social cohesion in CM is discussed later in this chapter.

A key difference between the ACMQ and the CMM is the contexts the tools were developed for and implications of this. The ACMQ was developed to assess CM in urban communities.

This is a strength of the research, as the majority of studies in the literature assess CM in developing countries (e.g. Abramsky et al., 2014; Pettifor et al., 2018). This is thought to be one of the first studies to assess CM in an urban setting using a tool specifically developed to measure CM. Urban settings are diverse and very different from village settings in developing countries, where there is often one centralised decision making group for a village. In urban settings, many different groups are involved in addressing different issues in different ways.

An implication of the different contexts on the tools is the focus on measuring issue specific CM or generalised CM. The CMM measures CM generally, with one issue specific scale on HIV prevention which is appropriate for the context it was developed for. In contrast, the ACMQ is an issue specific measure of CM on family violence and healthy relationships. Every ACMQ scale, apart from social cohesion, refers to the topic of the research. This is important in an urban setting when many initiatives are being implemented on many topics, as it ensures that participants respond to community efforts and attitudes about that issue and the results are specific. This is especially important for stigmatised issues such as family violence because when not asking directly about the issue, discussion of the issue is often avoided.

The ACMQ study was originally planned to involve two assessments—one in 2014 and the second in 2016. However, the improvements made to the ACMQ meant that the 2014 ACMQ assessment results were used for psychometric analysis of the tool, but the results of this assessment were not reported. Due to the changes made to the tool, it was not possible to compare the results of the ACMQ assessment within the communities between the two assessments, which would have made it possible to assess the reliability of the ACMQ over time. While it was possible to compare results between communities for the 2014 assessment, a decision was made that only the 2016 assessment results using the improved version of the ACMQ would be reported. This was because the 2014 assessment did not represent a full assessment of CM as it excluded social cohesion, and the attitudes and beliefs and critical thinking scales had low internal consistency. While the changes made to the tool were a limitation in one sense as this meant that reliability could not be assessed, the changes were a strength of the research as the 2016 version of the ACMQ is an improved measure.

The development of the ACMQ involved three phases of psychometric analysis using SPSS, STATA and R statistical packages. PCA was completed using SPSS in the first two phases, but for the 2016 data, a PCA was completed using R which is better suited to analysing ordinal data.

This PCA showed high internal consistency and an eight-component solution which mapped the ACMQ domain scales with one exception. The shared concern – family violence scale was split between two components signalling two distinct aspects of this component—the importance of family violence, and how much people talked about and did something about it. Identification of these two aspects of concern about family violence can inform practice, as this result indicates that importance and action on this issue are distinct but related functions. This may suggest that the importance of the issue will not necessarily lead to action. This finding could be explored more in future research.

Establishing the validity of the Aotearoa Community Mobilisation Questionnaire

In this research, case study design was used to achieve the research aim of assessing the validity of the ACMQ to measure CM in two real-world communities. Construct validity and internal validity of the tool were established in this study in the analysis of the ACMQ results and psychometric analysis. However, the external validity of the tool has not been established in this study as the ACMQ has only be used to assess CM once in two communities. Further applications of the ACMQ in other contexts are necessary to establish external validity. Likewise, the reliability of the ACMQ to assess CM has not been established in this study. If the same version of the ACMQ had been used in both assessments as was originally intended, it would have been possible to compare results of two ACMQ assessments, between and within communities, and to assess reliability. As this was not the case, further applications of the ACMQ are necessary to establish reliability. Ideally, this would involve completion of two or more ACMQ assessments in two or more communities, and analysis of the results of these assessments. The ACMQ appears to be a theoretically sound measure of CM, but needs further application with different populations and contexts in order to further establish its external validity and reliability. This study had a relatively small sample size and use of the ACMQ with larger samples would help to establish the external validity and reliability of the tool.

Utility of the Aotearoa Community Mobilisation Questionnaire

The ACMQ was designed for researchers and community groups as an easy to use tool that requires only basic statistical support for analysis. The utility of the tool was investigated in this study. An ACMQ assessment is easy to implement and to analyse. The main resource need is the time of people in communities to distribute and collect the questionnaire; this requires

some time and planning to achieve. In future applications of the tool, the questionnaire may be used online which could reduce the time burden on community networks. However, a dual approach of in person and online may be most appropriate for CM measurement, as engaging community networks is a key function of a CM initiative. Using the ACMQ online as well as in person would likely support a more representative sample of the community, as it could access people who work long hours and those who are less engaged in community activity for example.

Further testing of the ACMQ is required to establish whether the tool is sensitive to change in CM within a community. If it is sensitive to change, the ACMQ could be used to assess change in CM over time. It could be used to provide a baseline measurement of CM prior to implementation of new CM initiatives and to inform the development of CM initiatives through ongoing assessments. Baseline assessments could be used to guide community efforts using the scores for each domain to understand the level of activity in the community on each domain of CM and plan efforts cognisant of this information.

The ACMQ could also be used for evaluative purposes. It was designed to be used to assess the overall CM efforts in a community, not to assess the impact of a specific initiative. However, the tool could be used by those implementing initiatives on a specific issue in a community to understand the impact of their combined efforts, to guide programme development and to set community priority actions for all initiatives addressing the issue. For example, if an ACMQ community assessment showed that leadership scores were much lower than the other domains of CM, a community could decide to prioritise leadership development across all related initiatives in that community. Further applications of the ACMQ could establish whether it can be used by communities implementing CM initiatives to assess their own initiatives and to use the results to build evidence-based practice.

The relationship between measurement of community mobilisation and community readiness

An aim of this research was to investigate the relationship between measurement of CM and CR in the context of family violence prevention and healthy relationship promotion. This was achieved by using the ACMQ to assess CM and the CR assessment (Plested et al., 2006) to measure readiness and analysis the results produced by these two tools. The results showed

that the ACMQ and CR tools measure distinct but related constructs, and offered insights into the assessment of these two constructs.

The CR assessment uses semi-structured interviews, which means it not only assesses the level of readiness in a community to address an issue, but also provides useful information on the broader social context. This contextual information makes the CR assessment an important complimentary measure to the ACMQ, as the ACMQ does not capture this information. The results of this study support the assertions of Campbell and Cornish (2010) on the important role of social context in CM. Social context will be discussed later in this chapter.

The results of the CM and CR assessments showed a difference in the type of activity the two tools measure, and a distinction was made between measurement of formal and informal efforts to address issues in communities. Formal efforts can be understood as the planned efforts in a community to address an issue that usually involve organisations and community leaders. These efforts are financially resourced and often have people employed to work specifically on them. In contrast, informal efforts can be understood as the actions that community members do themselves to address an issue, intentionally or unintentionally. An example of informal efforts is conversation, when community members discuss an issue and increase awareness or understanding. The differentiation made here is that informal actions are performed by community members that are not necessarily planned or resourced by organisations, but happen because individuals and groups feel they should be done, or they naturally occur. Assessment of informal efforts is very important for CM, as to create change in communities using CM it is necessary to develop a critical mass of community members who are voluntarily contributing to CM efforts (Michau, 2012).

Both tools have the ability to measure formal and informal community efforts to address an issue. However, the items in each tool indicate a different emphasis. The ACMQ is more focussed on assessing informal efforts and the CR assessment is more focussed on assessing formal efforts. The following item from the ACMQ participation scale demonstrates the different emphasis— 'I have done something to help to prevent family violence'. Doing something to prevent family violence could include having a conversation with a family member, calling the police or babysitting children at risk of family violence. These are all informal actions that people may feel contribute to family violence prevention. In contrast, the item from the CR assessment—'Please describe the efforts that are available in your

community to address this issue' has more of an emphasis on the formal efforts in a community. The ability of the ACMQ to assess informal efforts is a strength of the tool. It is important for CM measurement to assess informal efforts, because the focus of CM is on the actions of community members rather than organisations. For example, CM is about all community members showing leadership on the issues, not only the actions of existing or established community leaders. However, the emphasis of the CR assessment on measuring formal efforts is also very useful in CM measurement as it investigates the support to address the issue in the wider community, and creates a supportive environment for the CM initiative. This distinction between assessment of formal and informal efforts highlights the complimentary nature of the two tools and is thought to be a new contribution to the literature on assessment of CM and CR.

An important difference between the two tools is the type of participant used in each assessment. The ACMQ uses community members as participants and the CR assessment uses key community informants. Key informants provide important information about a community because they are more knowledgeable about the problem and efforts to address it than most community members. Using key informants is common and often pragmatic because they are accessible and willing to participate in research. However, studies using key informants tend to use smaller numbers, and may not reflect the views of the wider community participating in CM. Also, key informants may be invested in the success of initiatives being implemented due to the formal, and often paid, roles they hold within the community. CM is a planned approach that aims to mobilise grass roots community members, with no special knowledge of, or connection to, formal efforts in a community to act voluntarily in ways that support CM efforts. For these reasons it is suggested that community members are the most important participants in CM assessment. However, the use of both the ACMQ and CR assessment is very helpful as the two tools provide information about two levels of engagement with CM in a community. The CR assessment provides useful information about the CM efforts implemented by organisations and established leaders. In contrast, the ACMQ is able to assess the mobilisation of grass roots community members, and if formal efforts filter down to the grass roots.

An important practical difference between the two tools is implementation and resourcing costs. The ACMQ requires considerably less time and resources to administer. The CR assessment on the other hand is more resource intensive because it involves interviews. The

CR assessment requires one interviewer and two people to score the interviews. Both interviewing and scoring interviews are time and resource intensive. Despite this, the CR assessment provides important information to understand CM in a community and is recommended for use in CM assessment if resources allow.

This study explored new ground by assessing healthy relationship promotion at the community-level. The ACMQ was developed to assess healthy relationships as well as family violence, and the utility was not affected by inclusion of this topic. However, the CR assessment was developed to assess an issue, and the framing of healthy relationships as an issue was somewhat ill fitting within the interview schedule. Due to framing healthy relationships as an issue, some participants in the CR assessment spoke about family violence or unhealthy relationships rather than healthy relationships and had to be prompted to respond specifically to healthy relationships. This did not affect scoring of the interviews as participants needed to respond to healthy relationship efforts specifically to be included in scoring.

This study also indicated that the interpretation and utilisation of the CM and CR assessment results are specific to the communities being studied. Comparison between communities is very useful for building evidence and understanding of CM and CM measurement. However, for communities implementing CM initiatives, comparison between communities may be less meaningful. It is likely that the most useful comparison for communities is the comparison of CM and CR results within their communities over time because of the importance of community context.

This study contributed new knowledge about the relationships between measurement of CM and CR. The study showed while CM and CR are related constructs, they are also distinct. The use of the ACMQ and CR assessment in this study demonstrated the benefits of assessing two constructs using different methods to understand CM. In particular the importance of social context and the differences in assessing formal and informal community efforts were highlighted through the investigation. However further research is required to comprehensively understand the relationship between measurement of CM and CR.

The impact of social context and social cohesion

The final aim of the research was to investigate the impact of social context on CM utilising case study design. There were several interesting findings that emerged from the study, with the most significant being the role that social context and social cohesion play in CM. Results for the ACMQ assessment indicated that social cohesion was significantly higher in Ranui than Glen Innes. Responses from participants in the CR assessment and previous research also support this result.

The analysis of the CM and CR assessment results support assertions made by Campbell and Cornish (2010), Watson-Thompson et al. (2008) and Lippman et al. (2016) that social context plays an important role in CM. Housing and development were important contextual factors in the case studies. In Ranui, the town centre development was reported to have had positive impacts on perceptions of the community and social connection. Glen Innes, on the other hand, was in a time of extraordinary change, and a number of negative impacts of the housing redevelopment were reported. These included increased residential mobility and the negative effects of this on social connections. The impact of housing and development were evident in the CR participant responses and may have contributed to the low agreement for social cohesion in the ACMQ assessment. The scale of the housing redevelopment intervention may have overridden the impact of the CM efforts in Glen Innes.

The responses of participants in the CR assessments in both communities indicated that other important contextual factors that impact on CM and CR include social isolation, poverty and other inequalities, and in Ranui, the family violence homicides. Participants said that social isolation meant that people were not aware of CM efforts in their community, and in some cases, did not want to know. Participants also described how experiences of poverty and other inequalities in employment, health and housing meant that for many community members day to day survival was their priority. They said that other activities such as getting involved in CM efforts were not a possibility for people who experienced high levels of stress and had few resources. The impact of the family violence homicides in Ranui in 2014 was clear in the CR assessment interviews. Participants expressed shock and fear about these deaths and there were a number of activities in response. The homicides may have contributed to the increase in readiness scores in Ranui on the CR assessment between 2014 and 2016 despite no planned or ongoing activity being implemented.

Contextual factors such as those mentioned above are beyond the control of the community members and local organisations implementing CM efforts. However, Campbell and Cornish (2010) state that it is critical for effective CM that the broader social context is assessed as contextual factors impact on CM. Watson-Thompson et al. (2008) support this assertion, and suggest that measurement on targeted indicators may not provide much insight into complex issues without measurement of the broader social and environmental context that contribute to the issue. Further, Campbell and Cornish (2010) state that part of the work to implement successful CM is to create a supportive environment for the initiative by addressing these contextual issues.

The results of this study support the evidence on the importance and impact of social context on CM. The ACMQ and CR assessments can be used to identify the key contextual issues in a community and to develop strategies to address these issues. It is important for researchers and practitioners to understand the importance of social context to plan and measure CM efforts. For researchers, developing indicators to assess key social contextual factors would support more comprehensive measurement of the impact of CM efforts. For practitioners, adopting a wider scope for CM initiatives that address an issue (e.g. family violence), but also include specific strategies to address key social contextual factors (e.g. social cohesion) may enable more successful CM.

Social cohesion

Social cohesion was an important aspect of social context that impacts on CM that was highlighted in this study. Lippman et al. (2016) theorised that social cohesion may play a key role in CM, and results from the ACMQ assessment support this theory. Lippman et al. (2016) state that social cohesion includes "working trust and mutual expectation to intervene for shared interests" (p. 128). The results showed that Glen Innes had significantly lower scores than Ranui on the social cohesion scale. The difference in the score for the item 'People in [community] are willing to help their neighbours' demonstrates this. In Ranui, 58% of participants agreed a lot to this item, compared to 18% in Glen Innes. Previous research included in the Glen Innes case study showed that there were long-term concerns about social cohesion (Scott, Shaw, et al., 2010). It is suggested that the long-term social issues, inequalities and the housing redevelopment contributed to the lower level of agreement on items on the ACMQ social cohesion scale for Glen Innes in this study.

The ACMQ social cohesion scores indicated that Ranui is a more socially cohesive community. Again, there are many factors that may have contributed to this result, and this may have existed long before the study period. However, the focus of CD work on social cohesion in Ranui may have contributed to higher social cohesion scores. As one CR participant in Ranui said, “Our community has recognised the importance of being together” (HR2 2016). The social cohesion scores for Glen Innes and overall lower scores on the ACMQ suggest that when social cohesion is low or disrupted it is more difficult for a community to mobilise. Future research is needed to explore this association further.

As Campbell and Cornish (2010) stated, CM is unlikely to be successful in adverse social environments. Measuring social cohesion using the ACMQ is useful as it identifies whether social cohesion is a concern, and if there is a need to increase efforts to promote social cohesion to support CM initiatives to be effective. The ACMQ is also a useful tool to measure attempts to improve social cohesion. This may include strategies to build social cohesion broadly or specifically, for example a specific strategy could to work to reduce the impacts of residential mobility on social cohesion. This is an important consideration in supporting CM efforts. If social cohesion is a foundation domain of CM and perhaps a certain level of social cohesion must be present to support CM, and for CM efforts to gain momentum in a community. CM relies on people coming together to talk, learn and act and it is very likely that low social cohesion will limit this.

This study contributed to the evidence supporting the importance of social cohesion in CM. Future research may investigate this association further to understand if social cohesion is indeed a critical factor in mobilising communities. The inclusion of social cohesion in the domains of CM and the ACMQ may help to highlight the importance of social cohesion for those planning, implementing and measuring of CM.

Assessing attitudes

Another interesting finding was that scores for the ACMQ domains and CR dimensions that assessed attitudes and perceptions of community attitudes were very similar between the two communities for both assessments. The ACMQ scales that assessed attitudes showed the most similar results of all ACMQ domain scales (shared concern – family violence and shared concern – healthy relationships). The CR assessment results showed that the results for the community climate dimension which assessed community attitudes were very similar between

the two communities and also showed very little change between the two CR assessments. It is important to note that it is difficult to directly assess people's attitudes, and that for this study, it may be more accurate to say that perceptions and beliefs about attitudes were measured, rather than attitudes directly. However, the results indicated that attitudes were the least community specific or contextualised aspect of CM assessed in this study. Abramsky (2012) and Michau (2012) assert that it is very difficult to measure changes in social norms at the community-level. Therefore, one possible explanation for these very similar results between the two communities is that the tools do not have the sensitivity to assess differences in attitudes.

Alternatively, it is possible that attitudes about issues such as family violence are held at the societal rather than community-level, hence the similar scores between the two communities. If this is the case, then attitude change efforts at the community-level may need to be coordinated with efforts at the societal-level to make change. Results from the Abramsky et al. (2014) study of SASA! showed change in attitudes in communities implementing CM on gender-based violence. This is promising new evidence. Future research into this aspect of CM measurement may increase understanding of what research methods are most effective to assess attitudes and social norms. This evidence could then be used to inform whether community or societal-level interventions are most effective and what types of interventions work to change attitudes. In addition, if attitudes are held at the societal-level, it would be useful to investigate what sort of societal-level interventions best compliment CM activity in communities to enable synergies in efforts across the levels of the ecological model (World Health Organization, 2014). These results for the ACMQ and CR assessments may suggest that making change on attitudes is more difficult than making change on other domains of CM. However, perhaps neither of these theories explain the results. It is important to note that psychological research has suggested for many years that attitudes are not good indicators of behaviour change (Bain, 1930), and therefore perhaps should not be given too much importance in CM measurement.

Strengths of the research

Strengths of this research were that it addressed gaps in the evidence on CM measurement and engaged with the complexity of measuring CM. These contributions have been discussed

in some detail above. In this section the specific strengths of inclusion of assessment of healthy relationships and the use of the case study design are discussed.

Assessing healthy relationships

A strength of this research is that it assessed CM to address a problem, namely, family violence, but also the goal of healthy relationships. As far as I am aware, this is the first time this has been done, as the majority of the evidence is on problem assessment. The focus on healthy relationships is relatively new in the evidence on prevention of family violence and denotes a paradigm shift away from only assessing problems, and towards building evidence on how positive change is made (Rogers et al., 2018). CM is a Freirean (2000b) transformative approach that aims to denounce harmful practices, such as family violence, and to announce transformative solutions, in this case creating new social norms of healthy relationships. To date, the measurement of CM has failed to measure the positive goal of CM efforts and has only assessed the problem. In this study, both the ACMQ and CR assessments assessed healthy relationship promotion as well as family violence prevention. As such, this is an example of measurement that assesses a whole transformative concept of CM.

In this study, the focus on healthy relationships came from practice and this contributed to knowledge building on the measurement of CM and healthy relationships. The results of the CR assessment showed the impact of the efforts in Glen Innes to build community leadership to promote healthy relationships which was a key focus of local activity. There is little that can be concluded about measurement of healthy relationships from the results and further investigation into this area is needed. However, assessment over time of the positive goal (e.g. healthy relationship promotion) as well as the issue (e.g. family violence) in CM may contribute to evidence building on what works to develop transformative CM approaches for complex issues.

Case study research

The use of case study research was also a strength of this study. The use of a two-case case study design (Yin, 2014) was an appropriate way to assess the complex construct of CM in real-world settings as recommended by Harrison et al. (2017). The two-case case study design was a novel and useful method to assess the utility and validity of the ACMQ, and to provide insights into the relationship between measurement of CM and CR and social context which

would not have been possible with a single case study design. Case study design increased understanding of the feasibility and logistics of administering the two tools in different contexts. Also as suggested by Yin (2014) the comparison of two communities supported theory development. In this research insights that may inform theory development included the role of social cohesion in CM, the effectiveness of measurement of attitudes, and the relationship between measurement of CM and CR.

Another benefit of employing case study research was that it provides the reader with enough information to assess transferability (Lincoln & Guba, 2000; Tashakkori & Teddlie, 2003). The transferability of this study relates primarily to the methods used to assess CM, specifically the two-case case study design and the utilisation of the ACMQ and CR tools. This study met a need articulated in the literature and the field for tools to assess CM. Case study has allowed for rich contextual data to be provided to the reader, and it is now up to the reader to assess the transferability of the methods to other contexts.

This study also contributed an example of a quantitative case study to assess a complex issue. This is somewhat rare in the literature as case study often employs qualitative methods, also qualitative research is commonly utilised to understand complex issues like family violence (Stake, 2000). Here case study was used to present quantitative results with contextual information on each community that allowed interpretation and analysis of the results in a way that would not be possible using an traditional experimental design. In this way the need to develop quantitative tools to assess CM was met, but did not mean that the engagement with the communities where the research took place was simplistic or decontextualised.

The case study design was a useful approach to build evidence of the utility, construct validity and internal validity of the ACMQ in the context of family violence prevention and healthy relationship promotion in two communities. The ACMQ can now be trialled in other contexts and on other issues.

Limitations of the study

The key limitations of this study were the inability to assess reliability and external validity of the ACMQ. Other limitations of this study included the lack of direct community involvement in the ACMQ development, the lack of use of cultural models and the comparatively short time

frame of the study to assess CM which is understood as a long-term approach to making change.

As discussed earlier, the key limitation of the study was that the reliability of the tool could not be assessed because of changes to improve the ACMQ between the 2014 and 2016 assessments. Future applications of the tool are necessary to establish reliability. The external validity of the tool was also not established in this study, and further applications of the ACMQ in other contexts are necessary to establish external validity.

Another limitation of the study was the lack of direct community involvement in development of the ACMQ. The ACMQ was developed using the literature and a practice example, namely, the theory of change or long-term plan developed by the HEART Movement in Glen Innes. While community members and practitioners were involved in the development of the ACMQ indirectly, there was no direct involvement of community members in its development. This decision was made because the only known CM initiative in Aotearoa was in the Glen Innes community, and involving members of that community in the development of the tool could have compromised results of the study. However, indirectly, the Glen Innes community shaped the focus of the ACMQ and the inclusion of healthy relationships in this research through the theory of change. It is also acknowledged that much of the literature on CM is informed by work in communities. However, community input could be invited to understand the participant's experience of using the ACMQ and to address any perceived overlaps or gaps in the tool from the perspective of community members involved in CM efforts, and to also assess how user friendly the tool is and if any improvements are needed. Gaining input from community members could also increase community acceptance and buy in to the use of the ACMQ and results of assessments.

The development of the ACMQ was informed by the literature and a practice example, but lacked inclusion of cultural models that may have made the tool more appropriate for our context in Aotearoa New Zealand. In Aotearoa, much of our health and social policy and practice is informed by Māori health and wellbeing models, and to a lesser extent Pacific models. These models demonstrate the importance of whānau (including ancestors), physical, mental and spiritual wellbeing, the physical environment, context, time, participation in society and cultural identity in individual, whānau and community health and wellbeing. Future research could investigate the relevance of the concept of CM and measurement of CM to

Māori, Pacific and other peoples. This could include investigation of how the domains of CM do and do not align with cultural models and, if relevant, how this relates to practice and measurement of CM. Like many Indigenous models, CM is a collective approach; however, the construct of CM and literature on CM are informed by Western thinking. Indigenous approaches often emphasise holistic wellbeing rather than a focus on one specific issue. As such, measurement of CM on one issue may not be a relevant approach, but this could be investigated and the ACMQ tool could be adapted to include specific cultural models if this was deemed appropriate.

Another limitation of this research was the short time frame. The primary purposes of the research were achieved, which were to develop the ACMQ, and to test the utility and validity of the tool and the methods to assess CM and CR. However, CM is a long-term strategy and assessment also requires long time frames. Longer time frames could have provided more insight into the implementation and measurement of CM in communities. This was not possible within the time constraints of this doctoral research, but could be achieved in future applications of the research tools as is discussed in the next section.

Future research

There is much that is not yet known about measurement of CM. Future research could make important contributions to inform the development of this work. Key next steps for research on CM measurement are understanding the weighting of the CM domains and the potential for an overall score for CM. Debate is needed about whether individual or community measures are most appropriate to assess CM. The use of longer time frames to assess CM is suggested. Finally, there are possibilities for development of qualitative research approaches to compliment the ACMQ.

Domain weighting and overall community mobilisation score

It is not yet known if the domains of CM included in the ACMQ are of equal weighting. For example, whether efforts to increase leadership are as important, more important or less important than efforts to increase critical consciousness in mobilising communities. The results of this research indicated that social cohesion may be a key domain in mobilisation, and that assessing attitudes may be of less importance. Future research could investigate the weighting or importance of the domains further. This could involve studies where the methods employed

in this study are intentionally used in different contexts, such as in communities where there is evidence of high or low levels of community participation and could be used to assess the impact of this on the domain scores. Understanding domain weighting could inform measurement of CM by indicating if some domains of CM require more in-depth investigation, perhaps through qualitative study, and which domains are adequately assessed using the ACMQ for example. This knowledge could also inform improvements in the implementation of CM by indicating the most effective allocation of resources across the domains of CM for specific communities.

As there is currently no understanding of the weighting of the CM domains, no overall score of CM was developed for the ACMQ. The evidence in this area is very limited to date. Lippman et al. (2016) theorised that collective CM action may require strong social cohesion, critical consciousness and shared concern. However, Michau (2012) and others have emphasised the important role of leadership in CM. Eng and Parker (1994) stated in their work to develop a tool to measure community competence, that there was a lack of empirical and theoretical evidence to support development of an overall score. This is also the case for measurement of CM at this stage in the development of the field. Further debate could examine the need for and merits of an overall score for CM.

Aggregation of individual responses

Current attempts to measure community change commonly use individual participant responses which are aggregated as a proxy measure for a community. The ACMQ is an example of a measure that aggregates individual responses to assess CM. Due to the lack of literature on this aspect of CM measurement, it is not yet known whether CM is best assessed by aggregating individual responses or if it would be more effective to develop a community measure which uses a collective assessment approach. This aspect of measurement would benefit from further debate and from new contributions to the literature on how best to assess CM. However, until a community CM measure is developed, it will be difficult to inform this debate with evidence.

Time frames

In future research, the methods used in this study could be implemented with longer time frames to investigate incremental change and long-term change on CM outcomes. Long-term

studies could also investigate the impact of major events and change on communities. In the context of CM on family violence, major events may include family violence homicides within a community, levels of resourcing, changes to policy and practice, or changes in the social context of a community. Understanding how major events and changes in a community increase or decrease CM activity on an issue would be of interest, and how increases in CM activity are sustained over time following a major event or change in the community would be of interest and of practical use to academics, practitioners and communities implementing CM.

Qualitative research

This research responded to a need in the field and literature to quantify CM. However, there is also a need to develop specific qualitative research approaches to study CM. The identified domains of CM could be used as the base for qualitative studies and could investigate the domains of CM in detail. This could involve in-depth interviews with key informants or groups for example. Qualitative research would be very useful in understanding social context and the impact of the specific events and activities in communities on CM. Future research could use the ACMQ alongside new qualitative methods using a mixed method approach. Development of specific qualitative approaches to study CM may remove the need to use the CR assessment, but this would need to be further investigated, and for now, the CR assessment is a very useful complimentary measure.

Conclusions

This research made important contributions to the emerging literature on the measurement of CM. The major contribution is the ACMQ—a new tool to assess CM. The tool was implemented in this study of two geographic communities, and can now be trialled in other contexts and on other issues to establish the external validity and reliability. The statistical analysis of the ACMQ results showed an eight-component solution and high internal consistency. The ACMQ is easy to use and has low implementation costs; the main resource requirement is the time to distribute and collect the questionnaire.

This research identified the domains of CM. The domains are: leadership; participation; organisation; critical consciousness; shared concern; and, social cohesion. This is the first study to support the domains of CM identified by Lippman et al. (2013). There can now be some certainty about the six domains of CM, as different methods were used in this study and by

Lippman et al. (2013) to identify the domains, and both methods arrived at the same conclusions.

This is thought to be the first study to assess both CM and CR and it provided important insights into the measurement of CM. The use of both the ACMQ and the CR assessment tools is recommended to assess CM because of the complimentary nature of the tools in assessing different aspects of community efforts and the broader community context. The results of this case study research indicated the importance of social context and social cohesion on CM. The study contributed to the evidence about the challenge of measuring change in attitudes at the community-level.

Results of the CR assessment suggested that Glen Innes had higher community readiness than Ranui, and the results of the ACMQ assessment indicated Ranui had higher CM than Glen Innes. These results were not expected. It was expected that the community with the highest CM scores would also have the highest CR scores. Initially, it seemed that these results were conflicting; however, further analysis showed that the results can be explained by the type of participants used in each tool (community members or key informants), the ability of the tools to assess formal and informal community efforts to address an issue, and the importance and impacts of community context on mobilisation.

CM is a transformative approach used to create social change on complex issues. The ongoing challenge for measurement is to embrace the complexity of the construct and to continue to develop tools and approaches that can assess this complexity as CM theory and practice develop. As this quote from Jane Addams suggests, there may be more to CM than we have as yet been able to quantify:

> "Our hope of [social] achievement … lies in a complete mobilization of the human spirit, using all our unrealized and unevoked capacity" (Addams, 1930).

This sentiment from Addams was later echoed by Freire in his assertion that each of us must become more fully human to enable to social change. We must sit with what this means for measurement and practice. There are many questions that remain about measurement of CM; however, this study has made an important contribution to the development of this field.

APPENDICES

Appendix 1

Final Aotearoa Community Mobilisation Questionnaire items to pilot

Domain	Scale items
Leadership	1. Leaders in my community speak out against family violence. 2. Leaders in my community promote healthy relationships. 3. Leaders in my community are role models of healthy relationships. 4. Community leaders are able to represent all sectors of the community 5. Community leaders are able to build consensus across the community. 6. Community leaders are able to involve community members in decision-making. 7. Community leaders are able to manage inter-group conflict within the community.
Participation	1. In my community I see messages about healthy relationships (E.g. posters, radio, community meetings, church etc). 2. In my community I know people in healthy relationships. 3. In my community I see people in healthy relationships. 4. I have done something to help to prevent family violence in my community. 5. I have done something to promote healthy relationships in my community. 6. In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in my community. 7. In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in my community. 8. Information (e.g. booklets, training) about family violence is available in my community. 9. The available information about family violence is useful. 10. Information (e.g. booklets, training) about where to get help for family violence is available in my community. 11. The available information about where to get help for family violence is useful. 12. Information (e.g. booklets, training) about healthy relationships is available in my community. 13. The available information about healthy relationships is useful. 14. Information (e.g. booklets, training) about where to get help for healthy relationships is available in my community. 15. The available information about where to get help for healthy relationships is useful.
Critical thinking	1. As a community we have opportunities to discuss why people use family violence to get what they want. 2. As a community we have opportunities to discuss why healthy relationships are good for people. 3. I understand how family violence happens. 4. I understand how you make a healthy relationship.

Domain	Scale items
Organisation	1. In my community we have the services we need to help to prevent family violence. 2. In my community we have the funds we need to help to prevent family violence. 3. In my community we have the people with the skills to help to prevent family violence. 4. In my community we have the services we need to help to promote healthy relationships. 5. In my community we have the funds we need to help to promote healthy relationships. 6. In my community we have the people with the skills to help to promote healthy relationships. 7. The support that people get from services for family violence helps to keep them safe. 8. The support that people get from services helps them to make healthy relationships. 9. When people need help for family violence the services in my community work together well. 10. When people need help to make their relationships healthier the services in my community work together well.
Attitudes and beliefs	1. Stopping family violence is good for me. 2. Stopping family violence is good for my family 3. Stopping family violence is good for my community. 4. Having healthy relationships is good for me. 5. Having healthy relationships is good for my family. 6. Having healthy relationships is good for my community. 7. I am worried about family violence in my community. 8. Working to prevent family violence is important to me. 9. Working to promote healthy relationships is important to me. 10. People in my community are comfortable talking about how to prevent family violence. 11. People in my community are comfortable talking about how to promote healthy relationships.

Appendix 2

Aotearoa Community Mobilisation Questionnaire preliminary pilot

Instructions

Thinking about the community that you live in, please circle the one response that best describes how you feel about each of the following statements. There are no right or wrong answers.

	Question	Response				
		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know
1	Leaders in my community speak out against family violence.	SA	A	D	SD	DK
2	In my community I see messages about healthy relationships (E.g. posters, radio, community meetings, church etc).	SA	A	D	SD	DK
3	As a community we have opportunities to discuss why people use family violence to get what they want.	SA	A	D	SD	DK
4	In my community we have the services we need to help to prevent family violence.	SA	A	D	SD	DK
5	When people need help for healthy relationships the helping services in my community work together well.	SA	A	D	SD	DK
6	Stopping family violence is good for me.	SA	A	D	SD	DK
7	I am worried about family violence in my community.	SA	A	D	SD	DK
8	The available information about where to get help for healthy relationships is helpful.	SA	A	D	SD	DK
9	Leaders in my community promote healthy relationships.	SA	A	D	SD	DK
10	In my community I know people in healthy relationships.	SA	A	D	SD	DK
11	As a community we have opportunities to discuss why healthy relationships are good for people.	SA	A	D	SD	DK
12	In my community we have the funds we need to help to prevent family violence.	SA	A	D	SD	DK
13	Stopping family violence is good for my family	SA	A	D	SD	DK
14	Working to prevent family violence is important to me.	SA	A	D	SD	DK
15	Leaders in my community are role models of healthy relationships.	SA	A	D	SD	DK
16	In my community I see people in healthy relationships.	SA	A	D	SD	DK
17	I understand how family violence happens.	SA	A	D	SD	DK
18	In my community we have the people with the skills we need to help to prevent family violence.	SA	A	D	SD	DK
19	Stopping family violence is good for my community.	SA	A	D	SD	DK
20	Working to promote healthy relationships is important to me.	SA	A	D	SD	DK
21	The available information about what family violence is helpful.	SA	A	D	SD	DK
22	Community leaders are able to represent all sectors of the community	SA	A	D	SD	DK

	Question	Response				
		Strongly Agree	Agree	Disagree	Strongly Disagree	Don’ t know
23	I have done something to help to prevent family violence in my community.	SA	A	D	SD	DK
24	I understand how you make a healthy relationship.	SA	A	D	SD	DK
25	In my community we have the services we need to help to promote healthy relationships.	SA	A	D	SD	DK
26	Having healthy relationships is good for me.	SA	A	D	SD	DK
27	People in my community are comfortable talking about how to prevent family violence.	SA	A	D	SD	DK
28	Information (e.g. booklets, training) about what healthy relationships are is available in my community.	SA	A	D	SD	DK
29	Community leaders are able to build consensus across the community.	SA	A	D	SD	DK
30	I have done something to promote healthy relationships in my community.	SA	A	D	SD	DK
31	Information (e.g. booklets, training) about what family violence is available in my community.	SA	A	D	SD	DK
32	The help that people get from services helps them to make healthy relationships.	SA	A	D	SD	DK
33	Having healthy relationships is good for my family.	SA	A	D	SD	DK
34	People in my community are comfortable talking about how to promote healthy relationships.	SA	A	D	SD	DK
35	Community leaders are able to involve community members in decision-making.	SA	A	D	SD	DK
36	In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in my community.	SA	A	D	SD	DK
37	In my community we have the funds we need to help to promote healthy relationships.	SA	A	D	SD	DK
38	Information (e.g. booklets, training) about where to get help for family violence is available in my community.	SA	A	D	SD	DK
39	When people need help for family violence the helping services in my community work together well.	SA	A	D	SD	DK
40	Having healthy relationships is good for my community.	SA	A	D	SD	DK
41	The available information about what healthy relationships are is helpful.	SA	A	D	SD	DK
42	Community leaders are able to manage inter-group conflict within the community.	SA	A	D	SD	DK
43	In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in my community.	SA	A	D	SD	DK
44	In my community we have the people with the skills we need to help to promote healthy relationships.	SA	A	D	SD	DK

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't know
45	The available information about where to get help for family violence is helpful.	SA	A	D	SD	DK
46	The help that people get from services for family violence helps to keep them safe.	SA	A	D	SD	DK
47	In my community homes actively grow loving, safe and supportive relationships.	SA	A	D	SD	DK
48	Information (e.g. booklets, training) about where to get help for healthy relationships is available in my community.	SA	A	D	SD	DK

49. What is your gender? (please circle) Male Female Other _____

50. How old are you? _____ years

51. How would you describe your ethnicity? (please circle)
a. Māori b. Pacific specify_____ c. Pakeha/NZ European d. Asian specify _____
e. Other specify_____

52. How do you find out about what is happening in your community?
_____
_____
_____

How long did it take you to fill in this questionnaire (approximately)? _____ mins

This questionnaire is in development. Do you have any suggestions, comments about this questionnaire?

Appendix 3

Aotearoa Community Mobilisation Questionnaire community pilot

Instructions

This survey is for people aged over 16 years who live in [Community name]. Please circle the one response that best describes how you feel about each of the following statements. There are no right or wrong answers.

	Question	Response				
		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
1	Leaders in my community speak out against family violence.	SA	A	D	SD	DK
2	As a community we have opportunities to discuss why people use family violence to get what they want.	SA	A	D	SD	DK
3	In my community we have the services we need to help to prevent family violence.	SA	A	D	SD	DK
4	When people need help to make their relationships healthier the services in my community work together well.	SA	A	D	SD	DK
5	I am worried about family violence in my community.	SA	A	D	SD	DK
6	Information (e.g. booklets, training) about where to get help for healthy relationships is available in my community.	SA	A	D	SD	DK
7	Leaders in my community promote healthy relationships.	SA	A	D	SD	DK
8	In my community I know people in healthy relationships.	SA	A	D	SD	DK
9	As a community we have opportunities to discuss why healthy relationships are good for people.	SA	A	D	SD	DK
10	Leaders in my community are role models of healthy relationships.	SA	A	D	SD	DK
11	In my community I see people in healthy relationships.	SA	A	D	SD	DK
12	I understand how family violence happens.	SA	A	D	SD	DK
13	In my community we have the people with the skills to help to prevent family violence.	SA	A	D	SD	DK
14	Information (e.g. booklets, training) about family violence is available in my community.	SA	A	D	SD	DK
15	Community leaders are able to represent all sectors of the community	SA	A	D	SD	DK
16	I have done something to help to prevent family violence in my community.	SA	A	D	SD	DK
17	I understand how you make a healthy relationship.	SA	A	D	SD	DK
18	Information (e.g. booklets, training) about healthy relationships is available in my community.	SA	A	D	SD	DK
19	The available information about family violence is useful.	SA	A	D	SD	DK

21	Having healthy relationships is good for my family.	SA	A	D	SD	DK
22	In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in my community.	SA	A	D	SD	DK
23	Information (e.g. booklets, training) about where to get help for family violence is available in my community.	SA	A	D	SD	DK
24	The available information about healthy relationships is useful.	SA	A	D	SD	DK
25	Having healthy relationships is good for my community.	SA	A	D	SD	DK
26	Community leaders are able to manage inter-group conflict within the community.	SA	A	D	SD	DK
27	In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in my community.	SA	A	D	SD	DK
28	The support that people get from services for family violence helps to keep them safe.	SA	A	D	SD	DK
29	The available information about where to get help to have healthy relationships is useful.	SA	A	D	SD	DK
30	In my community homes actively grow loving, safe and supportive relationships.	SA	A	D	SD	DK

31. What is your gender? (Please circle) Male Female Other _____

32. How old are you? _____ years

33. How would you describe your ethnicity? (Please circle)

a. Mäori b. Pakeha/NZ European

c. Pacific specify _____ d. Asian specify _____

e. Other specify _____

Appendix 4

Final Aotearoa Community Mobilisation Questionnaire

INSTRUCTIONS

This survey is for people aged over 16 years who live in [community].

Please <u>circle the ONE response</u> that best describes how you feel about each of the following statements. There are no right or wrong answers.

The survey will take approximately 10 minutes to complete.

1. These questions ask about your understanding of how concerned people in [community] are about family violence.

People in [community]…

are concerned about family violence	Agree a lot	Somewhat agree	Do not agree at all
consider family violence an important issue	Agree a lot	Somewhat agree	Do not agree at all
talk openly about family violence	Agree a lot	Somewhat agree	Do not agree at all
believe that family violence impacts the community	Agree a lot	Somewhat agree	Do not agree at all
talk about family violence at community meetings	Agree a lot	Somewhat agree	Do not agree at all
work together to prevent family violence	Agree a lot	Somewhat agree	Do not agree at all
take family violence seriously	Agree a lot	Somewhat agree	Do not agree at all
believe they can prevent family violence	Agree a lot	Somewhat agree	Do not agree at all
exchange information about family violence	Agree a lot	Somewhat agree	Do not agree at all
work together to reduce the effects of family violence	Agree a lot	Somewhat agree	Do not agree at all

2. These questions ask about how connected you think the [community] community is.

People in [community]…

are willing to help their neighbours	Agree a lot	Somewhat agree	Do not agree at all
can be trusted	Agree a lot	Somewhat agree	Do not agree at all
generally get along well with each other	Agree a lot	Somewhat agree	Do not agree at all
share the same values	Agree a lot	Somewhat agree	Do not agree at all
look out for each other	Agree a lot	Somewhat agree	Do not agree at all

This is a close knit community	Agree a lot	Somewhat agree	Do not agree at all

3. These questions ask about healthy relationships within families and how important they to people in [community].

People in [community]…

are concerned about healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
consider healthy relationships an important issue	Agree a lot	Somewhat agree	Do not agree at all
talk openly about healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
believe that healthy relationships impact the community	Agree a lot	Somewhat agree	Do not agree at all
talk about healthy relationships at community meetings	Agree a lot	Somewhat agree	Do not agree at all
work together to promote healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
believe they can promote healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
exchange information about healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
take healthy relationships seriously	Agree a lot	Somewhat agree	Do not agree at all

4. These next questions ask about community leaders. Leaders can be any person or group of people who have a leadership role in your community. Leaders may include community advocates, kaumātua, church leaders, business or sports people, and people involved in local organisations for example.

Leaders in [community] speak out against family violence	Agree a lot	Somewhat agree	Do not agree at all
Leaders in [community] promote healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
Leaders in [community] are role models of healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
Community leaders are able to represent all sectors of the community	Agree a lot	Somewhat agree	Do not agree at all
Community leaders are able to manage inter-group conflict within the community	Agree a lot	Somewhat agree	Do not agree at all

5. Do you know of any services in [community] that help people to prevent family violence or make healthy relationships?

	Yes	No

If you circled YES, please go to section 6 below.

If you circled NO, please go to section 7 over the page.

6. Can you please answer these questions about the services available in [community].

In [community] we have the services we need to help to prevent family violence	Agree a lot	Somewhat agree	Do not agree at all
In [community] we have the people with the skills to help to prevent family violence	Agree a lot	Somewhat agree	Do not agree at all
The support that people get from services for family violence helps to keep them safe	Agree a lot	Somewhat agree	Do not agree at all
When people need help to make their relationships healthier the services in [community] work together well	Agree a lot	Somewhat agree	Do not agree at all
The support that people get from services helps them to make healthy relationships	Agree a lot	Somewhat agree	Do not agree at all

7. These questions ask about how people think about community problems, including family violence, and how they work to address these problems.

People in [community]…

talk to each other about how to solve community problems	Agree a lot	Somewhat agree	Do not agree at all
enjoy discussing different ways to solve community problems	Agree a lot	Somewhat agree	Do not agree at all
are open to hearing different views about community problems and solutions	Agree a lot	Somewhat agree	Do not agree at all
volunteer to help solve community problems	Agree a lot	Somewhat agree	Do not agree at all
think about why family violence happens so they can address the cause of the problem	Agree a lot	Somewhat agree	Do not agree at all
not only talk about family violence but they also try to prevent it	Agree a lot	Somewhat agree	Do not agree at all

People work together to solve problems in [community]	Agree a lot	Somewhat agree	Do not agree at all
There is a lot of cooperation between groups in [community]	Agree a lot	Somewhat agree	Do not agree at all
If your community fails to resolve a community problem, they will try another-different approach to solving the problem	Agree a lot	Somewhat agree	Do not agree at all
If your community fails to resolve a community problem, they will learn from that experience and do a better job when they try to solve the problem in the future	Agree a lot	Somewhat agree	Do not agree at all
If leaders in [community] fail to resolve a community problem, people will work together to find a solution	Agree a lot	Somewhat agree	Do not agree at all

8. Do you know of any activity (e.g. information, posters, community events, media, talks, trainings) to prevent family violence or promote healthy relationships in [community]?

	Yes	No

If you circled YES, please go to section 9 below.

If you circled NO, please go to section 10 over the page.

9. Can you please answer these questions about what activity is going on and what information is available to prevent family violence or promote healthy relationships in [community].

In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in [community]	Agree a lot	Somewhat agree	Do not agree at all
In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in [community]	Agree a lot	Somewhat agree	Do not agree at all
I have done something to help to prevent family violence in [community]	Agree a lot	Somewhat agree	Do not agree at all
Information (e.g. booklets, training) about family violence is available in [community]	Agree a lot	Somewhat agree	Do not agree at all
The available information about family violence is useful	Agree a lot	Somewhat agree	Do not agree at all
Information (e.g. booklets, training) about where to get help for family violence is available in [community]	Agree a lot	Somewhat agree	Do not agree at all
Information (e.g. booklets, training) about healthy relationships is available in [community]	Agree a lot	Somewhat agree	Do not agree at all
The available information about healthy relationships is useful	Agree a lot	Somewhat agree	Do not agree at all
Information (e.g. booklets, training) about where to get help for healthy relationships is available in [community]	Agree a lot	Somewhat agree	Do not agree at all
The available information about where to get help for healthy relationships is useful	Agree a lot	Somewhat agree	Do not agree at all
In [community] I know people in healthy relationships	Agree a lot	Somewhat agree	Do not agree at all
In [community] I see people in healthy relationships	Agree a lot	Somewhat agree	Do not agree at all

10. Finally, please can you answer these questions about yourself.

What is your gender? (please circle) Male Female Other _____

How old are you? _____ years

How would you describe your ethnicity? (please circle as many as apply)

a. Māori b. Pakeha/NZ European

c. Pacific (specify) _____ d. Asian (specify) _____

e. Other (specify) _____

THANK YOU FOR COMPLETING THIS SURVEY

Appendix 5

Final Aotearoa Community Mobilisation Questionnaire domains, scale and items

Domain	Scale items
Shared concern – family violence	1. People in [community] are concerned about family violence 2. People in [community] consider family violence an important issue 3. People in [community] talk openly about family violence 4. People in [community] believe that family violence impacts the community 5. People in [community] talk about family violence at community meetings 6. People in [community] work together to prevent family violence 7. People in [community] take family violence seriously 8. People in [community] believe they can prevent family violence 9. People in [community] exchange information about family violence 10. People in [community] work together to reduce the effects of family violence
Shared concern – healthy relationships	1. People in [community] are concerned about healthy relationships 2. People in [community] consider healthy relationships an important issue 3. People in [community] talk openly about healthy relationships 4. People in [community] believe that healthy relationships impact the community 5. People in [community] talk about healthy relationships at community meetings 6. People in [community] work together to promote healthy relationships 7. People in [community] believe they can promote healthy relationships 8. People in [community] exchange information about healthy relationships 9. People in [community] take healthy relationships seriously
Leadership	1. Leaders in [community] speak out against family violence 2. Leaders in [community] promote healthy relationships 3. Leaders in [community] are role models of healthy relationships 4. Community leaders are able to represent all sectors of the community 5. Community leaders are able to manage inter-group conflict within the community
Organisation	1. In [community] we have the services we need to help to prevent family violence 2. In [community] we have the people with the skills to help to prevent family violence 3. The support that people get from services for family violence helps to keep them safe 4. When people need help to make their relationships healthier the services in [community] work together well 5. The support that people get from services helps them to make healthy relationships
Critical consciousness	1. People in [community] talk to each other about how to solve community problems 2. People in [community] enjoy discussing different ways to solve community problems 3. People in [community] are open to hearing different views about community problems and solutions 4. People in [community] volunteer to help solve community problems 5. People in [community] think about why family violence happens so they can address the cause of the problem 6. People in [community] not only talk about family violence but they also try to prevent it 7. People work together to solve problems in [community] 8. There is a lot of cooperation between groups in [community] 9. If your community fails to resolve a community problem, they will try another-different approach to solving the problem 10. If your community fails to resolve a community problem, they will learn from that experience and do a better job when they try to solve the problem in the future 11. If leaders in [community] fail to resolve a community problem, people will work together to find a solution

Participation	1. In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about family violence in [community] 2. In the last 12 months there has been activity (e.g. information, posters, community events, media, talks, trainings) about healthy relationships in [community] 3. I have done something to help to prevent family violence in [community] 4. Information (e.g. booklets, training) about family violence is available in [community] 5. The available information about family violence is useful 6. Information (e.g. booklets, training) about where to get help for family violence is available in [community] 7. Information (e.g. booklets, training) about healthy relationships is available in [community] 8. The available information about healthy relationships is useful 9. Information (e.g. booklets, training) about where to get help for healthy relationships is available in [community] 10. The available information about where to get help for healthy relationships is useful 11. In [community] I know people in healthy relationships 12. In [community] I see people in healthy relationships
Social cohesion	1. People in [community] are willing to help their neighbours 2. People in [community] can be trusted 3. People in [community] generally get along well with each other 4. People in [community] share the same values 5. People in [community] look out for each other 6. This is a close-knit community

Appendix 6

Aotearoa Community Mobilisation Questionnaire Consent forms and participant information sheets

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

CONSENT FORM
(Community leadership group)
This form will be held for 6 years

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.

Name of Researcher: Cristy Trewartha, PhD Candidate

I have read the Participant Information Sheet and understand the nature of the research. I have had the opportunity to ask questions and have had them answered to my satisfaction. On behalf of the [GROUP NAME]

- We agree to assist with the recruitment of participants
- We understand that this involves making the participant information sheet and questionnaire available at community meetings and gatherings and using the sealed box, provided, to collect completed questionnaires.
- We understand that the researcher will collect the sealed boxes at the conclusion of the data collection phases.
- We understand that participation is voluntary and people will not be pressured to participate
- We wish to receive a summary of the findings. Yes / No

If you would like to receive a summary of the findings please include an email address here

_____

Name: _____

Signature: _____

Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

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Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

CONSENT FORM
(Organisation)
This form will be held for 6 years

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.

Name of Researchers: Cristy Trewartha, PhD Candidate

I have read the Participant Information Sheet and understand the nature of the research. I have had the opportunity to ask questions and have had them answered to my satisfaction.

- I agree to assist with the recruitment of participants
- I understand that this involves displaying a poster about the study, having Participant Information Sheets and blank questionnaires available, and hosting a sealed collection box in my organisation for completed questionnaires
- I agree to display a summary of the findings of this study in my organisation
- I understand that participation is voluntary, and that participants are anonymous

Name: _____

Signature: _____

Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

PARTICIPANT INFORMATION SHEET
(Community leadership group)

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.
Name of Researchers: Cristy Trewartha, PhD Candidate

Researcher introduction

My name is Cristy Trewartha. I am a doctoral student supervised by Associate Professor Janet Fanslow in the Department of Social and Community Health, School of Population Health, and Associate Professor Robyn Dixon in the School of Nursing at the University of Auckland. My doctoral research is looking at how communities might be involved in preventing family violence and promoting healthy relationships. The current study involves an assessment of how engaged people are in community activity to prevent family violence and promote healthy relationships.

The study

The study involves members of the community being invited to complete an anonymous questionnaire about their awareness of and participation in activity in the community to prevent family violence and promote healthy relationships. Participation is voluntary. If people agree to participate in the research they will complete a questionnaire on their perceptions of activity in their community to prevent family violence and promote healthy relationships. The questionnaire does not ask about personal experiences of family violence or healthy relationships.

I am writing to ask if your community leadership group would be prepared to use its networks to assist in recruiting participants. This will involve using your networks to distribute the Participant Information Sheet and the questionnaire, and collecting completed questionnaires in a sealed collection box. It is anticipated that that this could possibly occur at community meetings and gatherings where we would ask you to draw community members' attention to the information sheets and questionnaires.

There will be two phases of data collection. The first phase will be in October and November 2014, and the second in a year later in October-November 2015. I will come and collect all materials and the sealed collection box at the end of each phase.

The data collected may be used in my thesis, presentations and publications etc.

Thank you for considering this invitation to participate in my research. If you agree to assist with the study would you please complete the attached consent form.

Contact details

If you have any queries or concerns about this research please contact any of the people named below.

Researcher
Cristy Trewartha: phone 021 911 467 or email ctre015@aucklanduni.ac.nz

Supervisors
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz
Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz

Head of Department
Dr Elsie Ho: phone 09 373 7599 ext 86097 or email e.ho@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Phone 09 373 7599 ext 87830/ 83761 or email humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

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The University of Auckland
Private Bag 92019
Auckland, New Zealand

PARTICIPANT INFORMATION SHEET
(Organisation)

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.

Name of Researchers: Cristy Trewartha, PhD Candidate

Researcher introduction

My name is Cristy Trewartha. I am a doctoral student supervised by Associate Professor Janet Fanslow in the Department of Social and Community Health, School of Population Health, and Associate Professor Robyn Dixon in the School of Nursing at the University of Auckland. My doctoral research is looking at how communities might be involved in preventing family violence and promoting healthy relationships. The current study involves an assessment of how engaged people are in community activity to prevent family violence and promote healthy relationships.

The study

The study involves members of the community being invited to complete an anonymous questionnaire about their awareness of and participation in activity in the community to prevent family violence and promote healthy relationships. The questionnaire does not ask about personal experiences of family violence or healthy relationships.

I am writing to ask if you would be willing for (name of the organisation) to assist in recruiting participants. This will involve displaying a poster, having the Participant Information Sheet and questionnaires available to the public, and hosting a sealed collection box for the collection of completed questionnaires.

There will be two phases of data collection. The first phase will be in October and November 2014, and the second a year later in October-November 2015. I will come and collect all materials and the sealed collection box at the end of each phase.

I would also ask that at the end of the study, sometime in 2016, that you agree to display a poster, which will provide a summary of the findings, from the study.

Thank you for considering this invitation to participate in my research.

If you agree to assist with the study would you please complete the attached consent form

Contact details

If you have any queries or concerns about this research please contact any of the people named below.

Researcher
Cristy Trewartha: phone 021 911 467 or email ctre015@aucklanduni.ac.nz

Supervisors
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz
Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz

Head of Department
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Phone 09 373 7599 ext 87830/ 83761 or email humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

Appendix 7

Community readiness assessment consent forms and participant information sheets

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
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261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

CONSENT FORM
(Practitioner)
This form will be held for 6 years

Project title: Assessing community readiness to address family violence and promote healthy relationships.

Name of Researchers: Cristy Trewartha, Associate Professor Janet Fanslow, Research Assistants (2) (TBC).

I have read the Participant Information Sheet and have understood the nature of the research, and why I have been asked to nominate potential participants. I have had the opportunity to ask questions and have had them answered to my satisfaction

- I agree to assist with recruiting participants for this research, which involves identifying and seeking the permission of potential participants to share their contact details with the researchers
- I understand that data from the interviews conducted may be used in the student's doctoral thesis, academic articles, reports, presentations and other similar publications.
- I understand that if the information provided is reported or published, this will be done in a way that does not identify participants.
- I understand that data will be kept for 6 years, after which they will be destroyed.
- I wish to receive a summary of the findings. Yes / No

If you would like to receive a summary of the findings please include your email address here
_____

Name: _____
Signature: _____
Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 October 2013 FOR 3 YEARS REFERENCE NUMBER 2013/010436

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

PARTICIPANT INFORMATION SHEET
(Practitioner)

Project title: Assessing community readiness to address family violence and promote healthy relationships.

Name of Researchers: Cristy Trewartha, Associate Professor Janet Fanslow, Research Assistants (2) (TBC)

Researcher introduction

My name is Cristy Trewartha. I am a doctoral student supervised by Associate Professor Janet Fanslow in the Department of Social and Community Health, School of Population Health, University of Auckland. My doctoral research is looking at how communities might be involved in preventing family violence and promoting healthy relationships. The current study is the first step towards answering this question and involves an assessment of how "ready" the community you work and/ or live in is to participate in programmes of action to address these issues.

You are being invited to assist in this research project because of your knowledge of the people involved in activity in this community to prevent family violence and/ or promote healthy relationships.

What does the study involve?

This study involves interviewing people who live and work in this community about either family violence, or healthy relationships in the community generally. It is important to note that they will not be asked about their own personal experiences of family violence or healthy relationships, rather potential participants are people who are knowledgeable about family violence or healthy relationships activity in your community. Participants will be asked to complete the same interview twice over a 12-month period. The interview questions are about resources in the community, leadership, and attitudes about family violence or healthy relationships. Two research assistants helping me with this study will conduct the interviews. The interviews will take approximately one hour, and can be completed face to face or over the phone. Participation is voluntary and participants have the right to withdraw from this study at any time without providing a reason, and they may withdraw their information within one month of completing each interview. In recognition of the time given to the project, participants will be offered a koha, in the form of a $20 grocery voucher.

What is being asked of you?

If you agree to assist me with this research you will be asked to nominate potential research participants. Twelve participants are needed from your community in total. Potential participants will be people you know who work or live in this community who have knowledge of the activity

in this community to prevent family violence or promote healthy relationships. You are being asked to seek permission from the people you nominate to share their names and contact details of potential participants with a research assistant who will then approach them and tell them more about the study. The research assistant will give them a Participant Information Sheet, and to ask them if they are interested in participating in the study. If they agree to participate the research assistants will then arrange an interview.

What will happen to the data?

With the consent of participants the interview will be audio recorded so that the research assistants can check the accuracy of the notes that they will be taking during the interview. The interviews will not be transcribed, but it will be stored electronically on a USB (universal storage bus) device. The interview recordings and written material will be stored for 6 years in a locked filing cabinet in my supervisor's office and will then be destroyed by a confidential information destruction company.

What will happen to the information?

Data from the interviews may be used in my doctoral thesis, academic articles, reports, presentations and other similar publications. Information will be presented in a way that will not allow participants to be identified. If you would like to receive a summary of the study findings please indicate this on the consent form, which accompanies this information sheet.

Thank you for considering this invitation to assist with my research.

Contact details

If you have any queries or concerns about this research please contact any of the people named below.

Researcher
Cristy Trewartha: phone 021 911 467 or email ctre015@aucklanduni.ac.nz
Supervisors
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz
Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz
Head of Department
Dr Peter Adams: phone 09 373 7599 ext 86538 or email p.adams@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Phone 09 373 7599 ext 87830/ 83761 or email humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 October 2013 FOR 3 YEARS REFERENCE NUMBER 2013/010436

Appendix 8

Aotearoa Community Mobilisation Questionnaire consent forms and participant information sheets

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
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North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

The University of Auckland
Private Bag 92019
Auckland, New Zealand

PARTICIPANT INFORMATION SHEET
(Participant)

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.
Name of Researchers: Cristy Trewartha, PhD Candidate

Researcher introduction

My name is Cristy Trewartha. I am a doctoral student supervised by Associate Professor Janet Fanslow in the Department of Social and Community Health, School of Population Health, and Associate Professor Robyn Dixon in the School of Nursing at the University of Auckland. My doctoral research is looking at how communities might be involved in preventing family violence and promoting healthy relationships. The current study involves an assessment of how engaged people are in community activity to prevent family violence and promote healthy relationships.

What does the study involve?

Participation is voluntary, that is you do not have to participate. If you agree to participate in the research you will complete the attached questionnaire on activity in your community to prevent family violence and promote healthy relationships. You will not be asked about your own personal experiences of family violence or healthy relationships. The questionnaire asks about leadership, participation, skills, organisation, and attitudes and beliefs and will take about 10 minutes to complete. When you have completed the questionnaire, please place it in the sealed box that will be supplied for this purpose.

Will any one know that I have participated in the research?

You are being asked to complete an anonymous questionnaire. That means that you will not be asked for any information that could identify you, such as you name or address. Further no individual or organisation will be able to be identified in any written reports or oral presentation resulting from this study.

What will happen to the data?

Your questionnaire will be stored for 6 years in a locked filing cabinet in my supervisor's office and will then be destroyed by a confidential information destruction company.

What will happen to my information?

The data from your questionnaire will be collated with all other responses. This data may be used in my doctoral thesis, academic articles, reports, presentations, and other similar publications. A summary of the study findings will be made available in the community library on completion.

Thank you for considering this invitation to participate in my research.

If participating in the study raises issues that you would like to discuss with someone you can contact

Shine 0508 744 633 – a region wide family violence specialist service
The It's not OK information line 0800 456 450 - for advice and services in your area

Contact details

If you have any queries or concerns about this research please contact any of the people named below.

Researcher
Cristy Trewartha: phone 021 911 467 or email ctre015@aucklanduni.ac.nz

Supervisors
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz
Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz

Head of Department
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Phone 09 373 7599 ext 87830/ 83761 or email humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

Appendix 9

Community readiness consent forms and participant information sheets

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

CONSENT FORM
(Participant)
This form will be held for 6 years

Project title: Assessing community readiness to address family violence and promote healthy relationships.

Name of Researchers: Cristy Trewartha, Associate Professor Janet Fanslow, Research Assistants (2) (TBC).

I have read the Participant Information Sheet and have understood the nature of the research, and why I have been selected. I have had the opportunity to ask questions and have had them answered to my satisfaction. I am under no pressure to participate and am doing so voluntarily. I understand I will not be advantaged/ disadvantaged in anyway if I choose to participate or not in this study.

- I agree to take part in this research, which involves completing two interviews.
- I understand that I am free to withdraw participation at any time, and to withdraw any data traceable to me within one month after each of my interviews.
- I understand I can stop the audio recording at any time.
- I understand I will not receive a copy of my audio recording.
- I understand that a research assistant who has signed a confidentiality agreement will also listen to and analyse my recorded interview.
- I understand that data from my interview may be used in the student's doctoral thesis, academic articles, reports, presentations and other similar publications.
- I understand that if the information I provide is reported or published, this will be done in a way that does not identify me as the source.
- I understand that data will be kept for 6 years, after which they will be destroyed.
- I agree to be audio recorded. Yes / No
- I wish to receive a summary of the findings. Yes / No

If you would like to receive a summary of the findings please include your email address here
_____

Name: _____
Signature: _____
Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 October 2013 FOR 3 YEARS REFERENCE NUMBER 2013/010436

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

PARTICIPANT INFORMATION SHEET
(Participant)

Project title: Assessing community readiness to address family violence and promote healthy relationships.

Name of Researcher: Cristy Trewartha, PhD Candidate

Researcher introduction

My name is Cristy Trewartha. I am a doctoral student supervised by Associate Professor Janet Fanslow in the Department of Social and Community Health, School of Population Health, and Associate Professor Robyn Dixon from the School of Nursing at the University of Auckland. My doctoral research is looking at how communities might be involved in preventing family violence and promoting healthy relationships. The current study is the first step towards answering this question and involves an assessment of how "ready" the community you work and/ or live in is to participate in programmes of action to address these issues.

You are being invited to participate in this research project because of your knowledge of the activity in this community to prevent family violence and/ or promote healthy relationships.

What does the study involve?

If you agree to participate in the research you will be asked to take part in two interviews about either family violence, or healthy relationships in your community generally. One interview will be completed shortly, and the same interview will be completed again in 12 months time. It is important to note that you will not be asked about your own personal experiences of family violence or healthy relationships. A research assistant helping me with this study will conduct the interview. The interview will take approximately one hour, and can be completed face to face or over the phone. You will be asked questions about resources in the community, leadership, and attitudes about family violence or healthy relationships. With your permission we would like to audio record the interviews. Even if you agree to being recorded, you may choose to have the recording stopped at any time. Participation is voluntary and you have the right to withdraw from this study at any time without providing a reason, and you may withdraw your information within one month of completing each interview. In recognition of the time given to the project you will be offered a koha, in the form of a $20 grocery voucher.

Will any one know that I have participated in the research?

Your participation in this study will remain confidential to the researchers. Two research assistants will help me by conducting and analysing the interviews. The research assistants have signed a confidentiality agreement and will not discuss any information about your interview or your participation in this study with anyone other than me and my supervisors. Please note there will be no advantage or disadvantage to you for participating/ not participating in this study.

What will happen to the data?

With your consent the interviews will be audio recorded so that the research assistants can check the accuracy of the notes that they will be taking during the interview. Your interviews will not be transcribed, but it will be stored electronically on a USB (universal storage bus) device. The interview recordings and written material will be stored for 6 years in a locked filing cabinet in my supervisor's office and will then be destroyed by a confidential information destruction company.

What will happen to my information?

Data from your interviews may be used in my doctoral thesis, academic articles, reports, presentations, and other similar publications. Information will be presented in a way that will not allow you to be identified.

If you would like to receive a summary of the study findings please indicate this on the consent form, which accompanies this information sheet.

Thank you for considering this invitation to participate in my research.

If participating in the study raises issues that you would like to discuss with someone you can contact

Shine 0508 744 633 – a region wide family violence specialist service

The It's not OK information line 0800 456 450 - for advice and a range of services in your area

Contact details

If you have any queries or concerns about this research please contact any of the people named below.

Researcher

Cristy Trewartha: phone 021 911 467 or email ctre015@aucklanduni.ac.nz

Supervisors

Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz

Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz

Head of Department

Dr Peter Adams: phone 09 373 7599 ext 86538 or email p.adams@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair, the University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Phone 09 373 7599 ext 87830/ 83761 or email humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 17 October 2013 FOR 3 YEARS REFERENCE NUMBER 2013/010436

Appendix 10

Community readiness interview schedule

Community Readiness Assessment Interview Questions

A. COMMUNITY EFFORTS (programs, activities, policies, etc.)
AND
B. COMMUNITY KNOWLEDGE OF EFFORTS

1. **Using a scale from 1-10, how much of a concern is this issue in your community (with 1 being "not at all" and 10 being "a very great concern")? Please explain.** *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

2. **Please describe the efforts that are available in your community to address this issue.** (A)

3. **How long have these efforts been going on in your community?** (A)

4. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being "no awareness" and 10 being "very aware")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)* (B)

5. **What does the community know about these efforts or activities?** (B)

6. **What are the strengths of these efforts?** (B)

7. **What are the weaknesses of these efforts?** (B)

8. Who do these programs serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A)

9. Would there be any segments of the community for which these efforts/services may appear inaccessible? (Prompt: For example, individuals of a certain age group, ethnicity, income level, geographic region, etc.) (A)

10. Is there a need to expand these efforts/services? If not, why not? (A)

11. Is there any planning for efforts/services going on in your community surrounding this issue? If yes, please explain. (A)

12. What formal or informal policies, practices and laws related to this issue are in place in your community, and for how long? (Prompt: An example of "formal" would be established policies of schools, police, or courts. An example of "informal" would be similar to the police not responding to calls from a particular part of town, etc.) (A)

13. Are there segments of the community for which these policies, practices and laws may not apply? (Prompt: For example, due to socioeconomic status, ethnicity, age, etc.) (A)

14. Is there a need to expand these policies, practices and laws? If so, are there plans to expand them? Please explain. (A)

12

15. How does the community view these policies, practices and laws? (A)

C. LEADERSHIP

16. Who are the "leaders" specific to this issue in your community?

17. Using a scale from 1 to 10, how much of a concern is this issue to the leadership in your community (with 1 being "not at all" and 10 being "of great concern")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

18. How are these leaders involved in efforts regarding this issue? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)

19. Would the leadership support additional efforts? Please explain.

D. COMMUNITY CLIMATE

20. Describe _____ (name of your community).

21. Are there ever any circumstances in which members of your community might think that this issue should be tolerated? Please explain.

22. How does the community support the efforts to address this issue?

23. What are the primary obstacles to efforts addressing this issue in your community?

24. Based on the answers that you have provided so far, what do you think is the overall feeling among community members regarding this issue?

E. KNOWLEDGE ABOUT THE ISSUE

25. How knowledgeable are community members about this issue? Please explain. (Prompt: For example, dynamics, signs, symptoms, local statistics, effects on family and friends, etc.)

26. What type of information is available in your community regarding this issue?

27. What local data are available on this issue in your community?

28. How do people obtain this information in your community?

F. RESOURCES FOR PREVENTION EFFORTS (time, money, people, space, etc.)

29. To whom would an individual affected by this issue turn to first for help in your community? Why?

30. On a scale from 1 to 10, what is the level of expertise and training among those working on this issue (with 1 being "very low" and 10 being "very high")? Please explain. *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

31. Do efforts that address this issue have a broad base of volunteers?

32. What is the community's and/or local business' attitude about supporting efforts to address this issue, with people volunteering time, making financial donations, and/or providing space?

33. How are current efforts funded? Please explain.

34. Are you aware of any proposals or action plans that have been submitted for funding that address this issue in your community? If yes, please explain.

35. Do you know if there is any evaluation of efforts that are in place to address this issue? If yes, on a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being "not at all" and 10 being "very sophisticated?")? *(NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)*

36. Are the evaluation results being used to make changes in programs, activities, or policies or to start new ones?

Appendix 11

Community readiness assessment researcher confidentiality agreement

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

RESEARCHER CONFIDENTIALITY AGREEMENT

Project title: Assessing community readiness to address family violence and promote healthy relationships.

Researcher: Cristy Trewartha

Supervisors: Dr Janet Fanslow and Dr Robyn Dixon

I agree to administer the Community Readiness Model questionnaire for the above research project and to analyse and score the interviews. I understand that the information contained within the interviews is confidential and must not be disclosed to, or discussed with, anyone other than the researcher and her supervisors.

Name: _____

Signature: _____

Date: _____

Appendix 12

Ethics approvals

Office of the Vice-Chancellor
Finance, Ehtics and Compliance

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Level 10, 49 Symonds Street
Telephone: 64 9 373 7599
Extension: 87830 / 83761
Facsimile: 64 9 373 7432

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE (UAHPEC)

06-Oct-2014

MEMORANDUM TO:

Assoc Prof Janet Fanslow
Social & Community Health

Re: Application for Ethics Approval (Our Ref. 013083): Approved with comment

The Committee considered your application for ethics approval for your project entitled **Assessing engagement in community mobilisation activity to prevent family violence and promote healthy relationships.** .

Ethics approval was given for a period of three years with the following comment(s):

1. Please provide more information on the PIS documents about who the community leaders and organisations are (are these church groups, sports clubs, school leaders….?).

2. Please add to the PIS forms for the community leader what the research data will be used for (thesis, publications, presentations, etc.).

The expiry date for this approval is 06-Oct-2017.

If the project changes significantly you are required to resubmit a new application to UAHPEC for further consideration.

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals if you wish to do so. Contact should be made through the UAHPEC Ethics Administrators at ro-ethics@auckland.ac.nz in the first instance.

All communication with the UAHPEC regarding this application should include this reference number: **013083**.

(This is a computer generated letter. No signature required.)

Secretary

University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Social & Community Health
Assoc Prof Robyn Dixon
Ms Cristy Trewartha

Additional information:

1. Should you need to make any changes to the project, write to the Committee giving full details including revised documentation.

2. Should you require an extension, write to the Committee before the expiry date giving full details along with revised documentation. An extension can be granted for up to three years, after which time you must make a new application.

3. At the end of three years, or if the project is completed before the expiry, you are requested to advise the Committee of its completion.

4. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

5. Send a copy of this approval letter to the Awards Team at the, Research Office if you have obtained funding other than from UniServices. For UniServices contract, send a copy of the approval letter to: Contract Manager, UniServices.

6. Please note that the Committee may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.

Office of the Vice-Chancellor
Research Integrity Unit

The University of Auckland
Private Bag 92019
Auckland, New Zealand

Level 10, 49 Symonds Street
Telephone: 64 9 373 7599
Extension: 87830 / 83761
Facsimile: 64 9 373 7432

UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE

17-Oct-2013

MEMORANDUM TO:

Assoc Prof Janet Fanslow
Social & Community Health

Re: Application for Ethics Approval (Our Ref. 010436)

The Committee considered your application for ethics approval for your project entitled **Assessing community readiness to address family violence and promote healthy relationships.**.

Ethics approval was given for a period of three years.

The expiry date for this approval is 17-Oct-2016.

If the project changes significantly, you are required to submit a new application to UAHPEC for further considerat

In order that an up-to-date record can be maintained, you are requested to notify UAHPEC once your project is completed.

The Chair and the members of UAHPEC would be happy to discuss general matters relating to ethics approvals if y wish to do so. Contact should be made through the UAHPEC Ethics Administrators at humanethics@auckland.ac.n the first instance.

All communication with the UAHPEC regarding this application should include this reference number: **010436**.

(This is a computer generated letter. No signature required.)

UAHPEC Administrators
University of Auckland Human Participants Ethics Committee

c.c. Head of Department / School, Social & Community Health
Ms Cristy Trewartha
Assoc Prof Robyn Dixon
Dr Denise Greenwood

Additional information:

1. Do not forget to fill in the 'approval wording' on the Participant Information Sheets and Consent Forms, giving the dates of approval and the reference number, before you send them out to your participants.

2. Should you need to make any changes to the project, write to the UAHPEC Administrators by email (humanethics@auckland.ac.nz) giving full details of the proposed changes including revised documentation.

3. At the end of three years, or if the project is completed before the expiry, please advise UAHPEC of its completion.

4. Should you require an extension, write to UAHPEC by email before the expiry date, giving full details

along with revised documentation. An extension can be granted for up to three years, after which a new application must be submitted.

5. If you have obtained funding other than from UniServices, send a copy of this approval letter to the Manager - Funding Processes, UoA Research Office. For UniServices contracts, send a copy of the approval letter to the Contract Manager, UniServices.

6. Please note that UAHPEC may from time to time conduct audits of approved projects to ensure that the research has been carried out according to the approval that was given.

Appendix 13

Documentation consent form and participant information sheet

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

CONSENT FORM
This form will be held for 6 years

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.

Name of Researchers: Cristy Trewartha, PhD Candidate

I have read the Participant Information Sheet and understand the nature of this request for information. I have had the opportunity to ask questions and have had them answered to my satisfaction.

- I agree to provide organisational reports (including monthly reports and any other relevant reports, research and evaluation), or an activity description log on activity to prevent family violence or promote healthy relationship between the period of April 2014 and October 2016.
- I understand that I can remove any information that is sensitive or confidential from reports or information before it is provided to the researcher.
- I understand that any information contained in the reports that is not relevant to this study will remain confidential.
- I understand that the information on activity to prevent family violence and promote healthy relationships may be used in the researcher's doctoral thesis, academic articles, reports, presentations and other similar publications.
- I agree to provide the requested information to the researcher before November 2016.
- I have the authority to sign this consent form for my organisation.

If you would like to receive a summary of the findings please include your email address here _____

Name: _____
Signature: _____
Organisation: _____
Date: _____

Contact details

If you have any queries or concerns about this research please any of the people named below:

Researcher
Cristy Trewartha: email ctre015@aucklanduni.ac.nz

Supervisors
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz
Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

SCHOOL OF POPULATION HEALTH
Social & Community Health
Bldg 730 Level 3
North Entrance, Tamaki Campus
261 Morrin Road, Glenn Innes
Telephone: 64 9 373 7599

PARTICIPANT INFORMATION SHEET

Project title: Assessing engagement in community mobilisation activity to address family violence and promote healthy relationships.

Name of Researcher: Cristy Trewartha, PhD Candidate

Researcher introduction

My name is Cristy Trewartha. I am a doctoral student supervised by Associate Professor Janet Fanslow in the Department of Social and Community Health, School of Population Health, and Associate Professor Robyn Dixon, School of Nursing, at the University of Auckland. My doctoral research is looking at how communities might be involved in preventing family violence and promoting healthy relationships.

This information request

As you know I am collecting data about community mobilisation and community readiness to prevent family violence and promote healthy relationships in your community. To provide context to the findings from these assessments I need to document the activity that has been implemented to prevent family violence or promote healthy relationships in [COMMUNITY NAME]. To do this I am asking for your permission to access existing organisational reports (e.g. monthly reports, and any other relevant reports, research and evaluation) that document activity in the community to prevent family violence or promote healthy relationships. The period I am interested in is between April 2014 and October 2016. This is the period of time between the first and second community readiness and community mobilisation assessments.

Please provide the reports in an electronic format (e.g. Word file or pdf.). If you would prefer not to provide the full reports you could instead complete an activity description log on the template I provide you with.

Anonymity and confidentiality

The organisations who provide reports for this analysis will not be named. Also the organisation who implements each activity will not be named. You may remove any information within the reports that is sensitive or confidential before providing the reports to me. Please de-identify any information about individuals before providing reports to me. Any information contained in the reports that is not relevant to this study will remain confidential.

What will the information be used for?

Information from the reports provided may be used in my doctoral thesis, academic articles, reports, presentations and other similar publications.

How will the data be stored?

The reports will be stored electronically on the University's server for six years, and will then be deleted.

Thank you for considering this invitation to participate in my research.

If you agree to assist with the study would you please complete the attached consent form.

Contact details

If you have any queries or concerns about this research please contact any of the people named below.

Researcher
Cristy Trewartha: email ctre015@aucklanduni.ac.nz

Supervisors
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz
Dr Robyn Dixon: phone 09 373 7599 ext 87388 or email r.dixon@auckland.ac.nz

Head of Department
Dr Janet Fanslow: phone 09 373 7599 ext 86970 or email j.fanslow@auckland.ac.nz

For any concerns regarding ethical issues you may contact the Chair, the University of Auckland Human Participants Ethics Committee, at the University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 3737599 ext. 83711. Email: roethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 6th OCTOBER 2014 FOR 3 YEARS REFERENCE NUMBER 013083

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